



Baseline Assessment: Alaska's Capacity and Infrastructure for Prescription Opioid Misuse Prevention

Alaska's Partnerships for Success Technical Report No. 2

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Executive Summary

The State of Alaska Department of Health and Social Services (DHSS), Division of Behavioral Health (DBH) was awarded the Partnerships for Success (PFS) grant by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2015. DBH contracted with the Center for Behavioral Health Research and Services (CBHRS) at the University of Alaska Anchorage (UAA) to conduct a comprehensive project evaluation. As part of the evaluation, CBHRS performed a baseline assessment of the state’s capacity and infrastructure related to prescription opioid misuse prevention.

Researchers conducted interviews with key stakeholders representing state government, healthcare agencies, law enforcement, substance abuse research, and service agencies. Interviews were semi-structured, with questions addressing five domains of interest: (1) state climate and prevention efforts; (2) partnerships and coordinated efforts; (3) policies, practices, and laws; (4) data and data monitoring; and (5) knowledge and readiness. Thirteen interviews were conducted and analyzed using a qualitative template analysis technique combined with a SWOT analysis (i.e. strengths, weaknesses, opportunities, and threats). Emergent themes are displayed in Table 1 below.

Table 1. Emergent themes from SWOT analysis

Strengths	Weaknesses	Opportunities	Threats
(1) New and revised policies and guidelines (2) Activities and partnerships between state agencies and communities (3) Knowledge and awareness of state leadership	(1) State policy limitations (2) Insufficient detox, treatment, and recovery support resources (3) Lack of full coordination within state agencies and with communities	(1) Education enrichment (2) Policy improvements (3) Expansion of treatment, recovery, and mental health support	(1) State fiscal crisis (2) Prescribing practices (3) Complexity and stigma of addiction (4) Legislative support

Despite limitations in sample representativeness and interview timing, participants agreed that agencies, communities, and organizations across Alaska have demonstrated great concern about the opioid epidemic and that this concern has translated into considerable efforts to address and prevent opioid misuse. Participants also noted a variety of opportunities as targets for future work, many of which would address some of the current weaknesses that exist. Results yielded clear recommendations for increasing awareness and providing education to a variety of groups, further improving relevant policies to promote prevention, and expanding services for prevention and treatment.

Introduction

In September of 2015, SAMSHA awarded the PFS grant to the State of Alaska DHSS, DBH. This five-year grant program focuses on preventing and reducing substance use and building prevention capacity and infrastructure at both the state and community level. Two priority areas were chosen for the Alaska PFS grant: non-medical use of prescription opioids among 12-25 year olds and heroin use among 18-25 year olds. [Please see Alaska’s Partnership for Success Grant – Technical Report 1 for quantitative data summaries related to these two priority areas.]

The PFS project funds community-level coalitions to engage in prevention and intervention activities; DBH provides leadership for the project and guidance to the coalitions and works to help strengthen the state’s prevention capacity and infrastructure. DBH contracted with the Center for Behavioral Health Research and Services (CBHRS), part of the Institute of Social and Economic Research (ISER) at the University of Alaska Anchorage (UAA), to conduct a comprehensive evaluation of the PFS project.

Strategic Prevention Framework

Drawing on a public health approach to behavioral health prevention, the SPF uses a data-driven process of five steps: **1 - assessment (i.e., identify the extent of the problem and the contributing factors); 2 - build capacity (i.e., identify resources and readiness); 3 - plan (i.e., develop a plan to address the problem and build capacity); 4 - implement (i.e., put the plan into action); and 5 - evaluate (i.e., determine effectiveness).**¹ As illustrated in Figure 1, the steps are related and the process can often be iterative. The SPF also includes two core principles: **cultural competence and sustainability.** The principle of cultural competence emphasizes the importance of working and interacting effectively with individuals of different cultures and being respectful and responsive to cultural differences.

The focus of sustainability is to ensure that effective programs that achieve prevention outcomes can persist. Sustainability involves garnering support from stakeholders and communities, demonstrating effectiveness and results, and acquiring ongoing funding and resources.



Figure 1: Substance Abuse and Mental Health Services Administration - Strategic Prevention Framework.¹

State Capacity & Infrastructure

The capacity and infrastructure of Alaska is an important factor that will contribute to the success of the PFS project. In this context, capacity is Alaska’s readiness and ability to address opioid misuse among Alaskans and the related problems occurring in the state. Capacity includes funding and resources allocated for addressing opioid issues. Infrastructure is defined as the fundamental elements of the systems working to address opioid issues and includes climate, policies, and partnerships. Assessment of the existing capacity and infrastructure allows for the identification of those resources and structural

¹ Substance Abuse and Mental Health Services Administration, “Applying the Strategic Prevention Framework (SPF),” Center for the Application of Prevention Technologies, last modified June 22, 2016. <https://www.samhsa.gov/capt/applying-strategic-prevention-framework>.

elements addressing non-medical use of prescription opioids, recognition of any gaps, and information to develop recommendations to enhance opioid prevention efforts through PFS activities.

To determine a baseline from which to evaluate the impact of the PFS project on Alaska's capacity and infrastructure related to opioid misuse prevention in Alaska, researchers from CBHRS conducted key informant interviews with stakeholders from a variety of relevant sectors. While the overall PFS project aims to address both prescription opioid misuse and heroin use, the capacity and infrastructure evaluation is specific to prescription opioids, the primary substance of focus for the PFS project. In addition to serving as a baseline, results from this assessment will assist the state and funded communities in identifying opportunities to enhance capacity and infrastructure for opioid misuse prevention.

Methodology

A semi-structured interview model was used to assess prevention capacity and infrastructure at the state level. This activity was reviewed and approved by the UAA Institutional Review Board (IRB) for research with human subjects.

Key stakeholders were interviewed to gather their perspectives on five domains:

- (1) State climate and prevention efforts
- (2) Partnerships and coordinated efforts
- (3) Policies, practices, and laws
- (4) Data and data monitoring
- (5) Knowledge and readiness

The interview guide consisted of a small number of scaled questions and a series of open-ended questions in each domain. Responses to the scaled questions will be used to compare responses from this administration (baseline) to responses provided during follow-up administration at the end of the PFS project in 2019. Open-ended questions extracted in-depth context for the numbered response and other information unique to the domain such as participants' perceptions of what is working well, what is not working well, areas of improvement, and any new ideas related to the domain. The interview guide included additional probing questions for use as needed. Closing questions provided participants the opportunity to offer any further comments or suggestions.

Participant Recruitment

Potential interview participants were identified based on either an individual's leadership position in the Alaska state government or involvement with and knowledge of current state-level efforts related to prescription opioid misuse. These individuals represented a variety of state departments and local agencies such as State of Alaska DHSS, law enforcement, education, service organizations, healthcare and treatment organizations, and pharmacies.

Potential key informants were contacted by email to request their participation in the baseline interviews. Initial emails were sent in July 2016 and described the purpose of the interview, explained to individuals why their participation was important and included an attached consent form. Participants were asked to respond via email or phone if they were willing to participate and interviews were scheduled. Follow-up emails were sent in mid-September with a letter of support from the leadership of the Alaska Department of Health and Social Services, Division of Behavioral health.

The initial recruitment effort yielded a smaller-than-expected response. Thus, a second group of potential participants was identified, and those individuals were also invited to participate. For non-responders, final attempts to contact were made via telephone.

Between July 2016 and November 2016, 27 potential key informants were contacted and invited to participate.

Interviews

Sixteen (16) key informants agreed to participate and were interviewed via telephone. The interviews began with a review of the IRB-approved informed consent, including language ensuring participation was voluntary. Before starting the interview, the interviewer gave participants the opportunity to ask questions or voice concerns about the interview or informed consent. Each respondent gave verbal consent to participate in an interview and be audio recorded prior to completion of the semi-structured interview. Interviews ranged from fifteen to ninety minutes in duration. Once completed, interviews were transcribed verbatim and uploaded into NVivo qualitative data software for analysis.

Three of the key informants did not participate fully in the interviews, resulting in insufficient information for analysis. Reasons included lack of relevant knowledge, insufficient confidence to respond accurately to questions and prompts, and misconceptions about the purpose of the interviews. Therefore, of the sixteen interviews performed, thirteen were retained and analyzed.

Qualitative Analysis

A thematic template analysis technique was used to construct a coding guide for analysis of the interviews. Template analysis is a preferred qualitative analysis technique when researchers have pre-existing ideas of structured themes before beginning analysis.² In building the first coding template, the primary coding themes were the five domains used in the interview guide (i.e., climate; partnership; policies, laws, and practices; data; knowledge and readiness).

Given the questions in the interview guide and the goal of analysis, the data was also suitable for a SWOT (i.e. strengths, weaknesses, opportunities, threats) analysis. The final coding template combined the five domains with a basic SWOT structure to organize themes.

All data was coded initially by a single researcher for domain(s) and SWOT category. Cross-analysis of the domains by SWOT categories allowed for the identification of similar or overlapping content and the organization of data into themes.

Table 2. SWOT analysis table

	Strengths	Weaknesses	Opportunities	Threats
Climate				
Partnership				
Policies, Laws, & Practices				
Data				
Knowledge & Readiness				

² Nigel King, "Doing Template Analysis," in *Qualitative Organizational Research: Core Methods and Current Challenges*, ed. Gillian Symon and Catherine Cassell (London, UK: SAGE Publications Ltd, 2012), 428-429.

A second researcher reviewed the coding and initial themes, refining and condensing the themes into the dominant themes with the greatest significance to the capacity and infrastructure of the state. Finally, the interviewer and first researcher reviewed the refined themes and created a final version for which there was consensus among all three (i.e. interviewer, first researcher, and second researcher).

Results

Results of the SWOT analysis are presented below and organized by SWOT category. Participant quotes are provided and identified by participant category (i.e. state employee, law enforcement officer, healthcare provider, etc.) and random identifier.

Strengths

Three overarching strengths emerged regarding prevention of and intervention for prescription opioid misuse in Alaska:

- (1) New and revised policies and guidelines
- (2) Activities of and partnerships between state agencies and communities
- (3) Knowledge and awareness of state leadership

1.) New and Revised Policies and Guidelines

Participants discussed recent changes to state policies that they believed were advantageous for addressing opioid misuse in Alaska. Informants mentioned multiple policies and improvements, including new Prescription Drug Monitoring Program (PDMP) regulations, expansion of Alaska Medicaid, new legislation providing protection and immunity from arrest and incarceration for certain drug-related offenses, and improved access to Naloxone. Though not specific to Alaska, participants also mentioned the Center for Disease Control and Prevention's (CDC's) guidelines for prescribing opioids for pain management as a strength. A state employee (D) suggested this resource could be a useful resource for creating prescribing policies in Alaska, saying:

"I think we should develop new policies or laws related to prescribing practices. I know the CDC has come out with a lot of recommendations."

Alaska Senate Bill (SB) 74, passed in 2016, includes two major improvements: new PDMP requirements and Medicaid expansion. When asked about policy strengths, a state employee (F) described SB 74, saying:

"SB 74, which was our omnibus Medicaid Reform Bill, [and it] included all the recommendations of the controlled substances advisory committee to strengthen the Prescription Drug Monitoring Program."

SB 74 imposed new regulations for the use of the PDMP, making it mandatory for prescribers and dispensers to register and report weekly on controlled substances prescribed and dispensed. These regulations are intended to enhance the ability of providers and dispensers to responsibly and ethically provide their patients prescription opioids and reduce non-medical use by patients and others. A state employee (K) described the improvements of the bill, stating:

"...the bill coming up - what's called SB74, the Medicaid Reform Bill - it made some changes as far as access to the PDMP. And also, made some mandatory use and registration with it."

Though participants acknowledged that these new PDMP requirements do not fully go into effect until July 2017, participants nonetheless described the regulations as a significant improvement to the

PDMP's tracking capability by increasing its use. A state employee (B) described how the changes will be meaningful, saying SB 74:

"...finally made the PDMP useful. That's a Prescription Drug Monitoring Program, and I think that it really wasn't very useful, because most doctors didn't use it, and they didn't check it regularly. I think a year from now, it will have to – all doctors will have to start, and pharmacists will have to start checking it, and I think that will make a difference."

Participants also discussed that the new PDMP regulations will improve the ability of PDMP users to guard against doctor-shopping behavior (i.e., visiting more than one physician in order to obtain multiple prescriptions) among patients. An state employee (K) discussed how these PDMP improvements would assist providers, saying:

"... for some it's going to be an eye-opener. 'Wow, I was scammed for a long time... This is someone I've known for years and didn't realize I was getting scammed.'"

Another state employee (F) emphasized the benefit of the PDMP with an example, saying:

"... (a provider) thought it was a little funny when he had a patient who was five years old with a chronic condition that he really was not excited about treating with opioids but was another physician's patient. But he (the provider) got a little suspicious when the mother said he (the patient) can't swallow syrup. He likes the 20-mg pill. And lo and behold when he went on the PDMP he was the third pediatrician she had seen in the past two weeks."

Overall, participants discussed multiple ways that the PDMP can be an effective method to help providers and dispensers recognize when patients are engaging in concerning or illegal behaviors and use that information to respond appropriately, including by limiting access to opioids.

SB 74 also expanded Medicaid to cover treatment for opioid addiction. Participants emphasized that this change should make treatment resources more accessible to Alaskans. A state employee (F) described this change, saying:

"So, the Medicaid reform, as well as Medicaid expansion, will help expand access to treatment for people who are 'recovery ready,' as we say."

Participants indicated that treatment access hinges on affordability and having Medicaid pay for this type of care would increase people's access. A healthcare provider (C) explained this further by saying:

"...we'll be able to accept Medicaid. Once that happens, that will certainly increase the number of people that we'll be able to address that have opioid use disorders, besides individuals that will self-pay or have insurance."

Another Alaska Senate Bill, SB 23, was also identified as a significant policy strength by interview participants who indicated the bill removed a major barrier to accessing and administering naloxone. Naloxone is medication that can prevent overdose death by reversing the effects of an opioid overdose and restoring respiration. In reference to SB 23, a state employee (I) described it as a law that removes barriers faced by providers, pharmacists, and responders or the public, saying SB 23 is:

"...a law providing immunity from civil penalties for prescribing and providing and administering Naloxone."

Participants also mentioned Alaska's Good Samaritan law as a policy strength. The law provides some immunity from arrest, charges, and prosecution for possession of certain controlled substances or drug paraphernalia for individuals who seek medical assistance during an overdose situation. A state employee (D) described this law as:

"...a mitigation law that encourages emergency treatment of people experiencing drug overdoses, by making the act of seeking help in an overdose a mitigating factor in a prosecution or at sentencing."

Participants clarified, though, that this mitigation law only applies to individuals seeking help for experiencing an overdose or witnessing another person overdose and that the protection does not extend beyond drug possession to other crimes. The same state employee (D) said:

“Good Samaritan laws do not protect people from arrest for other offenses, such as drug trafficking or selling or driving while drugged.”

Despite some limitations, participants were clear that SB 74, SB 23, and the Good Samaritan law were policy strengths for Alaska in that they help prevent opioid misuse and fatal overdoses by reducing the availability of opioids for misuse, expanding access to treatment, making a lifesaving drug more available to Alaskans, and reducing a major barrier to seeking medical assistance during an overdose situation.

2.) Activities and Partnerships between State Agencies and Communities

A second set of strengths identified by participants related to preventing opioid misuse is the array of activities and partnerships within and between State of Alaska agencies and Alaskan communities.

Participants identified numerous activities led by State of Alaska agencies to build support and momentum for prevention and intervention, particularly the Alaska Opioid Policy Task Force. The Task Force was identified as a major strength for initiating state policy reform by demonstrating a partnership between state agencies and community-based agencies. A substance abuse researcher (H) described the diverse composition of the task force as a strength in communication and coordination, saying:

“...the task force includes folks from the board on alcoholism and drug abuse, and they're cooperating and collaborating with DHSS and the [Alaska Mental Health] Trust, I think, is probably a clear sign of some of that communication and coordination.”

Participants indicated that having many diverse perspectives increases the group's ability to make informed decisions on policies. A healthcare administrator (L) also described the group's diversity as intentional, saying:

“...they've created a statewide Opioid Task Force, and this task force was developed to simply pull many disciplines across the board together to convene at one table and to discuss how we're going to battle this issue.”

Participants were especially impressed that the task force actively sought out and included the perspectives of people with intimate ties to opioid misuse in their discussions. The same healthcare administrator (L) described how impressed she was with the inclusion of people in recovery as well as the friends and families of people with an opioid addiction, stating:

“They really acknowledge the importance of lived experience from families that are affected by this disease, and then hearing from individuals in long-term recovery.”

Participants also identified other efforts within State of Alaska agencies as strengths, including the State Epidemiology Workgroup, the State Internal Opioid Working Group, funded community coalitions working on PFS, and groups working on other federal grant applications and projects.

Participants stressed the importance of federal grants to support efforts to prevent and address opioid misuse. A state employee (F) emphasized the importance of having federal grants to expand services, particularly with the current Alaska fiscal environment, stating:

“As you're probably aware we have a (fiscal) crisis in Alaska right now. So, it's going to be very limited to what we'll be able to do with new unrestricted general funds. So, we are going to be very dependent on some new federal funds to be able to address this epidemic.”

With federal grant funds, the state has implemented initiatives such as the PFS project, which help the state build stronger bonds with community organizations to address each community's unique needs. A substance abuse researcher (H) indicated that the state had received a grant allowing them to fund community prevention efforts, saying:

"I do know that one of the local grantees for that SPF grant that was awarded in Anchorage was awarded to a couple of coalitions, and they're collaborating together. So, I know about that collaboration. And my understanding is that there was also an award made for one or more groups in Mat-Su..."

Informants indicated grant funding was so important that some partnerships dedicated group responsibilities to searching for more grants targeting opioid misuse. A state employee (D) discussed the Internal Opioid Working Group, a partnership between the State of Alaska Divisions of Public and Behavioral Health, which has prioritized searching for grants and other funding opportunities as one of its primary responsibilities, saying:

"It (Internal Opioid Working Group) will focus on coordination of future funding opportunities because I know there are a lot of federal funding opportunities coming out for this epidemic."

Beyond the efforts within State agencies, respondents noted a prominent improvement in collaborative efforts between the agencies and community organizations than previously witnessed. A state employee (I) described observing a surge in new partnerships because of the rising prevalence of opioid-related issues, saying:

"...I think we're just starting to see more and more partnerships being built. We've always had these partnerships on some level, but they're being strengthened as a result of our unified interest and dedication to trying to combat this epidemic."

Participants discussed improvements in collaborative prevention efforts that expanded the engagement of community organizations in prevention and increased communication. Participants described local efforts throughout the state, with a state employee (B) saying:

"And there are of course now a number of local opioid groups that have formed, both in the valley and in Fairbanks in the southeast. So, I think there's evidence of a lot of communication and education and advocacy going on."

A law enforcement officer (G) further described local efforts that exist throughout the state, commenting:

"...there are a lot of smaller homegrown efforts out there as well. I know folks out in the Mat-Su have also been very, very engaged and involved, probably on a statewide level, but certainly their focus is in the Mat-Su Valley. Same thing down in southeast Alaska. I know in Juneau they've done a lot of work down there..."

3.) Knowledge and Awareness of State Leadership

A third strength emerged from participants' descriptions of state leadership. Participants indicated there were some particularly knowledgeable leaders within state agencies and other leaders had, at a minimum, a general awareness of the issues. Participants cited the leadership of the State of Alaska Divisions of Public and Behavioral Health as particularly knowledgeable and active in prioritizing

prevention of and intervention for opioid misuse. Multiple state employees (I; B) acknowledged strengths of leadership within these divisions, commenting:

"...our leadership in the Division of Public Health and the Division of Behavioral Health are very sharp, and really, I think, have a lot of expertise and knowledge in this area."

"...there are many people, particularly in the Division of Public Health and some in my own division [Behavioral Health], who are extremely knowledgeable."

At higher levels of state government, the executive and legislative level, participants indicated they were aware of the problems, but not necessarily knowledgeable about them. One state employee (F) described both branches by saying:

"The executive branch is very aware. The legislative branch is also very aware."

A law enforcement officer (G) echoed the belief that upper-level state leadership was aware but described uncertainty about the depth of knowledge, saying:

"...the state leadership that I'm aware of is paying attention to the legislative discussions, as I said, having met with the governor on a couple of occasions, I know they know there are issues out there. But I don't know how deep that knowledge is."

Weaknesses

Though participants described considerable improvements to addressing opioid misuse within Alaska government agencies and communities, three weaknesses also emerged:

- (1) State policy limitations
- (2) Insufficient detox, treatment, and recovery support resources
- (3) Lack of full coordination within state agencies and with communities

1.) State Policy Limitations

Participants agreed there had been considerable improvements made to state policies with more improvements planned for the near future, but weaknesses persisted. The areas of weakness focused on limitations of the PDMP and the criminal justice approach to addressing substance abuse, including opioid misuse.

For the PDMP, the shortcomings identified surrounded limitations in reporting responsibilities, use, and data reporting capabilities. Participants discussed problems caused by limited access to the PDMP. At the time of the interviews, only prescribing providers and pharmacists had direct access, meaning they were the only people at their organization with access to patients' records. A state employee (M) discussed this limitation of the program's capabilities and its inconsistent nature compared to most other functions within a medical setting, saying:

"... our program did not allow clinicians to delegate looking up the patient's history on file, even though your staff would have complete access to the patient's file."

Participants indicated limited access was a problem because time was a major limiting factor for providers and dispensers, and just adds more work to an already cumbersome workload. A pharmacist (E) often mentioned pharmacists did not have time to check the PDMP, saying:

"I mean pharmacists do not have time to make phone calls like that [phone calls to providers and other pharmacies to inquire about patients' prescription history], and rarely have time to look somebody up on a Prescription Drug Monitoring Program. So, I think it would be very difficult."

The second PDMP weakness identified was a lack of current or forthcoming requirements for providers or dispensers to review the database before prescribing or dispensing a controlled substance. A state employee (D) described that SB 74 will make only registration and reporting mandatory for providers and dispensers, saying:

“...providers will not be required to check the database before prescribing or dispensing controlled-substances, which is a problem.”

Other participants understood the forthcoming regulations differently. Another state employee (K) suggested that providers and dispensers would be required to check the PDMP, saying:

“...a prescriber, dispenser, if they're going to dispense or prescribe some Schedule II or III, it's mandatory they look in the prescription database to see if their patient or client, or whatever, is possibly misused or has another prescription for the same material.”

A second policy weakness identified by participants is the current criminal justice approach to preventing and treatment substance abuse. A state employee (F) described this weakness as:

“Probably the big thing is the criminal justice based approach. That as long as we see opioids as just bad decisions and not recognizing that the pathological use is often times addiction and address it as such we're not going to be able to solve this.”

A law enforcement officer (G) further emphasized this same point, saying:

“...drug or alcohol or substance abuse in general often leads to criminality not because an addict themselves is a criminal, but they may enact or engage in criminal behavior to sustain their addiction. And having those open and honest discussions, and I think trying to encourage people that are in career path in the law enforcement side of the house to have empathy and try to understand that addiction is more than just criminal behavior. Sometimes it involves criminal behavior, but oftentimes it does not, and it can affect anybody.”

A related specific weakness encountered by the criminal justice community is a lack of an established diversion program that would allow individuals to be diverted to treatment rather than detention. A law enforcement officer (G) explained:

“Then on the federal side, of course, one of the things that we've been lacking here in Alaska in particular is a diversion program...”

2.) Insufficient Detox, Treatment, and Recovery Support Resources

A concern identified by nearly all participants was the insufficient availability of detox, addiction treatment, and recovery support resources. A human service organization administrator (A) indicated the necessity of more detox beds, saying:

“We don't have enough detox beds, but when you are using that heavy-duty drug as an opioid, you have to go somewhere to detox.”

While some resources exist, participants indicated that they are not readily available to those who need more immediate care. Participants described this lack of availability and suggested that it might influence whether people seek help. A law enforcement officer (G) described:

“There just isn't a lot of availability, and for the availability that is there the waiting list is fairly long, and many folks know about these types of challenges.”

A healthcare administrator (L) further discussed the scarcity of services as a danger to individuals who are ready to seek treatment, saying:

“When somebody decides that they want help or they need help that door needs to be available and open to them right away, otherwise it won't take long for them to change their mind or put it off to another day and they never ultimately get the help they need.”

Affordability was another obstacle identified because treatment is expensive, regardless of whether the individual has insurance. A healthcare provider (C) described how the current health insurance climate does not make treatment affordable for everyone ready to start, stating:

“There is still a bottleneck, I think, in being able to get in and be seen, whether or not you have insurance or not, because not everybody does take Medicaid and then, if you have insurance, there's a huge deductible and treatment isn't cheap nor are the meds.”

In addition, participants indicated addiction treatment was only one part of the recovery process as struggles with addiction are often lifelong. A healthcare administrator (L) emphasized the necessity of continual support, stating:

“When an individual is sober, their lifelong chronic brain disease, the relapse, will continue for the rest of their lives. They constantly need to live a well-balanced life and access ongoing supports and resources.”

Because of a lack of treatment resources and an established diversion program, people engaging in criminal behaviors are frequently incarcerated rather than placed in substance abuse treatment. Participants discussed the lack of support for individuals after they are released from incarceration which increases their likelihood of relapse and overdose. A healthcare provider (C) with experience working in an Alaskan prison stated:

“...they, of course, would be at increased risk of overdose once they get out. Losing tolerance and then resuming drug use.”

Another barrier mentioned was the particular lack of treatment resources for individuals living in rural areas. A healthcare administrator (L) described that some effective treatments are only available in cities, saying:

“...people who are successfully on medications as treatment here in Anchorage, and one that really works for them, not one that they have to default to, they may not be able to go home back to their village, because that medication is not on the formulary, or that there's no prescriber authorized to provide that type of medication to clients out in that village or that region.”

3.) Lack of Full Coordination within State Agencies and with Communities

A lack of coordination and communication among state government agencies, local governments, and community groups emerged as another substantial weakness. While respondents indicated observing some improvement in coordination, some challenges remained. A substance abuse researcher (H) described:

“I feel like we're probably moving in that direction of communication and coordination, but I think right now we're probably more like a seventh-grade dance with people sort of doing some hand-holding, but a little bit of tripping over each other's feet as well.”

Participants indicated there were still people, state departments, and organizations that were not involved that should be. A human services organization administrator (A) said:

"...there are a lot of departments in our State that people forget ought to be involved in this I think... I don't see the Department of Transportation and people are driving when they are high and killing people and I don't see the Department of Education and kids are going to school and selling those drugs to their good little friends who are in sixth grade or whatever."

Participants described that the State of Alaska agencies had not been active enough in engaging other departments and community agencies. A law enforcement officer (G) noted that the state coordination was inadequate and outreach had often originated from local communities to the state, saying:

"It doesn't feel to me like somebody's actually behind the scenes coordinating this either at the state level, the local level obviously coordinates it, but a lot of times the state partners seem to get invited into these discussions, which are very valuable. But if I'm evaluating proactive coordination it seems to me like it's relatively low..."

Participants also discussed that Alaska's variety of cultural perspectives had not been represented or taken into consideration for existing efforts and activities targeting prescription opioid misuse. A healthcare administrator (L) indicated that state-level discussions and coordination did not involve tribal health organizations, saying:

"I know that for my own organization... people felt like there wasn't enough tribal representation."

Opportunities

Three distinct types of opportunities emerged from participants' responses:

- (1) Education enrichment
- (2) Policy improvements
- (3) Expansion of treatment, recovery, and mental health support

1.) Education Enrichment

All participants agreed that an ongoing focus should be on providing education. They suggested belief in education as the primary source of change, and the Alaskan population, as a whole, could be more educated on this subject. A law enforcement officer (G), asked to describe the three most important steps for addressing opioid misuse, said:

"Education, education and education."

Elaborating, the law enforcement officer (G) implied that people needed more education at all levels and abstinence-based education would not suffice, saying:

"I think education, for young people in particular, but for parents, for kids, in the homes, in their schools, in community venues, community arenas, and again, not the "Just say no.""

Participants discussed a number of misconceptions that could be addressed through education. A state employee (K) elaborated on people's misconceptions and knowledge of harm, saying:

"I think it's going to come back the education part. I think there's a lack of information when it comes to people thinking a prescription drug can't hurt you. It's an age old thing but a lot of people think it's a prescription drug and it can't hurt you. It's got to be a public education when it comes to also sharing your medication. Just because you have an Oxycodone that alleviates your pain, that doesn't mean that the next person should be getting that. A lot of people share and sometimes maliciously or sometimes just for a high, but for others it's, 'Hey I've got a pain. Well here, take this. This works great for me.' And there's an education component that's just lacking in society."

Participants specifically discussed the need for education regarding the addictive nature of prescription opioids. A pharmacist (E) described that clients often did not know the risks associated with their prescription and was a subject they should be more aware of, saying:

“They walk out not knowing how dangerous that prescription can be and how addicting it can be. So, I guess awareness of prescription drugs and knowing how similar Vicodin is to heroin.”

Relatedly, a healthcare provider (J) mentioned how people seemed aware that they should not share medications but not necessarily why, stating:

“I think they know they’re not supposed to share their prescribed medications with other people, but I’m not sure that they’re aware of the adverse outcomes that can have.”

Some recommendations focused on changing how to convey information about substances and opioids to young people. A healthcare provider (C) thought that school-based education could be more effective if the individuals developing and teaching the curriculums had real-life field experience working with individuals who have addictions or have had an addiction themselves, stating:

“...it would have to be people that are really dealing with the clientele. It can’t be people that are not involved, that read a book or read a paper and then try to distill the information. I think it really has to be people that are on the ground, on the field, that could be effective.”

Participants also noted the need to educate parents and adults, both for their own benefit and for the opportunity to benefit youth through their influence. For example, increasing adults’ knowledge of how to store prescription opioids could limit the availability of this substance to youth and others, decreasing the probability of misuse. A state employee (M) emphasized the need for knowledge of proper prescription drug storage, stating:

“Also, increasing and enhancing knowledge and awareness by parents and older adults regarding storage and potential misuse of these drugs not only by younger generations, but also by themselves.”

Education was identified by participants as an opportunity to promote change among all community members, including healthcare providers. Participants described that providers should be educated on how to prescribe opioids safely, how to help patients when they are dependent, and the importance of and how to use the PDMP. Participants discussed that some providers seem to approach prescribing situations without considering the potential for, and complications of, addiction. A healthcare provider (J) described:

“I think prescribing any other scheduled substance and not thinking of addiction would be a gap. I think people need to think of addiction as they’re prescribing any scheduled substance.”

Participants indicated concern that some providers and dispensers did not ensure that their patients understood the risks associated with prescription opioids. A pharmacist (E) discussed how it is part of the job of a provider or dispenser to educate clients, saying:

“I think that, I guess that we can control on our level is counseling and making sure those patients know what they're getting... So, we have to make sure that those people know what they're getting into.”

Participants also discussed the uncertainty faced by providers when it comes to knowing what to do when they suspect or have evidence a patient is misusing opioids. A healthcare provider (C) discussed

the opportunity to educate providers about what to do and provide resources that could help providers make referrals, saying:

“And also, outreach to practitioners in: what do you do when you have someone that you are getting uncomfortable prescribing opioids to or who you know is coming to you and wants them and you suspect a problem? Or, what do you do when you’ve identified a problem? What do you do then? I think that having clear-cut, easy, pick-up-the-phone, here’s someone, you’re gonna be able to be evaluated quickly in an expeditious manner. I think that’s helpful to physicians.”

Several participants discussed the need for provider education surrounding the PDMP, including promotion of the new PDMP policies. A state employee (K) described some ideas to increase awareness among providers, saying:

“I think from the PDMP there needs to be a little more of an awareness of it... It probably needs to do some more outreach. Hitting up some of these either associations or hospital type program groups to say, ‘Here’s the program. Let’s use it.’ And how do you give them some examples of its use. It’s more of an education.”

The last group of individuals that participants indicated could benefit from increased education was state leaders. Informants had described the existence of some extremely knowledgeable state leaders as a strength and also discussed that others would benefit from more complete and data-informed information. For example, a state employee (M) identified the legislature as being undereducated, saying:

“The legislature - they have anecdotal knowledge.”

A law enforcement officer (G) also indicated that state leadership might only have a few referential examples but lack a full conceptual understanding, indicating a need for further education, stating:

“... our leadership across the state kind of knows and sees what’s in the media but maybe don’t spend a lot of time with the practitioners at any level to really understand what all of that means.”

2.) Policy Improvements

Participants identified numerous opportunities to prevent or address opioid misuse through policy improvements. First, participants suggested additional revisions to PDMP policies that would decrease the burden on providers and increase the accuracy of the data collected. Other policy opportunities surround establishing state-specific opioid prescribing guidelines and Medicaid regulations for opioids. Finally, participants suggested establishing policies for more protection and immunity from arrest, prosecution, and incarceration and to encourage diversion from incarceration into treatment.

For the PDMP, participants recommended three opportunities for improvement: unsolicited reporting, delegate accounts, and increased frequency of reporting. Unsolicited reporting would allow providers to receive automatic notifications when a patient has exceeded a prescribing limit, informing them that a patient may be doctor shopping. A state employee (D) explained how unsolicited reporting could be a useful tool, saying:

“I think it will allow for providers to receive unsolicited reports, so they don’t actually have to login. They can just get an e-mail saying ‘John Doe exceeded his doctor-shopping threshold. Be on the lookout. Don’t prescribe him a controlled substance if he comes in.’”

Another state employee (K) mentioned how a threshold would trigger an unsolicited report, explaining:

“They have what they’re going to call unsolicited reporting. And basically there’s a threshold that the Board of Pharmacy has set that says that if you see five prescribers and five pharmacists within a three-month time period there’s potential that you’re doctor shopping...”

To address the significant barrier of only allowing prescribing health professionals and dispensers to access the PDMP, participants suggested delegate accounts as an opportunity for improvement. A state employee (K) described these accounts as:

“... a delegate account, which would allow any doctor's office who typically says it's onerous for them to have to look up a patient, it will allow them to delegate through a licensed associate and, it's usually a nurse, of some kind, to look up the database on their behalf. The same would go with the pharmacy that would allow a pharmacy tech type to do it.”

Both unsolicited reporting and delegate accounts are capabilities that were forthcoming at the time of interviews. A state employee (K) described the timeline as:

“...a lot of these are not taking into effect until July of 2017 which is why they are all kind of off in the future...”

Participants were inconsistent in their discussions about the PDMP reporting requirements and whether they were weekly or monthly. Regardless, participants indicated reporting should be more frequent. A number of participants discussed that real-time reporting and access to information is best practice for PDMPs. A state employee (D) commented on changes to the reporting requirements, saying in part:

“Providers will now submit information to the PDMP on a weekly basis. It used to be a monthly basis, so we are getting closer to real-time reporting, which is great.”

Another state employee (B) echoed the suggestion for stricter requirements, stating:

“In my opinion, we should have said that every prescription had to be entered before you could fill it. That would be on a daily basis. And I think we give them a week, which I think is certainly a vast improvement...”

A substance abuse researcher (H) discussed Alaska's standards relative to other states, stating:

“It also sounds like our standards are pretty low relative to other states in terms of the timeliness of reporting, and so that also, I think, affects the ability for that data to be utilized, because if you're checking if someone's doctor shopping, you might need current up-to-date data in the last 24 hours.”

A state employee (K) suggested that some pharmacy requirements already dictate reporting daily because of company protocols, indicating that such policy is feasible, saying:

“Many of the pharmacies are already doing it daily and weekly. Just based on it's easier for them because a lot of States' programs, a lot of them are already involved with, especially the chain stores, whether it be Fred Myers, Safeway, CVS type. It's easy for them just to comply with whatever their minimum is.”

Regarding prescribing guidelines, participants indicated that having strict procedural requirements for providers and dispensers to follow would benefit the climate. A state employee (D) described the absence of straightforward guidelines for prescribers and suggested the belief that these guidelines would be an improvement, saying:

“I think, also, we need to adopt state-wide opioid prescribing guidelines. I don't think really prescribers across Alaska have a consistent, clear set of guidelines to follow in various contexts and with various patient-groups on how to appropriately prescribe opioids and how to monitor patients that are taking opioids.”

Several participants highlighted that monitoring patients, particularly those prescribed opioids for chronic pain or medication-assisted treatment (MAT), is essential and suggested policies supporting that routine monitoring. Participants further recommended strict regulations for MAT, including monitoring

and education training requirements in addiction treatment, particularly with more provider groups administering MAT. A healthcare provider (C) explained:

“I think required CME [Continuing Medical Education] is important. I think that any – with the opening up of physician assistants and nurse practitioners to the use of Suboxone, I think it’s important and essential that they be linked to a substance use program and that the client attend, and that that be monitored very carefully. I think that if this is opened up to mid-levels, they should be – there should be inspection of some sort to make sure that this is happening.”

An additional recommendation, from this participant (C), related to policies for Alaska Medicaid that could also be applied to other insurance programs. She said:

“I think basically anybody on chronic opiates, if they’re on Medicaid, should have one sole-provider. I think that would be one law that I would institute. If a person is on Medicaid and is thought to need chronic narcotic prescribing for non-cancer pain, then they should have a sole-provider assigned by Medicaid...What it means is that this is the person’s primary care physician and any referral outside of that must be made by that person...And all prescriptions are usually coming through that person, and I think one pharmacy. I think Medicaid – the other thing that should be assigned is one pharmacy. One pharmacy, one provider, if you’re on opiates. Period.”

The final policy opportunity identified by participants relates to the identified weakness of the current criminal justice approach to treatment and intervention. Participants recommended providing more protection and immunity from arrest, prosecution, and imprisonment for individuals addicted to opioids and other substances in order to encourage individuals to seek help. A state employee (D) described how current Good Samaritan Laws should be expanded to provide protection beyond possession charges, saying:

“I think we should probably also expand our immunity laws to further protect people from criminal prosecution for more than just possession, otherwise I just don’t think we’re going to see the full effect of such immunity.”

Participants indicated that changing the culture and providing protection and immunity for some offenses might allow more people to seek help without worrying that they may face criminal charges or imprisonment for the behaviors adopted to sustain their addiction. A state employee (B) explained that these behaviors should be treated as a part of addiction as a disease, saying:

“I still think we could do more with making sure that the police understand sort of what motivates the criminal behaviors, so that they treat this more like a disease from which people are sort of looking for answers and are very desperate, so that we’re not necessarily criminalizing for lengthy periods of time these individuals who do trespassing and shoplifting and things like that, that we’re not overly criminalizing the behavior if it’s resulting from just trying to get money to get another hit.”

Similarly, participants discussed the benefits of a diversion program which involved redirecting an individual into treatment instead of jail or prison. A law enforcement officer (G) discussed how diversion had worked in other states and described the opportunity for Alaska to implement a diversion program, stating:

“But there is no component, there is no ability to divert out of and away from the penal institution to treatment programs. That’s usually handled by the courts, and a criminal case has got to be filed. But in many states where they’ve looked at this a little bit differently and because they have the capacity for treatment, law enforcement’s been given the ability to make that decision to divert an offender right into treatment as opposed to filing a criminal charge, or in lieu of, and I think those are things that would be good for us.”

3.) Expansion of Treatment, Recovery, and Mental Health Support

Participants emphasized the expansion of treatment and recovery services as a critical opportunity toward prevention and intervention for opioid misuse. As indicated previously in the description of weaknesses, participants suggested Alaska did not have enough opioid addiction services available for adequate detox, treatment, and recovery options. Recommendations were for comprehensive, holistic treatment that covers the continuum from detox through relapse prevention. A healthcare administrator (A) discussed comprehensive services as best practices for treatment, saying:

“I think if I were to summarize what’s working really well, it’s a comprehensive approach to dealing with each individual. When an individual is, ready and seeking treatment, I think I’ve learned and recognized and want to put forth that it is not about just detoxing. It is not about just accepting that these individuals want treatment. It’s not about just providing medication-assisted treatment. It’s about meeting every individual.”

Participants indicated that capacity for treatment and recovery services is a major area of opportunity because the number of people who need treatment far surpasses the resources and services currently available. A state employee (I) discussed MAT as an example, stating:

“... we need to increase access to medication-assisted treatment, because there are a lot of people out there that are ready for treatment, but they are sitting on a waiting list and that’s not okay.”

A healthcare administrator (L) also mentioned why having better capacity and ample resources available were crucial factors, saying:

“If the individual is ready for treatment, then it’s critical and it is happening – some people are successful where it’s taking a whole – we always say, it takes a whole village to raise a child. Well it takes a lot of resources to help somebody get into treatment, and then to stabilize and then come out of treatment and continue to help them to stabilize...”

Respondents also suggested that expansion of services should include harm-reduction methods such as Naloxone to provide for those who are not ready for or cannot receive treatment. A state employee (I) commented on the importance of having Naloxone widely distributed, saying:

“These are small villages that are now having issues with heroin and probably prescription opioids and we need to make sure that there’s Naloxone that’s available at the village in the small community level and large community level.”

Participants discussed expanded access to and provision of mental health counseling as an opportunity. A healthcare administrator (L) described:

“You can’t just prescribe medication as a treatment, because as you know, most if not all of these individuals have co-occurring disorders. They have mental health issues in addition to the chronic brain disease of what we know as addiction.”

Other participants focused on mental health promotion and supportive environments as an opportunity for prevention. A human service organization administrator (A) stressed the opportunity of ensuring good mental health among youth, saying:

“I think our prevention efforts need to really, really address some of the mental health concerns that drive kids to using. Some of that is bullying and dysfunction at home and all sorts of things. But I think if kids can learn early on that this is not – you know, there’s other things to do to make yourself feel better instead of drugs and alcohol...”

Additionally, participants identified opportunities to address the barriers of stigma and uncertainty related to seeking help for mental health concerns. The same administrator (A) described:

"... we have to start looking at mental health like it's a sprained ankle, almost. You know? Instead of, "Oh, I can't – I don't want to see a mental health professional. That's too scary, but I'll go to the doctor because of this or that.""

Threats

Four threats to preventing and addressing opioid misuse emerged:

- (1) State fiscal crisis
- (2) Prescribing practices
- (3) Complexity and stigma of addiction
- (4) Legislative support

1.) State Fiscal Crisis

Alaska is currently experiencing an economic crisis, and participants indicated that the challenging fiscal climate has significantly impacted efforts for opioid misuse prevention and intervention. All participants indicated that the lack of resources, including funding and staffing, were limitations that negatively impacted day-to-day work and efforts overall. A state employee (I) summed it up succinctly, saying:

"We need funding."

A substance abuse researcher (H) echoed that sentiment:

"We need sufficient funding..."

Another state employee (B) mentioned resources were insufficient, saying:

"I understand that resources widely in the field, particularly right now, are totally tapped out."

Participants suggested that these financial issues meant the state prevention capabilities were restricted. A state employee (F) discussed the impact on initiatives, saying:

"... our budget is to the point where we can't do more with less and we can't do the same with less. We've got to do less with less."

As discussed in strengths, the Divisions of Public and Behavioral Health have continued to apply for more federal grants to compensate for this budget deficit, which they are hoping will bolster their ability to provide a variety of prescription opioid misuse services. A state employee (B) described:

"So, we are going to be very dependent on some new federal funds to be able to address this epidemic."

Participants also discussed the limitations of federal funding, describing the funding as restricted in scope and timeline. Some participants indicated concerns related to sustainability and indicated that funding for opioid misuse prevention and intervention should be covered in the state's budget. A state employee (D) described:

"We cannot rely on federal grants alone. I think Alaskans need to take accountability for their own problems."

Participants described experiencing funding reductions most clearly as reduced and inadequate staff across a variety of departments and organizations, from public health nursing to criminal data analytics

to community service organizations. A state employee (I) summarized concerns related to staffing, stating:

"...the staff we have are good but the number of staff that we have are insufficient to really stand up to and meet the challenge."

A state employee (I) elaborated on this point discussing the need for more resources devoted to addressing this issue adequately, stating:

"The big thing is just devoting resources to addressing these issues. We really need the money to be able to fund these programs. So that's probably the big catchall in terms of how they can be improved because with the resources you've got program people at the health department level. You've got money for expanding treatment access, educational outreach, and all sorts of things. That would be the big thing that we could do to improve the situation."

Participants reflected that good progress is being made on the issue of opioid misuse but that more work is needed and that work requires funding. A law enforcement officer (G) stated:

"I think the state is about middle of the road, and I feel like we're trending upward to become better at it, but there is a lot of work to do and this is a very time-consuming and, frankly, expensive proposition, in my humble opinion."

2.) Prescribing Practices

Participants identified common prescribing practices of providers as a significant threat. The majority of participants described prescribing practices as contributing to prescription opioid misuse, frequently mentioning overprescribing as common practice. A healthcare administrator (L) related a personal story involving an excessive quantity of opioids, saying:

"... here's an example, my grandson went to get his wisdom teeth out, right? And he got a prescription for 30 pills. He's 16 years old."

Participants described the culture around pain management and that opioids have become a central part of pain management. A pharmacist (E) described:

"...we believe every time you're in pain you need to treat it with an opioid. Every time you have a toothache or anything else, you have to have an opioid for pain. Pain is a natural process. I mean, I don't think that giving an opioid is the answer to all pain, and that's just over prescribed. "

A state employee (K) insinuated overprescribing was indirectly a part of medical training because prioritizing pain reduction was a part of providers' training, stating:

"I think there's a kind of a lack of understanding. Most of them [healthcare providers] are taught, I think, in my own opinion, I think they're taught to alleviate any type of pain. So sometimes that has a tendency of giving people more than they think they need or more than they need."

Participants emphasized changing prescribing habits will be difficult and creating effective change will require changes to medical education. A pharmacist (E) indicated this starts with providers' initial medical education on prescribing and pain management, stating:

"...it starts with prescribing habits, and that's got to be dealt with and reduced, and for that to happen that has to start at the core at, you know, in medical school for that to change prescribing habits, because that's pretty hard to change. I mean doctors don't change their prescribing habits easily."

While most participants communicated a belief that the problem was overprescribing, a few participants also provided perspectives on under-prescribing or decreasing prescription opioid availability. One

healthcare provider (J) noted the more severe outcomes that may follow under-prescribing or sudden discontinuation, saying:

"I kind of see it as an overreaction by the medical community so that they aren't – first they were overprescribing, because pain was the fourth vital sign or whatever. Now, they're really under-prescribing... it's a real mistake to overreact to the people that are having addiction issues to opioids, because then people who may need opioids aren't being prescribed them and then they will go get them somewhere else and then they're on heroin."

Others implied similar worry of the consequences for decreasing prescription opioid availability because of the persuasive powers of both addiction and pain. A law enforcement officer (G) indicated one consequence of reducing prescription opioid availability, saying:

"I think the downside to that [decrease in OxyContin and oxycodone on the streets] though is it's obviously caused a resurgent of heroin and fentanyl and all the other synthetic opioids out there."

Overall, participants' comments reflected the difficulty in ensuring the right balance of prescribing opioids for pain management. Despite a lack of clarity on the exact direction of concern, a pharmacist (E) emphasized the importance of some kind of change in prescribing behaviors, stating:

"There is no changing any of it without changing prescribing habits."

3.) Complexity and Stigma of Addiction

Participants identified the complexity of addiction and opioid misuse as a threat to finding solutions. They described the need for multiple innovative solutions to address substance use in general and opioid misuse specifically. One participant, a healthcare administrator (L), related that some people involved are searching for a single, straight-forward solution and disagreed with that approach, saying:

"Thinking that one piece of the puzzle will solve this is irrational thinking."

A healthcare provider (C) described some of the challenges of addiction medicine as:

"... this is a complex population. This is not your usual hypertensive, I am diabetic, whatever population. This is the population that – with multiple comorbidities, psychiatric comorbidities, and these things have to be caught and treated."

Participants also identified stigma as a threat to preventing and treating opioid misuse. Many participants discussed how stigma interferes with people's ability to perceive addiction as more than a hindrance to society. A state employee (F) described:

"That as long as we see opioids as just bad decisions and not recognizing that the pathological use is often times addiction and address it as such we're not going to be able to solve this."

A healthcare administrator (L) elaborated on how stigma has been a significant barrier that impacts multiple levels, from direct care to policy, saying:

"... there's such a stigma. There's a major stigma by those who can prescribe medication-assisted treatment, or those who can capture these individuals during a routine medical appointment. There's such a stigma from the medical model that these individuals choose to have this chronic brain disease. And once that stigma is lifted, I think it'll change even how many of our policy makers make decisions... I think stigma is a huge barrier to some of the policies that need to be made, because people think this is a choice. They don't see it as a chronic disease. We have a lot of work to do to correct that."

While participants identified stigma as a threat, a few indicated hopefulness that stigma could be addressed and stigma reduction would result in positive change. A state employee (M) described stigma reduction as a goal, saying:

“I think that we’re going to be removing the stigma of addiction, so that treatment services will be available and that for those that are receiving treatment services, there won’t be that bounce back from family, friends, other of looking down upon them for getting those services.”

4.) Legislative Support

Participants indicated that the wavering support of the state legislature on prescription opioid misuse prevention initiatives was a barrier to the state government’s ability to increase preventative services. Participants identified both lack of funding allocated by the legislature and lack of support for policy initiatives as threats.

One recurring example was recent de-funding of the PDMP. A state employee (D) discussed that the legislature should take more responsibility and fund programs like the PDMP, saying:

“I think we need to have the legislature provide general fund dollars to support the implementation, expansion and enhancement of the PDMP instead of relying solely on federal grants and/or registration fees.”

Some participants indicated lack of legislative support stems from lack of knowledge about the issue or misconceptions. One state employee (F) described this threat as:

“I think there’s more misinformation in the legislative branch.”

Overall, participants indicated that the legislature’s full support is needed in order to provide necessary services to address opioid misuse in Alaska. A state employee (D) described the influence of the legislature on both funding and policy, saying:

“We need them [state legislators] to do their job and implement sound policies to protect the health of all Alaskans, and we need them to provide dedicated funding to address this crisis.”

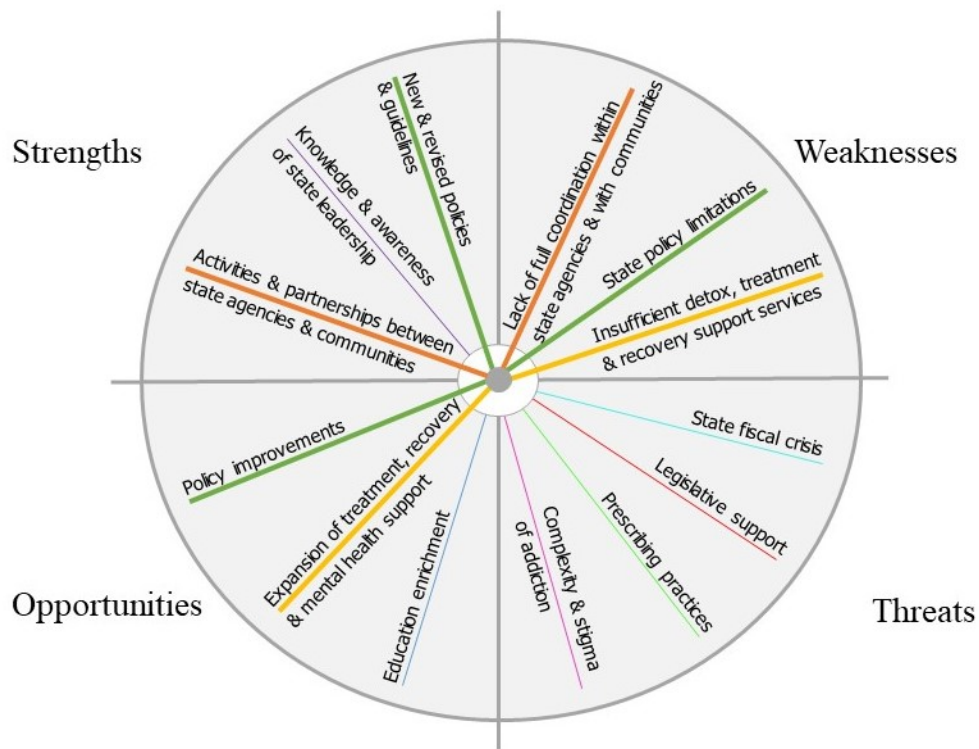


Figure 2: Graphic visualization of SWOT results. Thick colored lines extending to center indicate an overlap in the results between SWOT categories; thin lines not extending to center indicate no overlap between SWOT categories.

Discussion

Overall participants agreed that agencies, communities, and organizations across Alaska have demonstrated great concern about the opioid epidemic and that this concern has translated into considerable efforts to address and prevent opioid misuse. Participants noted a variety of opportunities as targets for future work, many of which would address some of the current weaknesses that exist. Additionally, participants articulated a number of real threats to consider going forward.

While participants’ comments reflected consensus in a variety of the emergent themes, analysis revealed discrepancies in two themes. The first was in participants’ perceptions of knowledge among state leaders. Some participants believed that state leaders were very knowledgeable about prescription opioid misuse as an issue and the climate of prevention in Alaska. Other participants described some leaders as only generally aware but not specifically knowledgeable.

The second discrepancy directly related to the PDMP. Specifically, discrepancies revolved around specifics of policy and timing of when the regulations become effective, when certain tools will be made available, and reporting frequency requirements. Senate Bill 74, passed in the summer of 2016, establishes new policies for the PDMP surrounding mandatory registration and reporting as well as new methods for reporting and solicitation of data. Some participants, perhaps because they were less knowledgeable about recent changes in legislation, spoke about historical PDMP details that may be

changing in the near future. Other participants focused on the upcoming changes to the PDMP. Specifically, participants gave mixed responses about when mandatory registration would begin for prescribers and dispensers and whether reporting would be required weekly or monthly. Responses also varied in relation to when tools such as delegate accounts and unsolicited reporting would be available. Lastly, the PDMP checking requirements were debated, with several participants suggesting it was compulsory and others indicating reporting to and checking the PDMP were voluntary.

From the ratified SB74 bill, all changes to the PDMP are effective July 17, 2017 (State of Alaska 29th Legislature, 2016). All qualifying prescribers and dispensers must be registered for the AK PDMP and weekly reporting on schedule II-IV prescription drugs prescribed and dispensed will be required.³ The option to use delegate accounts and receive unsolicited reports will be available on the same effective date. Checking the PDMP before prescribing or dispensing is described by legislation as mandatory, but how checking will be enforced is unclear. Ultimately, the decision of whether to prescribe or dispense a prescription medication is left to the healthcare professional.

Limitations

The data collection and analysis process was not without some limitations. Most notably, the sample was not entirely representative of state-level stakeholders. Approximately half of those individuals invited to participate successfully completed interviews. Therefore, a number of individuals who had been identified as holding important positions or likely to have meaningful contributions did not participate in an interview. Specifically, no one representing health boards, the military, or legal organizations/agencies participated and perspectives from those stakeholder groups may be different from those captured through the interviews. Additionally, given the concentration of state employees and many healthcare and service agencies in the more populated areas of the state, none of the participants specifically represented rural areas.

The timeline of the interviews also resulted in some limitations. As participants were more difficult to recruit than originally anticipated, the recruitment and data collection phases occurred over a period of five months. During this time, the Alaska legislature passed multiple relevant bills and state agencies received additional grant funding related to prescription opioid misuse. Therefore, depending on when they were interviewed, the current status of legislation and efforts varied for participants, which was a challenge for analysis.

Finally, while the PFS project aims to address both prescription opioid misuse and heroin use, the time-intensive nature of capacity interviews, the limited number of available participants, and the inter-related nature of the two issues necessitated that the capacity and infrastructure evaluation be limited to only prescription opioid misuse. Participants may have different opinions and perspectives on the issue of heroin use that were not captured.

Recommendations

The primary recommendation from participants focused on education for all Alaskan community members, from youth and parents to providers to legislators. Statewide awareness and educational campaigns could be used to increase awareness among the public in general and highlight resources for more information. Additional educational efforts could target specific needs of various groups. For example, youth could be educated about the risks of addiction from prescription medication that may

³ 29th Legislature, SB 74, "Medicaid Reform; Telemedicine; Drug Database," (HCS CSSB 74(FIN) am H), State of Alaska: Laws of Alaska 2016, (June 21, 2016).

be routinely prescribed and parents may benefit from education and awareness-raising efforts related to safe storage of prescription medications.

Other recommendations suggested by participants included state policies and prescribing guidelines and Alaska government agencies are already working on similar efforts. As of January 19, 2017, the AOPTF has completed their final recommendations to “increase prevention efforts, enhance addiction treatment, and provide better recovery support to reduce misuse in Alaska.” The official recommendations can be found on the [Alaska Department of Health and Social Services: Alaska Opioid Policy Task Force](#) page. This final list of recommendations provides an extensive list of solutions that would benefit Alaska.

On December 30, 2016, the Division of Corporations, Business and Professional Licensing’s Joint Committee on Prescriptive Guidelines submitted their recommendation for the adoption of the State of Washington’s Interagency Guideline on Prescribing Opioids for Pain, 3rd Ed., with one adaptation – reducing the milligram morphine equivalent dose from 120 mg to 90 mg.⁴ The SB 74 Prescriptive Guidelines cover letter can be found on the [Board of Pharmacy’s Prescription Drug Monitoring Program](#) page. Alaska House Bill 159 was signed into law July 25, 2017 and established requirements for training and prescription guidelines.⁵

Given the recent changes regarding the PDMP and prescribing guidelines and the corresponding lack of clarity among professionals directly impacted by these changes, additional education, training, and resources in these areas specific to providers and dispensers is also recommended.

Conclusion

The Alaska PFS project aims to reduce and prevent prescription opioid misuse and heroin use. The capacity and infrastructure of the State of Alaska is an important factor in the potential success of the PFS project. Participants in key informant interviews identified a number of strengths, weaknesses, opportunities, and threats in a variety of domains that inform recommendations for enhancing capacity and infrastructure. As part of the comprehensive evaluation of the Alaska PFS project, relevant activities targeting capacity and infrastructure will be tracked and the extent to which recommendations are enacted will be monitored. Additionally, results of these initial interviews will serve as a baseline and be compared to results from similar interviews that will be conducted near the end of the project in 2019, allowing for determination of potential impact of the PFS project on the state’s capacity and infrastructure related to prescription opioid misuse prevention.

⁴ Board of Pharmacy, “SB74 & the Prescription Drug Monitoring Program (PDMP),” Alaska Division of Corporations, Business, and Professional Licensing. (January 31, 2017).

⁵ 30th Legislature, HB 159, “Opioids; Prescriptions; Database; Licenses,” (SCS CSHB 159(FIN)), State of Alaska: Laws of Alaska 2017. (June 22, 2017).

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