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Center for Evidence-Based Policy

All for One and One for All: Developing Coordinated State Opioid Strategies

by Noam N. Levey

Issue Brief Summary

The opioid epidemic has spawned numerous state efforts to develop strategies that bring together law enforcement, public health, Medicaid, and other state agencies. This issue brief outlines key lessons learned by state officials around the country.

Key ingredients in a coordinated state opioid strategy include:

- Leadership from a governor who has prioritized the opioid crisis
- A formal organizational structure to bring together multiple state departments
- Robust engagement with outside stakeholders
- An intense focus on the collection and dissemination of timely, accurate data.

Foreword

Spurred by increasing opioid abuse, drug overdoses are now the leading cause of death for Americans under age 50. State governments play an important role in addressing this crisis.

The crisis's urgency and complex nature call for multiple approaches and have resulted in a proliferation of strategies to address both the demand for and supply

of opioids. These strategies have varying levels of evidence and rigor to support them. They involve agencies of public health, law enforcement, corrections, Medicaid, health care regulation, children and family services, schools, and emergency response. But no one strategy and no single agency will succeed on its own. Effectively coordinating efforts may prove to be the key to reducing the number of families and communities damaged by opioid abuse.

The challenge of improving coordination of opioid abuse reduction efforts is the responsibility of government leaders. To help them do this, the Medicaid Evidence-based Decisions Project (MED), run by the Center for Evidence-based Policy at Oregon Health & Science University, held a meeting in October 2017, with support from the Milbank Memorial Fund, to identify factors critical for improved coordination.

MED, a self-governing collaboration of state Medicaid agencies, invited state government partners, including public health officers, corrections staff, substance use treatment directors, and others. The meeting touched on many areas of state government affected by the epidemic, including Medicaid and the justice and treatment systems, as well as ways to coordinate across jurisdictions.

This issue brief, authored by health policy journalist Noam Levey, combines insights from the meeting on key ways to improve coordination with interviews of more than two dozen current and former state officials in public health, Medicaid, law enforcement, corrections, and behavioral health, as well as policy experts who work with state government. It is a report from the front lines, summarizing the critical experiences of state leaders working on the crisis and highlighting the vital role played by dedicated public officials.

The Milbank Memorial Fund and the Center for Evidence-based Policy are committed to gathering the best evidence and experience to help public sector leaders improve the health of populations. We hope the insights in this issue brief will inform state leaders and others engaged in the critical work of combating this deadly epidemic.

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Introduction

The escalating toll of America's opioid epidemic has sparked an increasingly urgent search by states for strategies to confront a crisis now responsible for more deaths than auto accidents. Across the country, state leaders are scrambling to rein in the supply of highly addictive pain medications and illegal narcotics. They are rushing to bolster their emergency response capacity to curtail deaths from overdose. And many states are looking for ways to expand long-term treatment and recovery options for the burgeoning population of Americans living with a substance use disorder.

The complex nature of this crisis has made the development and implementation of comprehensive strategies difficult. The epidemic touches many areas of society and, by extension, state government, including public health, law enforcement, corrections, Medicaid, health care regulation, children and family services, schools, and emergency response. And although there appears to be growing consensus around individual policy interventions to reduce opioid misuse and the harm caused by addiction—such as prescription drug monitoring, naloxone distribution, and expanded availability of medication-assisted treatment—putting all the pieces together remains challenging for state leaders. That has highlighted the critical importance of coordinated strategies that bring together multiple state agencies, enlist nongovernmental stakeholders, and align state and local efforts. "There won't be a single silver bullet for this," cautioned Dr. Jay Butler, Alaska's chief medical officer and public health director and immediate past president of the Association of State and Territorial Health Officials. "It's going to take all of us to address this. That means we're going to have to work together."[1]

This issue brief—produced in partnership with the Center for Evidence-based Policy at Oregon Health & Science University—cannot offer a simple recipe for crafting a coordinated state opioid strategy. Nor is this an exhaustive review of academic literature on individual policy interventions. But the brief—based on interviews with more than two dozen current and former state officials in public health, Medicaid, law enforcement, corrections, and behavioral health, as well as with policy experts who work with state government—endeavors to share the thoughts and observations of state leaders working on the front lines of this crisis. It is hoped that their perspectives can help inform states' ongoing search for ways to control this deadly epidemic.

Background

The explosion in opioid addiction over the last two decades has emerged as one of the nation's most pressing public health challenges. More than 20 million Americans now suffer from a substance use disorder,[2] including some 2.5 million whose disorder is linked to use of either prescription opioids or heroin.[3] In 2015 alone, more than 52,000 deaths were attributed to drug overdose; 33,000 involved an opioid.[4] That surpasses the death toll attributed to automobile accidents in the United States and means more Americans are now dying each year from drug overdoses than died at the height of the HIV/AIDS epidemic a generation ago.

A number of factors have fueled this crisis, including a revolution in the use of opioid-based prescription painkillers that were aggressively marketed and distributed by physicians and other prescribers beginning in the 1990s. These highly addictive medicines, in turn, set off a boom in the illicit trade of prescription drugs and heroin. In many parts of the country, heroin became available at much cheaper prices than prescription opioids.[5] More recently, drug traffickers have introduced fentanyl, an extremely potent and very dangerous opiate linked to a rising number of overdose deaths.

The growing recognition of a public health crisis has galvanized state governments, particularly in regions of the country hit hardest by the epidemic, including New England and Appalachia. In 2016, the 10 states with the highest age-adjusted rates of overdose deaths were in these two regions, according to federal data, although overdose deaths are increasing in many more states.[6] (See Figures 1 and 2.) State government efforts to confront the epidemic have been supported by a growing body of public policy research and aggressive work by organizations such as the National Governors Association,[7] the National Conference of State Legislatures, the Association of State and Territorial Health Officials, the National Academy for State Health Policy, the National Center on Addiction and Substance Abuse,[8] and the Center for Evidence-based Policy,[9] all of which have helped aggregate and distribute information on effective strategies for tackling the crisis.

This intensive focus on the epidemic has helped build support in the public policy community for several broad areas of policy.

Figure 1

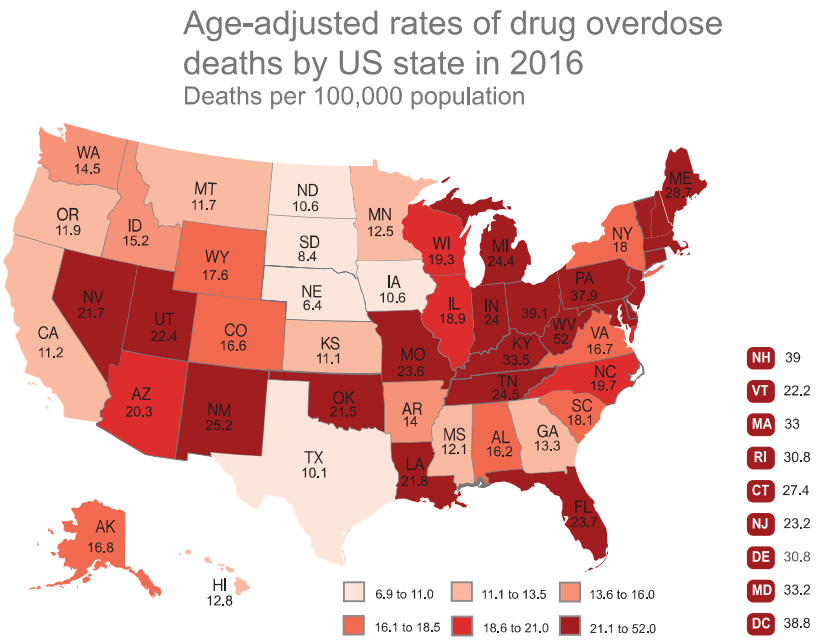
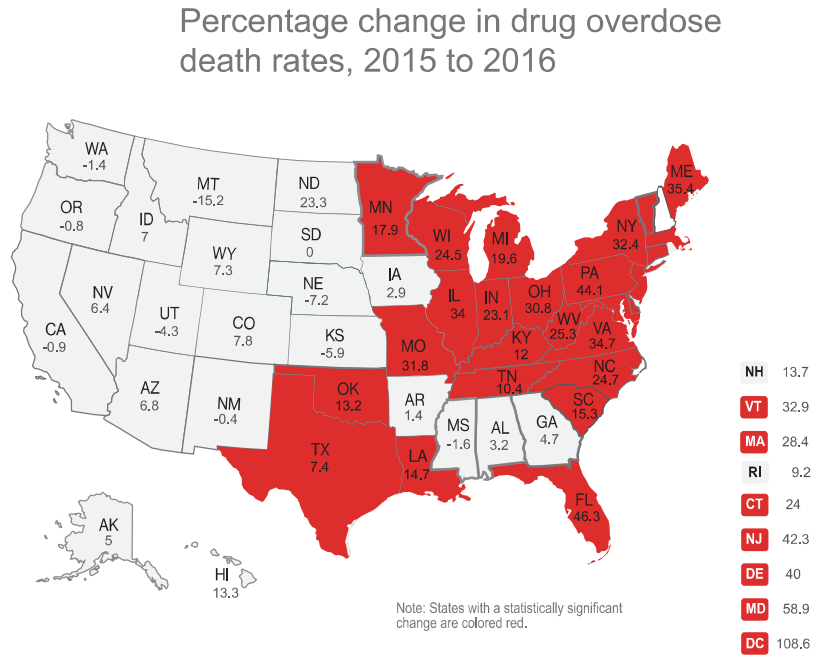


Figure 2



Sources: Rudd RA, Seth P, David F, Scholl L. Increases in drug and opioid involved deaths–United States, 2010-2015. *MMWR Morb Mortal Wkly Rep.* 2016;65(50-51):1445-1452; Centers for Disease Control and Prevention. Drug overdose death data, 2015-2016. https://www.cdc.gov/drugoverdose/data/statedeaths.html.

Many states are now working intensively to limit the supply of prescription painkillers and illicit drugs such as heroin and fentanyl. This has involved enhanced law enforcement efforts to track drug trafficking and to use shared data systems to identify where illicit opioids are being sold, often in partnership with public health officials and local health care providers who are frequently the first to see overdose spikes. States are also increasingly focused on tracking opioid prescriptions, educating prescribers about the risks of opioid-based medications, and identifying medical providers who overprescribe and patients who seek prescriptions from multiple sources. These efforts have involved the development of prescription drug monitoring programs, or PDMPs, which feed prescriptions into a state-maintained database that typically can be used to identify overprescribers. In 2017 alone, states enacted 42 laws to strengthen PDMPs, according to a tally by the National Conference of State Legislatures.[10]

At the same time, states are setting standards for how opioids are used to treat pain, in many cases building off the release in 2016 of guidelines from the federal Centers for Disease Control and Prevention for safe opioid prescribing.[11] Twenty-three states now have laws that set guidelines or limits on how long opioid-based painkillers should be prescribed to patients, often with exceptions for certain medical care such as cancer treatment or palliative care.[12] Some states, such as Oregon and Ohio, have also begun implementing policies to encourage the use of non-opioid treatments for pain, often through their Medicaid programs.[13]

In addition to controlling the supply of opioids, most states are actively bolstering their emergency response capacity in an effort to reduce the death toll from drug overdose. Much of this work has focused on increasing access to naloxone kits to revive overdose victims, making kits available not only to emergency response personnel but also, in some cases, directly to members of the public. Several states are experimenting with over-the-counter distribution of naloxone or, as in Massachusetts, co-prescribing naloxone kits to the family members of people who use opioid-based medication for chronic pain.[14] Health officials in many states are also working to develop better opioid surveillance systems that will allow emergency responders to see where drug overdoses are happening in real time and deploy resources accordingly.

Finally, states are increasingly looking to expand access to medical treatment for people with substance use disorders while working to overcome the stigma associated with addiction. This reflects, in part, a realization that addiction is a chronic disease like diabetes that requires ongoing medical attention. The interest in treatment also comes out of an emerging body of evidence that medication-assisted therapies, including methadone and buprenorphine, can be very effective in controlling opioid addiction and helping people return to normal lives.[15]

States are working to boost the availability of qualified medical providers who can provide medication-assisted treatment, and they are building new systems to connect people with care. With substance use disorders so prevalent among populations in the criminal justice system, many states are bolstering diversion programs that offer alternatives to incarceration. New York is experimenting with a special court for defendants who are addicted to opioids,[16] and Illinois is undertaking a major effort led by Gov. Bruce Rauner to expand the state's capacity to move defendants into treatment rather than jails.[17] And many states that have expanded Medicaid eligibility through the Affordable Care Act, such as Massachusetts, Ohio, Arizona, and Louisiana, have set up systems to enroll people with substance use disorder, particularly those who are leaving correctional facilities and are at high risk of relapse and overdose.[18]

Other states, such as New Hampshire, Vermont, and West Virginia, are using federal Medicaid waivers to build more comprehensive systems to care for people suffering from a substance use disorder. These have put a premium on not only medical treatment but also support and recovery services such as counseling, housing, job training, and education. In Maryland, for example, the state Medicaid program boosted reimbursement to encourage methadone providers to also offer counseling services to patients getting treatment.[19]

Crafting a Coordinated Response

The proliferation of policy interventions has generated considerable enthusiasm and spawned even more policy experiments in recent years. But the dizzying number of initiatives at the state level has also underscored the critical importance of coordination, as state agencies run the risk of duplicating efforts, wasting precious resources, and even unwittingly undermining their own programs. While coordination is simple in concept, it has proven considerably more challenging in practice. Logistical barriers such as limits on data sharing can make it difficult for government departments to work together. And different organizational cultures and missions at departments such as law enforcement and Medicaid can be hard to overcome. Nevertheless, state officials say several strategies have been helpful. These include:

- Strong, clear, and consistent leadership from a governor who has made the opioid crisis a top priority;
- A formal organizational structure to regularly bring together senior state officials from multiple departments to develop and implement coordinated policies;
- Robust engagement with outside stakeholders, including local and tribal government leaders, health care providers, and patients and families with direct experience with substance use disorder; and
- An intense focus on the collection and dissemination of timely, accurate data on opioid prescribing, use, and misuse.

Gubernatorial Leadership

Although any major public policy initiative at the state level usually requires engagement from the state's highest office holder, the ingredients of effective gubernatorial leadership are often complicated and nuanced. This is particularly true for an issue as complex as the opioid epidemic, which demands not only strong organization, strategic planning, and creative problem-solving, but also sensitivity to multilayered and evolving attitudes about addiction. "This can't just be a talking point, something that is announced in a State of the State address," said Marylou Sudders, health secretary of Massachusetts, where Gov. Charlie Baker has emerged as a national leader in addressing the crisis. "The governor has got to be all in."[20]

The Four Elements of a Successful Strategy

- Gubernatorial Leadership
- Institutionalizing Collaboration
- Outside Stakeholder Engagement
- Data

At the most basic level, many current and former state officials say, governors can signal to state agencies the importance of focusing on an issue like opioids. That makes a big difference when state agencies confront many competing demands and challenges, noted Hemi Tewarson, who heads the health division at the National Governors Association Center for Best Practices.[21] Several governors have done this by declaring a state of emergency. Equally important for crafting a coordinated opioid response, only governors have the authority to bring together multiple state agencies and demand cooperation. That changes the expectations for department heads and can expedite swift resolution of the kind of turf battles and logistical roadblocks that often impede cooperation in large organizations, state officials said. "If we have a problem overcoming a barrier, we can call the governor's office to get involved, because we know this is a top priority," said Dr. Cara Christ, health director in Arizona, where Gov. Doug Ducey has made the opioid crisis a focus of his administration.[22]

In Massachusetts, the governor's demand for swift action and cooperation helped expedite sharing of opioid mortality data between the state public health department and local government leaders who wanted the data to work on their own opioid strategies, according to Sudders. Public health officials had initially been reluctant to share the data for fear of stigmatizing individual communities.[23] By contrast, without clear signals from the governor's office, state departments tend to drift back to working on their own issues, noted several current and former state officials.

Governors are also uniquely positioned to drive innovative policy solutions that challenge existing ways of confronting problems, several state officials said. That is particularly important in a crisis like the opioid epidemic, which has strained the capacity of existing public and private institutions and which demands that state agencies forge new collaborations. "There has to be a reforming mindset, and that starts with the governor," said

Gary Mohr, the longtime head of the Ohio Department of Rehabilitation and Correction.[24] Ohio, a leader in the effort to confront the opioid epidemic, is overhauling how its prison system deals with inmates with substance use disorders. The state is substantially boosting treatment capacity in correctional facilities and building systems to connect patients leaving prisons with both Medicaid coverage and medical services in the community. These efforts are the direct result of collaboration with the state's behavioral health and Medicaid offices that wouldn't have been possible had Gov. John Kasich not demanded this kind of work, said Mohr and Tracy Plouck, who directs the state Department of Mental Health and Addiction.[25]

Mohr also credits Gov. Kasich with using his position to fight the stigma associated with addiction, which many senior state officials said remains a major barrier and one governors are well positioned to take on. "There has to be compassion," Mohr said. "Gov. Kasich has stressed how important it is to put a focus on people in the shadows.... He realizes, unlike some other folks, that we have human beings in our criminal justice system, not some lower form of life."[26] Many state officials and public health experts say that message is particularly critical in taking on the opioid epidemic as people with substance use disorder cannot be effectively treated if they remain marginalized.

In Massachusetts, Sudders similarly credits Gov. Baker with helping support expansion of medical treatment in the face of resistance from some in the community who favor more traditional abstinence-based strategies for dealing with addiction. "If you have a governor who believes that this is just about willpower, I don't know what you do," Sudders said.[27]

Institutionalizing Collaboration

States routinely create task forces or special commissions to respond to pressing issues, and the opioid epidemic has spawned numerous panels around the country. This approach, though hardly novel, has important benefits, many state officials say. A special commission or task force can underscore the urgency of an issue and signal its importance to stakeholders inside and outside state government. And bringing together state leaders regularly to confront a single issue is essential to promoting and sustaining collaboration. "It's important to have a place where things can be hashed out," said Katja Fox, the behavioral health director at the New Hampshire Department of Health and Human Services.[28] This is especially important as different state agencies can have competing priorities and clashes of culture. A senior health official in one state said, for example, that it had been challenging to work with corrections officials in the state, many of whom are more comfortable with traditional abstinence-based approaches to dealing with opioid addiction than medication therapies. In another state, a senior Medicaid official said the agency has struggled to overcome resistance to sharing data from the state's emergency response department.[29]

To emphasize the pressing nature of this crisis, several governors have tried to formally distinguish their opioid task forces from the many commissions that state governments

routinely convene. For some, that meant a charge to act fast. In Rhode Island, the governor gave her opioid task force just four months to develop a plan after she signed an executive order.[30] In Alaska, state officials modeled their organizational response on a traditional incident command structure that the state might use for a pressing emergency like a wildfire, according to Butler.[31] Massachusetts called its opioid effort a "working group," so it would stand out from more commonplace commissions.[32] And in Arizona, the opioid effort was organized as part of a gubernatorial initiative to convene "goal councils" to develop breakthrough projects to transform state government.[33]

While urgency is important, several state officials and others also emphasized that organizational structures designed to foster collaboration must be sustainable. "This is not a short-term issue," noted Tewarson at the National Governors Association. "It's something that is going to be around a long time, and so building systems that will be around awhile is key."[34] That durability has taken particular importance now as so many gubernatorial administrations are expected to turn over following the 2018 elections.[35]

New Hampshire's biweekly opioid meeting, first convened by the state's Democratic governor, has proved so essential that it has been kept by the new Republican governor who took office this year. In Rhode Island, the monthly meeting of the governor's opioid task force is still standing room only.[36] In Alaska, Governor Bill Walker holds regular cabinet-level meetings to discuss the latest situation report of the opioid incident command response and to plan action across all state departments.[37] And in Arizona, all cabinet members whose departments are involved in any way with the opioid crisis meet monthly to discuss the state's opioid action plan, which was completed in September.[38]

Finally, several state leaders emphasized that to be most effective, these interagency meetings need to be focused and goal-oriented and rely on measurable data. "People are not going to all of a sudden start singing Kumbaya. That's not human nature," cautioned Dr. Jeff Schiff, medical director for Minnesota Health Care Programs at the Minnesota Department of Human Services. "But if there are concrete tasks and goals—like how much naloxone am I responsible for getting into ambulances—that is more likely to get results."[39]

Louisiana's health secretary, Dr. Rebekah Gee, who has been helping lead that state's opioid response effort, agreed. "You have to have specific goals," Gee said.[40]

Outside Stakeholder Engagement

Many state officials said that in addition to bringing together state agencies, it is critically important to regularly and deeply engage stakeholders outside state government. "This is really a different kind of public health challenge," said Butler, the Alaska public health director. Butler compared the complexity of taking on the opioid epidemic to the comparatively more straightforward task of eradicating smallpox, often cited as one of the greatest triumphs in public health. "In that case, there was a vaccine and global response, but everyone was pretty much doing the same thing," Butler explained. By contrast, a success-

ful opioid strategy involves many more stakeholders and may require different approaches in different places, he said.[41]

Health care providers—including physicians who are prescribing opioids, hospitals that are handling overdoses, and clinics that are treating patients with substance use disorders—play a critical role. Medical schools and professional societies have been key partners in state efforts to improve training for physicians and others who prescribe opioid-based pain medication.[42] So, too, are more traditional abstinence-based programs that provide recovery services to many patients. Institutions such as churches are very important in some communities. Local government agencies—including police, first responders, and coroners—are on the front lines of the crisis and often are leading innovative efforts of their own to confront the crisis.[43] In some parts of the country, tribal governments are vital partners, particularly given the huge impact that opioid addiction is having in many Native American communities. And patients recovering from addiction and their families bring essential perspectives, according to many state officials.

Several state leaders said involving outside stakeholders helped overcome resistance to potentially controversial policy interventions. Many states, for example, have had to work hard to get buy-in from physicians for PDMPs and for stronger rules for prescribing opioid-based painkillers. For some states, resistance among medical providers and others remains a major barrier. "It's complicated," said Dr. Judy Zerzan, chief medical officer at the Colorado Department of Health Care Policy and Financing.[44] Colorado health officials drew the ire of disability advocates after the state imposed a cap on the amount of opioid-based pain medication that Medicaid patients could get. Advocates, who hadn't been consulted on the policy change, complained to the governor's office. That, in turn, precipitated a series of meetings in which state health officials explained the reason for the cap and the procedures for getting exemptions. "While the department regularly engages advocates and stakeholders before implementing new policies, this is one case where our policy got ahead of that process," Zerzan said. "Our mantra is to go slow and work with people."[45] Since February of 2016, the number of Medicaid beneficiaries who exceed the cap has declined by approximately 75%.

Other states that have broken through these barriers often cite the need for sensitivity to opposing viewpoints and a willingness to compromise. Officials in Massachusetts, for example, wanted to restrict prescriptions of opioid-based painkillers to three days but settled for seven in the face of resistance from the state medical society. Massachusetts nevertheless became the first state to put prescribing limits in state statute, and officials there are now moving on to the next phase of regulation by focusing on prescribers who are outliers.[46]

Officials in several states said similar kinds of engagement have helped break down resistance to expanding medication-assisted treatment for people with substance use disorders. This has been particularly important in places where abstinence-based programs have been dominant and where there is lingering mistrust of methadone and other opioid maintenance

therapies. In Minnesota, officials discovered that sensitivity to these misgivings was critical to working with tribal communities in the state. But by sitting down with tribal leaders and engaging them in the development of an opioid strategy, officials were able to work with several tribes to set up Suboxone programs. "It takes a long time to build relationships," said Schiff, the Minnesota medical director. "But this was a success because they were at the table from the very beginning."[47]

Engagement with outside stakeholders has also helped bring innovative ideas to the table, according to numerous officials. In Arizona, the state set up a 24-7 hotline for primary care physicians after hearing from the medical community that many more doctors would be willing to care for patients with substance use disorder if they knew they could reach someone with more expertise who could help them.[48] Ohio officials broadened their opioid education campaign, which had primarily involved schools and faith groups, after employers suggested they could also be good messengers. Ohio now is partnering with the state's largest amusement park company to reach young patrons and employees at the company's parks.[49] "It is often much more important to listen than to talk," said Butler. "Lots of people have experiences and observations that they are willing to share."[50]

Data

Without exception, every current and former state official interviewed for this brief identified the collection and dissemination of timely, accurate data as a key foundation for a coordinated state opioid strategy. This includes basic data on the use of opioids, which allow state leaders to track the volume and source of opioid prescriptions and to quickly pinpoint overdoses and deploy emergency response and law enforcement personnel. And it includes information that allows states to measure the effectiveness of state policy initiatives. "You have to have data to connect your initiatives," said Gee of Louisiana. "Without it, you have no idea what you are doing." But gathering data and measuring the impact of what is being done have been difficult for states and remain significant impediments to collaborative policymaking.

In many cases, the barriers are technical. Simply standardizing how deaths linked to opioid overdose are classified by local coroners and medical examiners has proven a major enterprise in some states. Crafting data-sharing agreements between state agencies or between state governments and private sector stakeholders like hospitals has been problematic for other states. In still others, resistance from stakeholders in the medical community and elsewhere has stunted the development of robust data collection and monitoring programs.

As discussed above, strong gubernatorial leadership can help overcome some of these barriers, according to many state officials and experts. Major Juan Colon of the New Jersey State Police, who led development of that state's model Drug Monitoring Initiative and now travels around the country to share lessons with other states, said he can always tell how strong the leadership in a state is by who shows up at his meetings. New Jersey's

program—which collects data from emergency medical services, police, hospitals, and other agencies to alert authorities in real time about where spikes in overdoses are happening—depends on the participation of all these stakeholders. "The tool works best if everyone is feeding into it.... So, if I go to a state, I say I want lab directors, medical examiners, children and family services, public health, and others all there," Colon said. "That's not always the case."[51]

Some states have found that an emergency declaration can help expedite data sharing. That worked in Arizona, where state officials were able to use the state's existing system for reporting disease outbreaks to speed collection and dissemination of data on drug overdoses, said Christ, the state's health secretary.[52] In Alaska, Butler said state officials created a dedicated data team within incident command structure with representatives of key state agencies. That helped underscore the importance of data collection in the state's coordinated strategy, he said.

Engagement with outside stakeholders, as mentioned above, can also make a difference, state officials said. In New Jersey, Colon convened what he said was the first ever meeting of the state's local medical examiners to get them to feed data into the drug monitoring program. "I've bought a lot of coffees up and down the state," Colon said. In addition to helping state leaders identify where opioid use is most problematic, good data is critical to tracking progress. In Rhode Island, for example, the state's system of monitoring buprenorphine use helped identify an unexpected plateauing in the use of the medication-assisted treatment and prompted a new effort to ensure access to the therapy.[53] Equally important, data can help identify what may be working and what is not. This remains one of the largest challenges for states, which often don't have the luxury of waiting for rigorous academic studies of their many policy interventions. Even now, when there are encouraging declines in opioid prescribing and overdose deaths in many states, teasing out the precise cause of the changes is difficult. Butler, the Alaska public health director, noted: "I have been asked if I attribute (progress) to the public outreach, to the increased access to naloxone, to the mandatory use of the PDMP, or to the regulation of the number of pills dispensed, all of which have been part of the incident command response this year. My response is 'yes.'"[54]

Interagency collaboration can help address some of this measurement challenge, according to state officials and experts. Maryland, for example, has developed an overdose fatality review program that brings together officials from multiple state agencies to review drug and alcohol overdose deaths and assess what could be done differently to prevent similar deaths, a model used for years in many states to address child abuse deaths.[55] Still other states have engaged outside stakeholders to help develop and assess policy responses to the opioid crisis. In October, for example, Indiana University announced a $50 million partnership with the state and other stakeholders to address the opioid crisis there.[56]

Conclusion

None of the state officials interviewed for this brief claimed to have discovered the perfect opioid strategy. And nearly all emphasized that major challenges remain, not the least of which is that state residents and political leaders are demanding immediate results. "I don't think expectations could be any higher," said Fox in New Hampshire. "Unfortunately, change takes time."[57] Even some of the recent progress in reducing opioid prescriptions carries new risks, as health authorities fear that the crackdown on legal prescribing is driving more of the market underground. At the same time, officials in many states must navigate unusually difficult political terrain around health care, as Congress and the White House continue to threaten major cuts in federal Medicaid funding and repeal of the Affordable Care Act. And it remains unclear what the president's recent disaster declaration will mean for states and whether Congress will follow it up with additional funding for states to combat the epidemic.

Even in this unsettled environment, however, state officials in red states and blue voiced strong commitment to developing collaborative strategies to deal with the opioid crisis. Many said collaboration represents the best hope for reducing addiction and the human suffering caused by opioids. "All the things we do may be great," said Schiff in Minnesota. "But without integrating, we are never going to get to the heart of this problem."[58]

Acknowledgments

The author wishes to express thanks to the numerous state officials and policy experts around the country who generously shared their thoughts and experiences dealing with this public health crisis. The expert staff at the National Governors Association, especially Hemi Tewarson, Jeffrey McLeod, Melinda Becker, and Jeff Locke, were particularly helpful, providing numerous examples of state policy interventions that helped inform this issue brief and reviewing the brief before its publication. Dr. Jay Butler, Alaska's chief medical officer and public health director and immediate past president of the Association of State and Territorial Health Officials, also reviewed the brief and provided valuable feedback.

A Note on Sources

This brief is based primarily on interviews with current state officials and policy experts who work with state government, as well as presentations and conversations at the October 20, 2017, meeting of the Medicaid Evidence-based Decisions Project in Portland, Oregon, convened by the Center for Evidence-based Policy at Oregon Health & Science University. Among those interviewed at greater length were the following:

State Government Officials

Dr. Jay Butler, Chief Medical Officer and Director, Division of Public Health, Alaska Department of Health and Human Services

Dr. Cara Christ, Director, Arizona Department of Health Services

Dr. Judy Zerzan, Chief Medical Officer, Colorado Department of Health Care Policy and Financing

Dr. Rebekah Gee, Secretary, Louisiana Department of Health

Dr. Esteban Gershanik, Chief Information Officer, Louisiana Department of Health

Marylou Sudders, Massachusetts Secretary of Health and Human Services

Dr. Jeffrey Schiff, Medical Director for Minnesota Health Care Programs, Minnesota Department of Human Services

Katja Fox, Director, Division for Behavioral Health, New Hampshire Department of Health and Human Services

Kelley Capuchino, Administrator, New Hampshire Transformation DSRIP Waiver Program

Major Juan Colon, Commanding Officer, Office of the Regional Operations & Intelligence Center, New Jersey State Police

Tracey Plouck, Director, Ohio Department of Mental Health and Addiction

Gary Mohr, Director, Ohio Department of Rehabilitation and Correction

Stuart Hudson, Managing Director of Healthcare and Fiscal Operations, Ohio Department of Rehabilitation and Correction

Dr. Rachel Levine, Acting Secretary and Physician General, Pennsylvania Department of Health

Jennifer Koziol, Program Coordinator, Rhode Island Department of Health

Dr. Mark Levine, Vermont Health Commissioner

Dr. James Becker, Medical Director, West Virginia Medicaid

Keith King, Program Manager, West Virginia Department of Health and Human Resources

Jeff Lane, Substance Use Disorder Program Manager, West Virginia Department of Health and Human Resources

Cynthia Parsons, Program Manager, West Virginia Department of Health and Human Resources

Nongovernment Officials

Pam Curtis, Director, Center for Evidence-based Policy

Allison Leof, Senior Policy Analyst, Center for Evidence-based Policy

Jeffrey S. McLeod, Director, Homeland Security & Public Safety Division, National Governors Association Center for Best Practices

Hemi Tewarson, Director, Health Division, National Governors Association Center for Best Practices

Margaret Wile, Policy Specialist, Health Program, National Conference of State Legislatures

Karmen Hanson, Program Manager, Health Program, National Conference of State Legislatures

Kate Blackman, Senior Policy Specialist, Health Program, National Conference of State Legislatures

Trish Riley, Executive Director, National Academy for State Health Policy

Robin Rudowitz, Associate Director, Kaiser Family Foundation Program on Medicaid and the Uninsured

Samantha Artiga, Director, Disparities Policy Project, Kaiser Family Foundation

Notes

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[20] Author interview with Marylou Sudders. November 15, 2017.

[21] Author interview with Hemi Tewarson. November 8, 2017.

[22] Author interview with Dr. Cara Christ. November 22, 2017.

[23] Sudders interview. November 15, 2017.

[24] Author interview with Gary Mohr. December 1, 2017.

[25] Author interview with Tracey Plouck. November 16, 2017.

[26] Mohr interview. December 1, 2017.

[27] Sudders interview. November 15, 2017.

[28] Author interview with Katja Fox. November 15, 2017.

[29] These officials asked not to be identified speaking frankly about problems they have encountered working with colleagues in other branches of state government.

[30] Rhode Island Office of the Governor news release, July 12, 2017. https://www.ri.gov/press/view/30945. Accessed December 26, 2017.

[31] Butler interview. November 17, 2017.

[32] Sudders interview. November 15, 2017.

[33] Christ interview. November 22, 2017.

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[35] National Governors Association summary of 2018 gubernatorial elections. https://www.nga.org/cms/1718Elections. Accessed December 26, 2017.

[36] Author interview with Jennifer Koziol. November 15, 2017.

[37] Author interview with Dr. Jay Butler. December 8, 2017.

[38] Christ interview. November 22, 2017.

[39] Author interview with Dr. Jeffrey Schiff. November 8, 2017.

[40] Author interview with Dr. Rebekah Gee. November 16, 2017.

[41] Butler interview. November 17, 2017.

[42.] Author interview with Dr. Rachel Levine. December 14, 2017.

[43.] Innovative initiatives include several efforts by local law enforcement agencies around the country to steer people with substance use disorders into treatment rather than into the criminal justice system. Among them are the Police Assisted Addiction & Recovery Initiative (PAARI) program, pioneered in Massachusetts, see http://paariusa.org/wp-content/uploads/sites/46/2016/11/PAARI-Annual-Report-1.pdf; the Stop, Triage, Educate, Engage, Rehabilitate (STEER) program undertaken in Maryland; and the Law Enforcement Assisted Diversion (LEAD) program in Seattle and King County, Wash., see http://leadkingcounty.org/about/.

[44.] Comment by Dr. Judy Zerzan at MED Project meeting. October 20, 2017.

[45.] Author interview with Dr. Judy Zerzan. December 7, 2017.

[46.] Sudders interview. November 15, 2017.

[47.] Schiff interview. November 8, 2017.

[48.] Christ interview. November 22, 2017.

[49.] Plouck interview. November 16, 2017.

[50.] Butler interview. November 17, 2017.

[51.] Author interview with Major Juan Colon. November 29, 2017.

[52.] Christ interview. November 22, 2017.

[53.] Koziol interview. November 15, 2017.

[54.] Butler interview. December 9, 2017.

[55.] For information on this program, which the National Governors Association has identified as a model for other states, see: https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Pages/OFR-.aspx.

[56.] Indiana University news release. October 10, 2017. https://news.iu.edu/stories/2017/10/iu/releases/10-addiction-grand-challenge.html. Accessed December 26, 2017.

[57.] Fox interview. November 15, 2017.

[58.] Schiff interview. November 8, 2017.

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