ASTHO Report
In-depth coverage of leading state and territorial public health issues.
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Cross-Agency Approaches to Substance Use Disorder Prevention and Treatment **NATIONAL RECOMMENDATIONS**

States around the country are aligning policies, funding, staffing, and data across agencies to more effectively and efficiently utilize resources to meet the needs of people living with or at risk of developing substance use disorder (SUD). In 2018, the Association of State and Territorial Health Officials (ASTHO) and the National Academy for State Health Policy (NASHP) convened the Cross-Agency Leaders Roundtable—a group of 10 Medicaid and public health officials—to develop recommendations that showcase how public health and Medicaid agencies can engage in effective cross-agency work to advance their collective goals of preventing and treating SUD. These four recommendations are presented below.

The roundtable consists of state officials with demonstrated cross-agency leadership to address the needs of people living with or at risk of developing SUD, including representatives from the Alaska Department of Health and Social Services, the California Department of Health Care Services, MassHealth (Massachusetts), the New York State Department of Health, the Ohio Department of Medicaid, the Oregon Health Authority, the Pennsylvania Department of Health, the Virginia Department of Medical Assistance Services, and the Washington State Department of Health.

RECOMMENDATION 1: Determine an appropriate mechanism to catalyze cross-agency collaboration and create a unified administrative structure.

Effective cross-agency collaboration requires an infrastructure that allows agencies to work together on financial planning, coordinating communications, and assessing evolving priorities. The issuance of public health emergencies and disaster declarations has served as an impetus for several states' opioid workgroups or command centers. Because each state has different types of declarations, each state must closely assess the authority a declaration will provide and determine the best mechanism to achieve its overall objective. For example, a public health declaration might be appropriate to bring public attention to the issue or reinforce the governor's support for cross-agency partnerships; however, it may not be the best mechanism to develop legislation. In other states, collaboration might be driven by a voluntary champion or goodwill among partners, and involvement from the governor's office or state legislature may not be necessary for convening.

It is highly beneficial to have a central locus of responsibility and centralized administrative structure, through which an administrator can serve several key roles and perform activities, such as:

- Convening regular meetings among partners or agencies to drive action forward and break down possible silos.
- Ensuring wide representation within workgroups. Given the multifaceted nature of the opioid epidemic, states have necessarily broadened conversations beyond health and human services and to engage with public safety and law enforcement, education, labor, and commercial insurance plans.
- Leading a discussion to establish goals and priorities, as partners often have different perspectives and approaches. It can be useful for the convener to set broad goals and let each agency determine their own activities, with all efforts evaluated under common metrics. State health assessments and state health improvement plans can be an opportunity to align cross-agency activities or encourage cross-sector collaboration.
- Reinforcing accountability and reduce duplication of efforts among partners.

State Example: Alaska
The governor of Alaska issued a 2017 disaster declaration on the opioid crisis, which facilitated partnerships at the highest level and brought new partners, like the fishing and game industry, to the table due to a shared awareness of the economic impact of addiction. The declaration also immediately gave the state health official authority for a statewide standing order for naloxone and created an incident command structure.

State Example: Pennsylvania
In January 2018, the governor of Pennsylvania issued a disaster declaration, which created an Opioid Command Center and the Unified Coordination Group representing 14 state agencies. The declaration led to 13 initiatives with three key focus areas: enhancing coordination and data collection to bolster the state and local response; improving tools for families, first responders, and others to save lives; and expanding access to treatment. State agencies had previously collaborated informally, but the disaster declaration brought additional agencies beyond health and human services to the table (e.g., law enforcement, public safety, military and veterans affairs, education, and labor and industry). The governor must reissue the declaration every 30 days to continue the work, but the legislature may consider creating a mechanism to allow the department of health to declare an emergency in order for the collaborations to continue without a mandate by the governor.

State Example: Virginia
The Virginia health commissioner declared a public health emergency in 2016, which did not provide any new legal authorities but did focus public attention on the issue. The declaration built upon two previous years of work by a cross-agency taskforce that had met bimonthly with ad hoc workgroups; the 2016 declaration was able to bring new partners to the table. The declaration has no renewal process and is in place until the department of health terminates it. Virginia's former governor also signed an executive directive in 2016 that established the Governor's Executive Leadership Team on Opioids and Addiction, a cross-agency working group co-chaired by the Secretary of Health and Human Resources and the Secretary of Public Safety. The directive remains in effect under the current governor.

State Example: Washington
A Washington state executive order established a cross-agency Opioid Response Group, with designated executive sponsors and workgroup leads responsible for implementation. The executive order has been reportedly effective in raising public awareness of the issue and reinforcing existing partnerships. The group also hosts a website to centralize information and communicate progress towards shared targets.

RECOMMENDATION 2: Optimize the use of state resources, including funding and staff, to maximize reach and impact.

The opioid epidemic requires partners to think globally, since every community has been affected. Cross-agency workgroups that strategically allow partners to lead activities in which they have the most expertise are very effective. For example, public health leaders—as trusted figures across government and the public—can assess the epidemic across the entire state and promote health equity by identifying populations with unmet health and social needs. Law enforcement, with its local presence, can help to link communities and individuals in need with resources made available through public health and health care delivery systems. State offices of rural health can provide insights into how SUD programs can be most effectively implemented to meet the needs of rural communities.

State public health and Medicaid officials can also see seize a leadership role in advancing policies and mechanisms that allow state agencies to more nimbly respond to evolving SUD trends and more effectively use finite resources by:

- Exploring flexibilities in amending state contracting requirements to ensure efficient distribution of new grant funds.
- Considering building new projects off existing programs and structures to avoid recreating the wheel.
- Looking for opportunities to braid funding between partners and agencies.

State Example: Alaska
In Alaska, the governor's leadership and disaster declaration helped pool resources across agencies. Several staff positions and their funding were moved across divisions of the health department, which required a shared agency-wide vision for improving pain management in the state. Alaska's centralized structure (with Medicaid, public health, and behavioral health falling under the same umbrella agency) was cited as a factor for success.

State Example: California
The California Department of Health Care Services includes language in the state budget trailer bill each year, allowing the department to be exempt from all state contracting requirements for federal dollars related to State Opioid Response and State Targeted Response grants. This supports a nimbler approach to federal grant dollar distribution.

State Example: Virginia
The Virginia Department of Medical Assistance Services and department of health have collaborated on Project ECHO, a biweekly collaborative for providers that offers free buprenorphine waiver training using Medicaid funds. The Virginia Department of Behavioral Health and Developmental Services (DBHDS) funded training for providers and clinicians on the American Society of Addiction Medicine criteria. DBHDS also used funds from the Substance Abuse and Mental Health Services Administration to provide SUD treatment in correctional facilities, as well as to Federally Qualified Health Centers to expand medication-assisted treatment access.

RECOMMENDATION 3: Align policies across agencies for prescribing, treatment, training, and use of evidence-based best practices among providers.

Both public health and Medicaid leaders can serve as touchpoints to interact and work with providers to improve utilization of evidence-based best practices around SUD screening, prevention, and treatment. Natural points for partnerships between Medicaid (which is often focused on treatment) and public health (which is often focused on prevention) can include:

- Expanding access to naloxone, including when people are transitioning out of correctional facilities.
- Setting prescribing guidelines and offering coaching and training for providers.
- Expanding access to medication-assisted treatment (MAT) by eliminating prior authorization requirements.
- Supporting access to peer recovery support specialists, community health workers, and other non-clinical workforces, which can improve an individual's success in long-term recovery and treatment.

Specific mechanisms to align policies between Medicaid and public health agencies include encouraging and supporting the adoption of value-based payment models that incentivize prevention and ongoing treatment, establishing requirements for managed care and provider contracting to ensure coverage for preventive services or whole-person care, and quality improvement incentives or requirements.

State Example: New York
The New York State Department of Health supports a peer-delivered syringe exchange program (SEP) that offers clients the opportunity to enter into treatment. SEPs that are authorized and waived by the New York State Department of Health (and have established Medicaid Provider IDs) can bill Medicaid for harm reduction services (e.g., plan of care development, individual and group supportive counseling, medication management, and treatment adherence counseling) through a 2017 state plan amendment.

State Example: Oregon
Oregon's 2015-2019 state health improvement plan includes reducing alcohol and substance misuse as a top public health priority. The state Medicaid program includes alcohol or substance misuse screening through Screening, Brief Intervention and Referral To Treatment (SBIRT) as an incentive measure within their coordinated care organizations (CCOs), which may incentivize CCOs to move upstream in their prevention and response efforts. Medicaid CCOs are also required to develop community health needs assessments and improvement plans, in partnership with local public health, and many CCOs have included SUD in these plans.

State Example: Virginia
In 2017, Virginia's Board of Medicine promulgated prescribing regulations for buprenorphine in addition to opioid and pain management regulations for all prescribers. Virginia recently removed the prior authorization for the preferred buprenorphine/naloxone product, Suboxone films, prescribed by in-network buprenorphine waivered practitioners who are Medicaid providers. Evidence indicates that some individuals may benefit from buprenorphine doses greater than 16 milligrams per day through higher rates of treatment retention and abstinence from illicit substances.

RECOMMENDATION 4: Utilize a range of data sources to measure progress, inform state leadership and the public, and develop policy.

Linking data from law enforcement, social services, healthcare, state offices of rural health, and public health can be valuable to inform state decisionmaking with respect to effectively targeting interventions and available resources. Predictive analytics, for example, can identify trends within populations at risk of SUD or opioid use. A robust data aggregation could also be used to convene mortality review committees to conduct psychosocial "autopsies" of opioid-related deaths and look for potential touchpoints within the health system where people can be reached.

Cross-sector data sharing and interoperability is a top priority among all participating states and will remain an ongoing, complex conversation among state agencies, as the authorities, technologies and platforms, and available datasets vary from state to state. Regardless of state circumstance, however, cross-agency collaboration is important to build this complete data picture, especially when conducting the following activities:

- ***Identifying available data sources to measure and benchmark progress:*** Consider what sources of data are available and most reliable in your state, possibly including prescription drug monitoring programs (PDMPs), all payer claims databases (APCDs), clinical data from electronic health records, emergency medical services data, and death certificates.

- ***Pursuing interoperability:*** When linking data systems, state agencies should consider whether the current systems are interoperable and have a process in place to ensure that any new systems adopted or developed can be interoperable with other agency data systems. Some health agencies, including Massachusetts, have created a central data repository or data warehouse to collect data of interest to multiple agencies.

- ***Communicating findings from the data with the public and among agencies:*** States may also have internal dashboards to display information reserved for internal decisionmaking purposes, while also building external dashboards to display data that partners have agreed to share publicly. Common measures that states are tracking through their dashboards include number of prescriptions or pills dispensed, total number of pain relievers dispensed by state licensed pharmacies, average days' supply, and how providers are utilizing PDMPs.

State Example: Massachusetts
Massachusetts passed a 2015 state law that permitted state agencies to link multiple state datasets to analyze opioid overdoses and formulate policy responses. An APCD provides the "spine" of the model, the next version of which will link 20 data sets across public health and health and human services, corrections, and housing agencies. The department of public health has led the data analysis, along with partners in academia and private industries. The resulting Chapter 55 reports have allowed Massachusetts to identify populations at most risk of overdoses in order to effectively target interventions. The report also notes that the Chapter 55 initiative demonstrated that access to a unique dataset can attract new public and private partners and lead to mutually beneficial outcomes. In 2017, the Public Health Data Warehouse was established under permanent statute (M.G.L. c. 111 s. 237) to continue the opioid-focused efforts under Chapter 55 and expand to other areas of public health priority.

State Example: Pennsylvania
The Pennsylvania Department of Health and Department of Public Safety built an opioid data dashboard to share community-level trends with the public, drawing upon data from both departments and PDMP data. The datasets track various outcomes related to prevention, rescue, and treatment. The state is also considering using this dashboard to conduct predictive analytics or create a psychosocial autopsy review board to analyze a statistical section of deaths and review the cases behind drug use and missed connections with the health system.

State Example: Washington
Washington state's opioid response plan has four goals: (1) prevent opioid misuse and abuse, (2) treat opioid use disorder, (3) reduce morbidity and mortality, and (4) use data to monitor and evaluate. Each goal has specific metrics with defined data sources from different state agencies and reporting frequencies (e.g., the state Health Care Authority provides an annual update on the number of Medicaid clients with an opioid use disorder receiving MAT to track progress on the goal of identifying and treating opioid use disorders).

THE NEXT FRONTIER: Incorporate upstream prevention into SUD programs and policies.

Upstream prevention is critical to stem the tide of emerging addictions, as well as prevent trauma and other events that result in high "downstream" social and healthcare costs. Several states are using Section 1115 demonstration waivers as levers to fund SUD treatment services in institutions for mental disease (IMDs) and engage public health partners. North Carolina, however, is currently beginning an 1115 "Health Opportunity" demonstration pilot to cover non-medical services that address health-related social needs of Medicaid beneficiaries, which could serve as a foundation for future state Medicaid and public health activity on the social determinants of health.

Ultimately, state leaders recognize the importance of building community structures that prevent social isolation and allow partners to address the social determinants of health and community resiliency.

Specific strategies include:

- Emphasizing provider update of ASAM Level 0.5, which focuses on prevention and individuals who are at risk of developing SUD (e.g., assessment and educational services).

- Supporting community health worker interventions and other place-based initiatives that may be effective in engaging isolated populations and connecting individuals to healthcare and social services.
- Screening for and collecting data on adverse childhood experiences (ACEs), as well as using ACEs data to target community-level interventions or prevention efforts.
- Addressing stigma around SUD, such as by amending language in statute (e.g., there may be a preference for "individuals in long-term recovery" or "people who use drugs").
- Developing mechanisms to support safe and accessible recovery housing opportunities.

Public health, Medicaid, and other executive branch leaders can use these strategies to promote effective SUD programs and treatments, utilize and expand access to existing data sets, and invest in the social and community-level conditions that impact health and well-being. Cross-sector collaborations that are underway across the nation can serve the SUD epidemic and have the potential to become the backbone infrastructure to support population health improvements and other emerging health issues.

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