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TRANSCENDING MET (MONEY, EGO, TURF)

A WHOLE PERSON, WHOLE GOVERNMENT APPROACH TO ADDRESSING SUBSTANCE USE DISORDER THROUGH ALIGNED FUNDING STREAMS AND COORDINATED OUTCOMES

O'NEILL INSTITUTE
FOR NATIONAL & GLOBAL HEALTH LAW

GEORGETOWN LAW

ABOUT THIS REPORT

This report is a product of the Addiction and Public Policy Initiative of the O'Neill Institute for National and Global Health Law at Georgetown Law Center. The essential vision for the O'Neill Institute rests upon the proposition that the law has been, and will remain, a fundamental tool for solving critical health problems in our local, national, and global communities. The Addiction and Public Policy Initiative works to advance a public health approach to substance use disorders and the overdose epidemic through policies, practices, and regulations that promote evidence-based treatment and recovery.

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A GUIDE FOR SYSTEMIC CHANGE IN STATES AND LOCAL COMMUNITIES, WITH A FOCUS ON ALIGNING REFORMS WITH FLEXIBLE, COLLABORATIVE FUNDING TO PROMOTE POSITIVE, COMMUNITY-DRIVEN OUTCOMES

EXECUTIVE SUMMARY

STATES AND LOCAL GOVERNMENTS ARE GRAPPLING with escalating rates of overdose and ongoing challenges with addiction, exacerbated by the COVID-19 pandemic and an unpredictable and volatile drug supply. The multiple, disconnected systems that address substance use disorder (SUD) create a longstanding challenge to the state and local response to addiction. These systems include not only prevention, treatment, harm reduction and recovery, but also mental health, healthcare, hospitals, emergency medical services, courts, corrections, child welfare, schools, shelters, housing supports, vocational training, economic development, public assistance, and more. Individuals with SUD must often engage with these multiple, disjointed systems through various government agencies in order to access needed services and supports.

Money, Ego and Turf (collectively “MET”) perpetuate structural barriers to addressing SUD, including an onerous regulatory structure and disjointed funding, impede access to quality treatment and non-clinical community-based supports, and lead to challenges with linkage, engagement, and achieving long-term recovery. Societal barriers, including stigma, discrimination, and longstanding racial inequality, also prevent people from accessing needed care, services, and supports.

Further, a lack of coordinated infrastructure that helps to facilitate shared goals, evidence-based practices, and data consistency across these systems creates silos and inefficiencies that prevent a comprehensive strategy necessary to address addiction in the United States. For providers and government program administrators, these disconnected systems create disorganization, fragmentation, and duplication within the larger landscape of care. For many individuals and families, the current structure is, at best, ineffective, and at worst, contributes to the skyrocketing number of drug-related deaths. This system architecture has also led to initiative fatigue, duplicative and onerous reporting and regulatory structures, and a lack of trust among providers.

A recent infusion of significant federal dollars, opioid litigation proceeds, and other funding sources, such as philanthropy and cannabis tax revenue, as well as innovation and research, has created an opportunity for governments to re-imagine traditional approaches to SUD. With the opportunity to direct local, state, and federal funds, governments can implement a new, cohesive system to promote access to evidence-based, individualized, low-barrier care.

This brief proposes guiding principles and concrete recommendations for governments to leverage this momentum and transform government budgets to incentivize investment in a coordinated, targeted, and outcomes-driven approach to SUD. The principles presented were developed through research on best and promising practices in the SUD space and other health and social justice areas, as well as focus group and individual interviews across

the spectrum of government, public health, law enforcement and criminal justice, health and behavioral health systems. These interviews and focus groups included persons with lived experience with substance use disorders, as well as representatives from innovative programs that have used incentives and funding structures to drive positive outcomes.

This brief is not exhaustive and is intended to be the beginning of a roadmap to re-imagine how we address addiction in this country. It builds on a body of work that includes recommendations[1] for federal reforms to restructure how SUD is financed and measured in the United States.

COMPONENTS OF AN ALIGNED SYSTEM FOR SUD ACROSS THE WHOLE OF GOVERNMENT

SUMMARY OF RECOMMENDATIONS

1. POLICIES AND PROGRAMS ACROSS ALL OF GOVERNMENT SUPPORT RECOVERY AND REFLECT SCIENCE AND EVIDENCE

- Evidence-based, evidence-informed, high-quality services across government
- Services, support and treatment on demand
- Racial equity, economic disparities, and cultural awareness
- Whole person and recovery-oriented system
- Trauma-informed and compassionate systems
- Continuous quality improvement

2. STANDARDIZED OUTCOMES FOR SUD ACROSS GOVERNMENT AGENCIES

- Standardized data reporting across government agencies
- Whole-person outcome measures across the government
- Standardized, outcome-based data framework to address SUD across government agencies

3. ALIGNING FUNDING FOR SUD ACROSS GOVERNMENT AGENCIES TO MEET A COHESIVE SET OF OUTCOMES

- Leverage federal programs to blend and braid funding across systems
- Implement models to map funding across government agencies and align goals, missions, and outcomes

4. GOVERNANCE FOR AN ECOSYSTEM OF CARE

- Coordinated governance that transcends leadership changes
- Coordinated data collection and data sharing to support aligned funding and outcomes

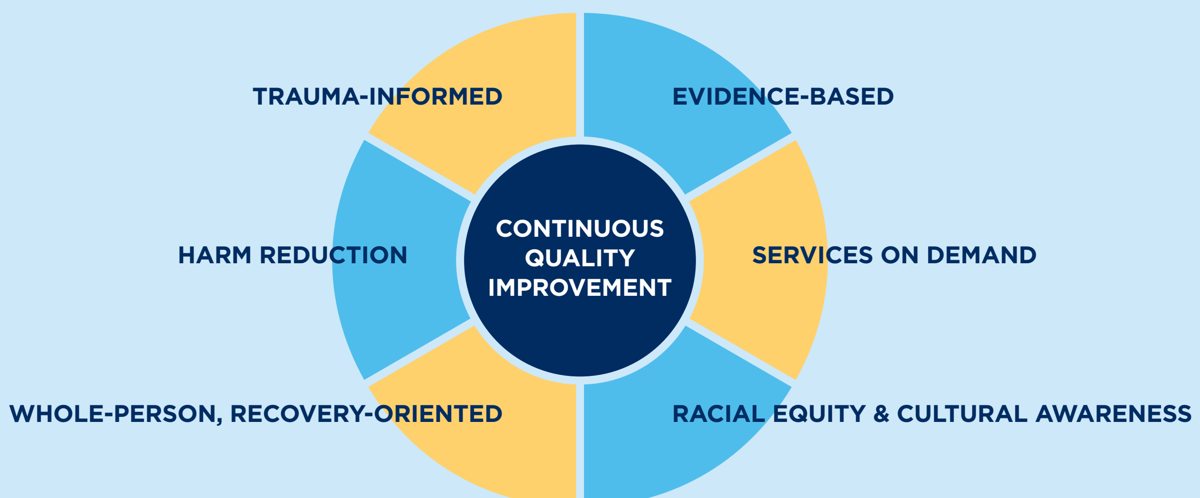
THE FOLLOWING RECOMMENDATIONS ARE TO SUPPORT GOVERNMENTS IN THE DEVELOPMENT AND IMPLEMENTATION OF A COORDINATED SYSTEM TO ADDRESS SUD.

1. ENSURE POLICIES AND PROGRAMS ACROSS ALL OF GOVERNMENT SUPPORT RECOVERY AND REFLECT SCIENCE AND EVIDENCE

THE QUALITY, ACCESSIBILITY, AND PHILOSOPHY OF POLICIES AND PROGRAMS affect retention in treatment and sustained recovery. Medical advances, the science of addiction, and lived experiences inform our current understanding of SUD as a complex, life-long condition, requiring a multi-faceted and evidence-based approach to prevention, treatment, and recovery.[2]

Structural and social barriers preventing a strategic and aligned approach to addressing SUD require attention. Regulatory hurdles, bureaucratic delays, and outdated frameworks for SUD stand in the way of systems that prioritize individual choice, consent, and engagement. Further, reform efforts must recognize and dismantle health inequities within SUD systems.

GUIDING PRINCIPLES FOR A WHOLE PERSON, WHOLE GOVERNMENT APPROACH TO SUD



The centerpiece of the approach described in this report is an aligned funding and expanded outcomes framework across all government agencies touching individuals and families experiencing, or at risk of developing, SUD. It also moves beyond the narrow goal of preventing overdose and providing acute care towards outcomes focused on broader positive health and social outcomes. This approach seeks to expand outcomes across the spectrum of prevention, treatment, and recovery. Recovery is defined as a process "through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[3] This strategy also includes a governance infrastructure that codifies reform efforts to ensure continuity through shifts in leadership and political landscape.

This approach to system reform is guided by the following principles:

EVIDENCE-BASED, EVIDENCE-INFORMED, HIGH-QUALITY SERVICES ACROSS GOVERNMENT

Evidence-based and evidence-informed practices can reduce overdose morbidity and mortality, contribute to sustained recovery, promote consistency and accountability, increase cost-effectiveness, and improve the overall quality of care.

Governments across all agencies addressing SUD can require or incentivize programs to use evidence-based and evidence-informed practices through regulatory frameworks and funding.[4] Initiatives should include sufficient funding, adequate reimbursement rates, training, and supervision to enable practitioners and programs addressing SUD across different systems to deliver quality services rooted in evidence. Governments should partner with researchers, practitioners, and service recipients to ensure research evaluates the viability of current practices in real world settings, developed using diverse samples, and update practices that may no longer be effective.

Further, funding for SUD is largely limited to acute treatment, rather than addressing the full array of supports and services necessary for people to achieve sustained recovery.

There are promising models that drive funding towards supporting evidence-based practices. For example, the Results First Clearinghouse Database from the Pew Charitable Trusts consolidated and centralized national data and evidence from over 3,000 social policy programs in areas such as behavioral health, criminal justice, education, and public health.[5] Since 2010, 27 states and 10 counties have used this initiative to inform their policy and budget decisions with evidence-based and customizable tools, such as cost-benefit analysis.[6]

In the SUD space, there is significant research on evidence-based treatment and best practices that prevent overdose and support recovery. For example, medications for opioid use disorder (MOUDs) are the gold standard of care for treatment of opioid use disorder (OUD).[7]

Despite MOUD efficacy and safety, however, less than 30% of patients are provided any medication treatment options in the year following a non-fatal opioid overdose.[8]

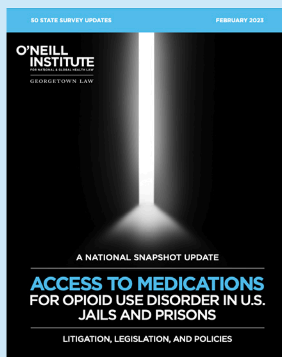
Ensuring that laws, regulations and policies across all government programs addressing SUD permit, and in some instances, require and fund access to MOUD is one meaningful step that governments can take to operationalize access to evidence-informed, high-quality SUD care. For example, in 2022, Congress eliminated the DATA Waiver (or X-Waiver), which

required practitioners to obtain a waiver from SAMHSA to prescribe buprenorphine to treat OUD. Removing the waiver paved the way for providers to use buprenorphine without additional bureaucratic hurdles.[9] However, each state must now examine its own regulatory framework to support and advance increased access to this medication.

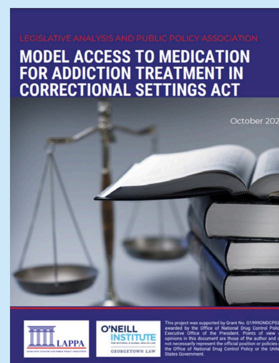
A new approach must ensure that all systems touching addiction—including those outside of the traditional treatment system—incorporate evidence-based and evidence-informed practices. U.S. carceral systems are an example of a siloed system operating outside of traditional addiction treatment. Lack of screening for SUD and inadequate access to medical and psychological treatment, including SUD treatment,[10] has led to increased drug-related deaths both in correctional settings and upon reentry.[11] Unclear protocols and insufficient training for staff in jails and prisons further exacerbates the issue.[12] Prioritizing funding and policies requiring access to health services in correctional settings, including mental health and evidence-based SUD treatment, will save lives and reduce costs associated with deaths in custody.[13]

In recent years, at least thirty-one states have issued executive orders, passed legislation, budgeted significant funding, taken administrative action, and established agency policies governing SUD treatment for incarcerated individuals.[14] While the scope and quality of these actions vary across states, they have collectively led to an incremental increase in access to evidence-based treatment, including MOUD, in correctional settings. In 2023, the Centers for Medicare and Medicaid Services (CMS) approved a novel request by California to use Medicaid funding to pay for certain health services—including to treat SUD—in correctional settings.[15] CMS also released guidance on how other states can develop similar initiatives to use Medicaid funding during incarceration to support reentry.[16]

RELATED PUBLICATIONS



The ***National Snapshot: Access to Medications for Opioid Use Disorder in U.S. Jails and Prisons*** presents laws, policies, and court actions related to access to medications for opioid use disorder (MOUD) in correctional facilities in the U.S.



The Model Access to Medication for Addiction Treatment in Correctional Settings Act sets forth a comprehensive, evidence-based framework for ensuring that all incarcerated individuals with a substance use disorder be provided access to FDA-approved medication for addiction treatment in state and local correctional settings.

RECOMMENDATIONS

- **Identify and address regulatory burdens to delivering and receiving evidence-based treatment, harm reduction, and recovery supports**
- **Tether grant funding to evidence-based and evidence-informed services**
- **Ensure adequate funding and reimbursement to support delivery of evidence-based treatment and practices across all systems touching SUD, including for practitioner training and supervision**
- **Leverage Medicaid Section 1115 waiver opportunities to fund innovative demonstration programs, including in carceral settings**
- **Ensure that research is regularly translated into actionable policy and practice**
- **Expand funding for SUD to include the full array of supports and services necessary for people to achieve sustained recovery**

SERVICES, SUPPORT AND TREATMENT ON DEMAND

Systemic barriers to treatment and lack of comprehensive recovery supports, as well as social conditions that increase the risk of addiction, help drive the disjointed approach to prevention, treatment, harm reduction, and recovery support systems for people with, or at risk of developing SUD.[17]

According to the 2021 National Survey on Drug Use and Health, of the 43.7 million people ages 12 and over with SUD, only 13% (or 4.1 million) received any care.[18]

Redesigning the system must prioritize on demand treatment that involves immediate access to an appropriate level of care that centers patient consent, engagement, and evidence-based practices.

Often, people with SUD have a range of co-occurring medical, mental health and social needs. States can begin to address this with initiatives aimed at incentivizing the integration of physical health, mental health and SUD services through: (1) streamlining the regulations governing each system, (2) establishing incentives for payers and providers to achieve outcomes related to integration, (3) providing technical assistance and targeted funding to support the development of workforce and staff competencies across systems, and (4) incorporating care management and care navigation elements into historically disconnected systems.

Additionally, a “no wrong door” approach[19] allows individuals wanting or needing SUD treatment or supports to immediately access care through the multiple systems touching upon SUD, including primary care facilities, shelters, mobile outreach units, criminal justice settings, or emergency services. This approach encourages individuals with SUD and their families to seek treatment without fear of punishment and promotes the implementation of whole-person, integrated care, leading to a higher quality of care and improved health outcomes.

SPOTLIGHT ON...
TREATMENT IN EMERGENCY DEPARTMENTS

Providing people who present to emergency departments with alcohol and other drug-related emergencies with immediate access to evidence-based treatment, including medications where clinically indicated, and "hot handoffs" to harm reduction, recovery supports, and further treatment. Examples: The California Bridge to Treatment Initiative[20] and New Jersey Opioid Overdose Response Program[21]

State legislation can be an important vehicle for reform. The O'Neill Institute, in collaboration with the Legislative Analysis and Public Policy Association, developed a model state law requiring emergency departments to offer a suite of services to people who present with a drug-related emergency, including medications for opioid use disorder, naloxone, and peer support.

Further, prioritizing investments in initial engagement in care or support through non-clinical environments, such as Recovery Community Organizations and harm reduction organizations, will expand access to care and may result in more person-centered, recovery-oriented systemic approaches.

RECOMMENDATIONS

To begin this process, governments must (1) assess their regulatory frameworks, policies and practices—including reimbursement and payment structures—across all systems touching addiction to identify the barriers that exist through systematic review and engagement with impacted populations, (2) take steps to remove these barriers, and (3) affirmatively incorporate policies and practices that promote access.

RACIAL EQUITY, ECONOMIC DISPARITIES, AND CULTURAL AWARENESS

A truly responsive system will consider the unique cultural needs and individualized history of the person seeking assistance. In re-designing the system, policymakers must engage communities in defining the barriers faced and in determining how the system could be restructured to alleviate some of these barriers.

Poverty and lack of insurance are key barriers to receiving treatment.[22] The lack of Medicaid expansion in some states is a missed opportunity to leverage federal dollars[23]; as a result, states must use other sources of funding that could otherwise be spent productively on services that are not reimbursable by Medicaid.[24]

RACIAL DISPARITIES IN SUD TREATMENT[25]

COMPARED TO WHITES, BLACKS ARE:

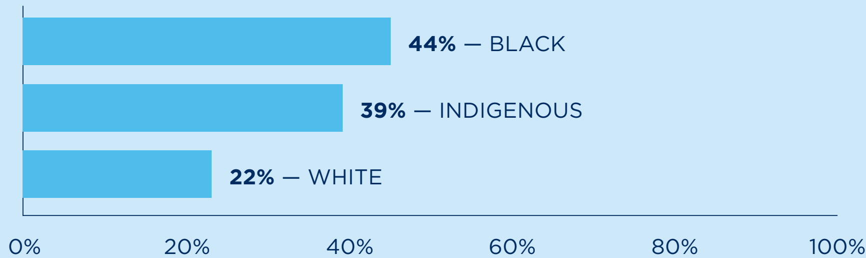
70% LESS LIKELY
TO RECEIVE BUPRENORPHINE

50% LESS LIKELY
TO OBTAIN ANY SUD TREATMENT FOLLOWING OVERDOSE

3.64X MORE LIKELY
TO BE ARRESTED FOR POSSESSION OF CANNABIS

PERCENT INCREASE IN OVERDOSE DEATHS

2019-2020



- Overdose death rate among Black males 65+ years old was nearly 7X higher than that of White males 65+ years old.
- Overdose death rates for Indigenous women 25-44 years old were nearly 2X higher than that of White women 25-44 years of age.

Despite similar rates of substance use among various racial and ethnic populations, racial disparities in access to treatment and incarceration persist.[26] As overdose deaths in Black and Indigenous communities exponentially increase, there is an urgent need to actively address the barriers faced by Black, Indigenous, and other communities of color in accessing care and needed services.[27]

These barriers exist for underrepresented minority communities at both acute and chronic care access points. It takes Black people up to five years longer to access OUD treatment than their White counterparts,[28] at a time when the fastest growing demographic for overdose death is Black and Indigenous people.[29] Moreover, the type of care received by Black individuals can differ greatly, as buprenorphine and methadone treatment rates differ significantly among racial and ethnic groups. Black patients are four times less likely to receive a referral to a buprenorphine provider, compared to White patients, who make up 92% of all buprenorphine patients.[30] Black patients were much more likely to receive methadone as their medication.[31] Unlike buprenorphine, which may be dispensed by a licensed practitioner in a traditional office setting, methadone is subject to stricter federal regulations and is largely dispensed in opioid treatment programs (OTPs).[32] Black and Hispanic patients also receive methadone doses lower than the recommended amount, compared to White patients.[33]

There are examples across the country that governments can invest in, support, and scale. The Gwayakobimaadiziwin Bad River Harm Reduction program, for example, operates a syringe service and harm reduction program in northern Wisconsin. Rooted in the seven teachings of the Ojibwe, Bad River has offered culturally appropriate harm reduction services to people who use drugs in Indigenous communities and beyond since 2015.[34] Similarly, Black Faces, Black Voices is a collaborative that promotes the humanity, recovery,

SPOTLIGHT ON... KENTUCKY OPIOID RESPONSE EFFORT

METHADONE ENROLLMENT
FOR BLACKS WAS 4X LOWER THAN THAT FOR WHITES[35]

FATAL OPIOID-RELATED OVERDOSES
INCREASED 34.3% FOR BLACKS, COMPARED TO 12.8% FOR WHITES[35]

DATA

- Interventions in data alignment, identification & monitoring of disparities, identification of data gaps, such as missing race/ethnicity data in Medicaid beneficiary reports

POLICY

- Increase Medicaid enrollment for Black Kentuckians
- Increase Managed Care Organization (MCO) engagement by reducing burdens in contract language and reporting

PROVIDERS

- Incentivize with grants to support equitable services access
- Amend contract language to facilitate increased access
- Provide grant writing support for providers
- Promote workforce diversity in behavioral health
- Racial equity training for all behavioral health providers

CLIENT

- Support expansion of underrepresented organization capacity, including focus on culturally relevant innovation, reduce barriers to contracting with state, & technical assistance for grantees
- Host community education & outreach strategies
- Establish new partnerships to engage communities of color
- Monitor effectiveness & training

and well-being of Black individuals with SUD, through collective lived experiences and equitable access to resources.[36]

Motivated by stark racial disparities in overdose deaths and access to evidence-based treatment, Kentucky implemented an equity-focused initiative to increase access to funding for Black-serving organizations by focusing on culturally relevant and innovative proposals, reducing barriers to contracting with the state, and monthly grantee meetings where technical, funding assistance was provided to Black-led and -serving agencies.[37] The initiative also focused on improved data collection for the identification of disparities and previous data gaps, such as missing race or ethnicity data in Medicaid beneficiary reports.[38] The Governor's Office also led an initiative to increase Medicaid enrollment for Black Kentuckians, implement reporting requirements, and disaggregate data to monitor and hold accountable Kentucky's Medicaid insurance providers.[39]

Infusing racial equity and cultural awareness to address SUD across government agencies requires the intentional incorporation of equitable principles at every level, with ongoing championing at the highest leadership levels.

RECOMMENDATIONS

- **Identify gaps in demographic data to address racial equity**
- **Incentivize providers to increase access to evidence-based treatment, harm reduction, and recovery support services for communities of color**
- **Ensure services are culturally responsive and evaluated for effectiveness**
- **Ensure meaningful engagement and representation of affected communities across the spectrum of policy and program development, implementation, and funding**

WHOLE PERSON & RECOVERY-ORIENTED SYSTEM

A comprehensive and aligned ecosystem addressing addiction must go beyond treatment and prioritize improving the overall health and well-being of individuals, families, and communities. Services across government agencies must address not only the individual's immediate needs but the needs of the family, and must incorporate services that address long-term goals, building a support community, and developing skills for social and economic mobility.[40]

Recovery capital refers to the quantity and quality of internal and external resources that one can bring to bear to initiate and sustain recovery from addiction.[41] It has four overlapping dimensions—personal, social, community, and cultural capital. Concrete actions governments can take to incorporate recovery capital into the policy response for SUD include: (1) Incorporating projects that promote recovery capital into funding opportunities, (2) identifying standard outcomes measures to support recovery, (3) providing support and incentives for the ability to measure recovery capital to service providers across systems, (4) funding technical assistance to incorporate recovery supports into individualized recovery plans, and (5) interpreting results for government decision makers across systems. Tools such as the Recovery Capital Index[42] and the Recovery Data Platform[43] can help measure outcomes focused on wellbeing, recovery capital, and social determinants.

People with SUD may have experienced trauma, domestic violence, poor nutrition, unstable housing, and lack of other social support.[44] In a recovery-oriented system of care (ROSC) model, individuals engage with an integrated infrastructure of services that "encompasses a menu of individualized, person-centered, and strength-based services within a self-defined network."[45]

In 2019, Palm Beach County, Florida established a readily accessible, person-centered, recovery-oriented system of care with the goal of improving long-term recovery outcomes. Its system model includes (1) assessment for SUD and mental health needs with subsequent coordination of care, (2) a care provider network which includes both clinical and non-clinical services, and (3) a network of recovery community organizations and

allied recovery community centers providing recovery support services. The system utilizes a recovery capital index to measure outcomes such as stable housing, employment, social capital, and other risk and resiliency factors.

Individual programs around the country are beginning to incorporate a whole person approach and can be brought to scale through funding and other incentives. In Phoenix, Arizona, for example, Hushabye Nursery provides infants experiencing neonatal abstinence syndrome (NAS) and their caregivers with the facilities and staff to provide short-term holistic medical care and therapeutic support, and reduce adverse childhood experiences.[46]

RECOMMENDATIONS

- **Adopt a recovery-oriented system of care model**
- **Incorporate projects that promote recovery capital into funding opportunities**
- **Identify standard outcomes measures to support recovery and mechanisms to collect and interpret data**
- **Provide support and incentives for the ability to measure recovery capital to service providers across systems**
- **Fund technical assistance to incorporate recovery supports into individualized recovery plans**
- **Interpret results for government decision makers across systems**

TRAUMA-INFORMED & COMPASSIONATE SYSTEMS

Trauma puts individuals at risk for developing a substance use disorder. Trauma is "multidimensional, including physical and psychological injuries with long-term effects on well-being and function."[47] Such trauma can occur in childhood or adulthood, including trauma that occurs due to intimate partner violence or grief and loss. Additionally, because of the continued use of criminal legal tools to address substance use and legacy policies that may stigmatize rather than support, people who use substances often continue to experience trauma as they encounter or engage with the systems addressing SUD.[48] This can include violence during interactions with police and during incarceration and stress related to involvement in the court system and child welfare system. In addition, collateral consequences of criminal legal involvement, such as the loss of the ability to obtain and maintain certain licenses or employment and restrictions on housing, can compound the direct consequences of SUD (e.g., consequences imposed by the court in judgment), making community reentry socially and economically much more challenging.[49]

A "whole person, whole government" approach can only be trauma-informed if policies within each component system are examined and amended to ensure the response to SUD reduces, rather than contributes to, trauma.

Each component system must be organized to assess, identify, and provide linkages to services to address any underlying trauma that contributes to substance use or occurs during system engagement. Additionally, governments must incorporate a prevention strategy that proactively includes opportunities to evaluate for and mitigate adverse childhood experiences.

Our systems also consistently fail to address intergenerational trauma. Two million children live in families with at least one parent with an "illicit SUD."[50] The number is even higher if families where one parent has an alcohol use disorder are included. Our current response to SUD engages many of these children and families into a child welfare system that is underfunded, workers are under-trained, and parental rights may be terminated for seeking evidence-based treatment using MOUD.[51]

States should adopt legislative approaches that prioritize, rather than criminalize, SUD treatment for pregnant persons and link parenting people and their children to assistance. The Office of National Drug Control Policy released the Model Substance Use During Pregnancy and Family Care Plans Act, which: (1) provides certain protections to pregnant or postpartum individuals with a substance use disorder so that such individuals are not penalized for receiving medical treatment, including medication(s) to treat the substance use disorder and (2) establishes that an infant born affected by parental substance use disorder or showing signs of withdrawal is not, by itself, grounds for submitting a report of child abuse or neglect.

Adopting laws with these protections is an important first step, but wholesale systems reform is still necessary to ensure an evidence-based approach to family welfare.

RECOMMENDATIONS

- **Assess individual components of the SUD ecosystem and adopt policies and practices to ensure that services are ameliorating, rather than exacerbating trauma**
- **Incorporate a prevention strategy that proactively includes opportunities to evaluate for and mitigate adverse childhood experiences**
- **Invest in training and supervision to operationalized "trauma-informed" care and support across all systems touching SUD**
- **Adopt laws and policies that prioritize, rather than criminalize, SUD treatment for pregnant persons and link parenting people and their children to assistance for any special health or educational needs they may encounter**
- **Expand policies and practices to ensure that interactions with systems and programs addressing SUD include opportunities for family support and linkages to treatment and support for the whole family, including children**
- **Require managed care plans to pay for linkages to mental health treatment/supports as well as treatment and supports for families and children**

CONTINUOUS QUALITY IMPROVEMENT

Creating a culture of continuous quality improvement is essential. Such quality improvement would include working with the communities served to identify metrics of success, monitoring metrics regularly, and adjusting the system based on performance. It would include regular solicitation of feedback from program participants and incorporation of feedback into actionable reforms.[52] Additionally, it would involve review of emerging research, dissemination of new findings, and alignment of service delivery with the evolving evidence-base.

Some jurisdictions have leveraged funding to better prepare their communities for the future. Private funding from the Pittsburgh Foundation enabled the Health Department in Alleghany County, Pennsylvania, to develop a long-term, evidence-based, equitable approach, called The Plan for a Healthier Allegheny 2023-2027, to improve the health of its residents.[53] This ongoing and forward-looking evaluation strategy aims to expand low-barrier, technology-supported access to SUD treatment, increase the number of certified recovery specialists, work with community healthcare providers to normalize and promote MOUDs in the treatment of OUD, revise county protocols to support sterile syringe programs, and include people with lived experiences in positions throughout the Health Department.[54]

RECOMMENDATIONS

- **Include and engage communities to identify comprehensive measures of success**
- **Identify and monitor metrics of success and adjust system based on performance**
- **Engage in regular solicitation of feedback from program participants and incorporation of feedback into actionable reforms**[55]
- **Review emerging research, disseminate new findings, and align service delivery with the evolving evidence-base**

2. DEVELOP A SET OF STANDARDIZED OUTCOMES FOR SUD ACROSS GOVERNMENT AGENCIES

INCOMPLETE, UNRELIABLE, AND INCONSISTENT DATA COLLECTION has long plagued the public health field and other systems addressing SUD, hampering the ability of policymakers to identify gaps in access to quality care and implement effective change. In its current forms, the infrastructure surrounding SUD data collection, analysis, and sharing is lacking in both how data is collected and what type of outcomes are being measured.[56] The result is a patchwork of data sets that are increasingly difficult to coalesce into an evidence-based comprehensive approach useful for community leaders, policymakers, and healthcare providers.

THE NEED FOR STANDARDIZED DATA REPORTING ACROSS GOVERNMENT AGENCIES

Inconsistent reporting parameters are a significant challenge. Different programs are required to collect and stratify data across different sets of classifications, including basic demographics. These inconsistencies often begin with federal data collection requirements. For example, the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS) and the Community Mental Health Services Block Grant (MHBG), two of the largest sources of funding to states for SUD services, have inconsistent demographic classifications for age, race, gender identity, and sexual orientation.[57] Inconsistencies in data collection provide an incomplete picture of individuals seeking and receiving SUD care across systems, and the impact that funding and services have on an individual's quality of life. It further hinders our ability to address health disparities,[58] as the collection and analysis of accurate, consistent demographic data helps to identify areas of inequitable access to quality healthcare.[59]

Recognizing the need for comprehensive, consistent data, the National Institutes of Health (NIH) and the Substance Abuse and Mental Health Services Administration (SAMHSA) partnered to launch the HEALing Communities Study, a multi-site, $350 million endeavor within the larger NIH HEAL Initiative, to examine the efficacy of coordinated systems of healthcare and support services on access to SUD treatment and care at the local level.[60] The overall objective of HEALing is to evaluate the impact of integrated, community-engaged, data-driven, and evidence-based interventions on opioid overdose deaths.[61]

Delays in data reporting prevent real-time, nimble responses. For example, healthcare practitioners have reported delays of 18 months or longer in finalizing Medicaid claims.[62] This results in a delay in reporting to state oversight agencies. These reporting delays make

it difficult to implement timely improvements to care, as data on who is receiving services and where gaps in care exist are already outdated by the time they are relayed.

THE NEED FOR WHOLE-PERSON OUTCOME MEASURES ACROSS THE GOVERNMENT

SUD measures also fall short. Self-reports of drug use, urine testing, overdose episodes, or morbidity/mortality alone do not sufficiently reflect the complexity of SUD. These measures frame SUD as an acute, episodic condition with a narrow set of process measures that define "success" rather than as a life-long condition requiring a range of outcome measures. Moreover, because return to use ("relapse") is often a part of the recovery process, recovery must be defined by more than substance use and overdose.[63]

Recovery supports, including policies and infrastructure to access housing, transportation, education, parenting and employment goals, are an integral component of an individual's recovery journey.[64] Outcomes that reflect recovery, such as sustained employment, are valuable measures of progress often overlooked in traditional data collection. In keeping with care management for other chronic conditions, data collection for SUD treatment and success should include a more comprehensive and long-term model.[65] The Criminal Justice Kentucky Treatment Outcome Study adopted such an approach.[66] The Outcome Study measured a variety of post-release metrics concerning incarcerated persons who participated in SUD treatment while in state prison. Participants were evaluated for 12 months post-release and outcomes such as employment, stable housing, and participants' feelings of fulfillment were measured, incorporating metrics beyond overdose and use into their assessment to evaluate the program.[67]

A STANDARDIZED, OUTCOME-BASED DATA FRAMEWORK TO ADDRESS SUD ACROSS GOVERNMENT AGENCIES

The COVID-19 pandemic exposed the United States' fragmented system for collecting and evaluating public health data, which hindered the timely and efficient integration of case information with demographics and, ultimately, our policy response.[68] To meet this challenge, steps were taken by the federal government to modernize and improve the nation's data infrastructure.[69]

Governments at all levels have implemented consolidated data systems to ease analytics and facilitate actionable insight for decision-makers. While some states consolidated healthcare information across private and public payers,[70] other intergovernmental data systems integrated data across a wider array of government services.[71] These initiatives allowed states, cities, and counties to capture a more comprehensive picture of residents engaging with various governmental agencies, including tracing veterans experiencing homelessness across multiple social services to gain a holistic picture of challenges they face, as well as opportunities for improved providing of services.[72]

SPOTLIGHT ON...
DATA SHARING MODELS

COLLABORATIVE DATABASES
EXAMPLE: CALIFORNIA

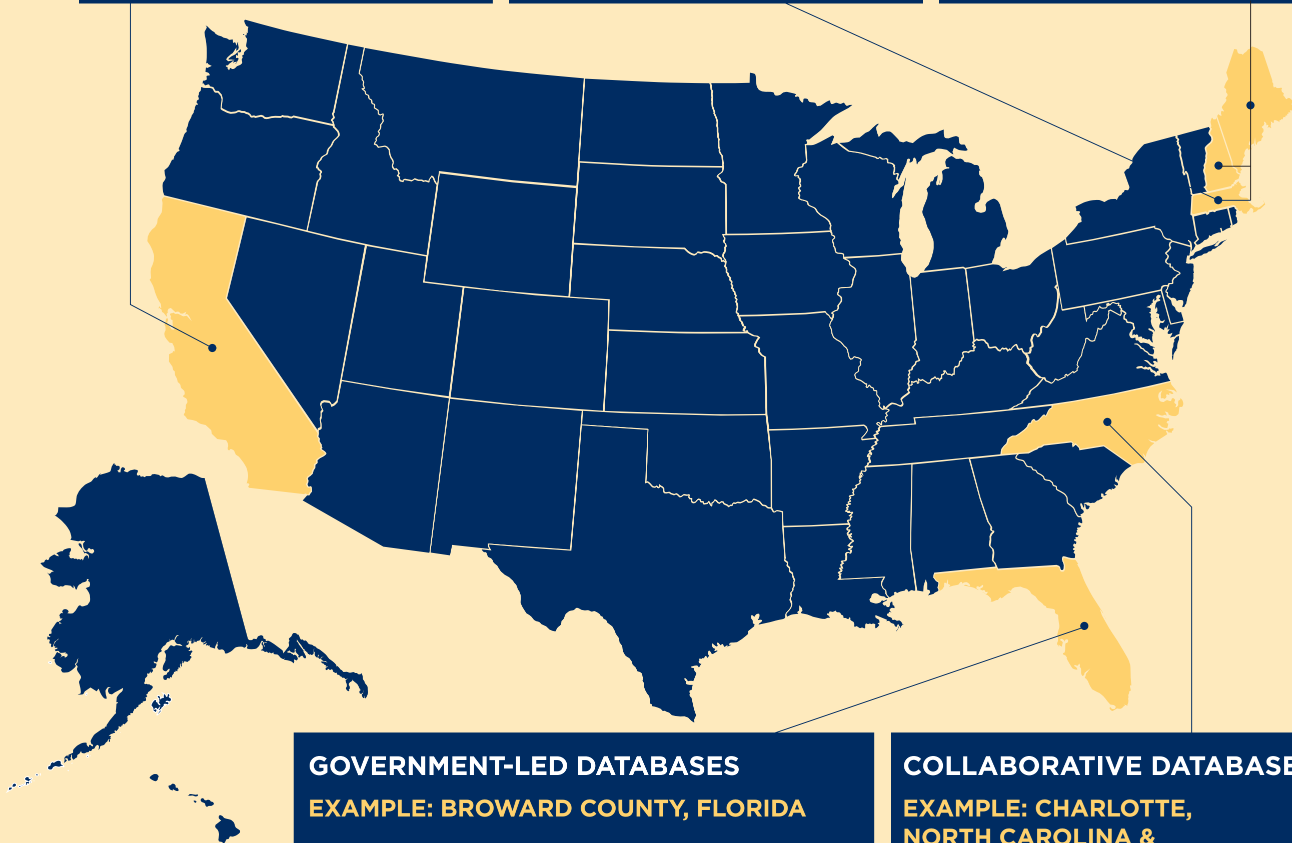
- California Department of Education partnered with University of California, Davis to collect & analyze data to determine best practices for preparing high school students for college

GOVERNMENT-LED DATABASES
EXAMPLE: CITY OF BOSTON, MASSACHUSETTS

- Centralized data across 31 city departments in a comprehensive platform that allows for streamlined access & analysis across multiple parameters
- Managed by the Citywide Analytics Team who is tasked with analyzing city-wide data to improve how the city itself operates for its residents

ALL-PAYER CLAIMS DATABASES (APCDS)
EXAMPLE: MASSACHUSETTS, MAINE, NEW HAMPSHIRE

- State-wide databases that collect information from both private & government insurance entities on claims, eligibility, etc.
  - Inform policymakers on the quality, efficiency, & affordability of healthcare
  - Capture large cohorts across standardized demographic parameters in a longitudinal manner



GOVERNMENT-LED DATABASES
EXAMPLE: BROWARD COUNTY, FLORIDA

- Funded by the Performance Partnership Pilots for Disconnected Youth (P3) programs at the federal level
- Managed by the Children's Services Council (CSC)
- Developed an integrated data system to standardize & ease data collection, analysis, & sharing for local programs serving disconnected youths
- Established work groups to steer specific aspects of this shared initiative, including & bypassing systemic barriers to access across agencies.

COLLABORATIVE DATABASES
EXAMPLE: CHARLOTTE, NORTH CAROLINA & MECKLENBURG COUNTY

- Integrated Data System (IDS) which links data from 45 different social service agencies, including the police department & early learning programs
- Overcame problem of incompatible systems across and within agencies by collaborating with the Charlotte Regional Data Trust at the University of North Carolina at Charlotte

SPOTLIGHT ON...
NORTH STAR METRICS PROJECT

PHASE 1
30-day public comment period, prioritizing the input & lived experiences of the residents of Staten Island

PHASE 2
Convening of multiple public agencies, organizations, & expert groups, in order to centralize & coordinate the borough-wide data collection effort to address opioid-related harms

PHASE 3
Opioid data working group, where nationally renowned experts on data strategies and best practices provided final recommendations on the aligned data strategy

FINAL RECOMMENDATIONS
15 meaningful & geographically-specific measures were identified & provided with opportunities for future monitoring & continuous improvement

- Number & retention of individuals receiving buprenorphine or methadone
- Number of healthcare providers prescribing MOUD
- Number of individuals inducted on buprenorphine in the ED & their outcomes 30 days post-induction

Governments should identify and develop a standardized set of outcome measures for SUD across government agencies,[73] to provide policymakers with regionally relevant data stratified by age group, race/ethnicities, community, and socioeconomic factors to enable evidence-based decisions to meet local needs. Governments should actively involve impacted communities in the outcome selection. In addition to streamlining and modernizing data collection and analysis across SUD services, these systems represent a centralized resource for individuals at risk for SUD, consistent with patient-centered, whole person care, and increase accountability for funding expenditures and promote efficient, outcome-motivated results.

In response to the overdose crisis, Staten Island's Heroin and Opioid Task Force expanded efforts and interventions, including the availability of overdose prevention programs and practices.[74] Importantly, the Task Force also implemented a data alignment strategy, called the North Star Metrics Project, which required uniform data collection to monitor opioid use and related problems across the state, so that recovery and treatment efforts could be scaled up on a borough-wide level. This initiative saw positive results, as Staten Island was able to quickly track a 10% reduction in overdose deaths during this project's first year.[75]

Governments should develop a set of reporting parameters related to SUD, including standard demographic categories, across government agencies. This process should build upon what the United States Office of Management and Budget (OMB) has begun in standardizing classifications for racial and ethnic groups.[76] Standardized data will help to facilitate consistent data collection, analysis, and sharing.[77] Further, outcome measures for SUD treatment should reflect the science of the recovery process, beyond overdose and substance use, to include a range of social determinants.[78] Finally, governments should prioritize development and implementation of integrated data resources to determine how people access services and what gaps exist in access.

RECOMMENDATIONS

- **Convene policymakers, providers, community members, and people with lived experiences to determine local needs & priorities**
- **Assess reporting parameters and practices across agencies and systems that touch SUD to identify gaps in data and standardize future reporting across the government**
- **Establish a centralized source for data repository across the government, that includes analytical capacity and trans-agency data accessibility**
- **Align goals and mission across SUD-related agencies to identify outcome measures to reflect the whole of the recovery process**

3. ALIGNING FUNDING FOR SUD ACROSS THE GOVERNMENT AGENCIES TO MEET A COHESIVE SET OF OUTCOMES

IN ADDITION TO SOCIAL AND STRUCTURAL DETERMINANTS OF HEALTH, a variety of systems touch people with SUD, their families and communities. Each of these systems is segregated and comprised of discrete agencies with different eligibility, priorities, and missions. The cross-utilization of programs translates into program fragmentation and overlap, resulting in "administrative burdens, additional work for local service providers, and a confusing service delivery system for beneficiaries."[79]

Policies to address SUD must be comprehensive and cut across multiple sectors to effectively address addiction. Funding sources for the types of services needed to create a comprehensive system of care across government silos are numerous, diverse, and vary from state to state.[80] While the primary funding sources for SUD treatment are Medicaid and large federal block grants, these funding streams are separate from those that fund other systems, such as systems that are designed to primarily address housing insecurity, education needs, employment, family services and criminal legal issues.[81] These other systems are typically funded by narrowly tailored funding streams that target a single "symptom" of the condition, rather than the whole person. To that end, the future of SUD treatment must reflect a whole person, whole-of-government approach to integrating services and its associated funding into a more efficient and sustainable model.

BRAIDED AND BLENDED FUNDING SYSTEMS

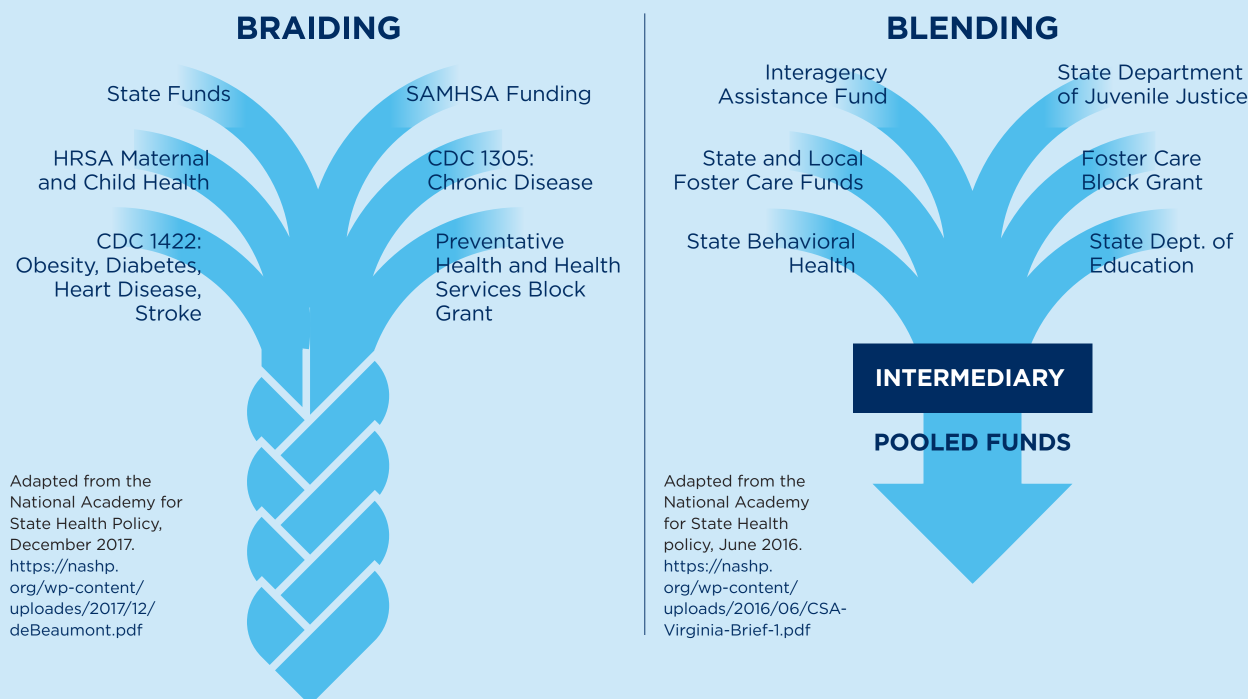
Collaborative funding models allow for flexible spending across agencies for a common mission. In a ***braided*** system of funding, financial assistance is combined with supporting a common outcome, but individual funding sources maintain their award-specific identity.[82] In contrast, ***blended*** funding systems combine funds under a single set of reporting and other requirements, wherein each individual funding stream loses its original award-specific identity.[83]

While both methods of funding provide higher levels of flexibility for the management of funds, blended funding streams provide more administrative ease and optimal resource allocation than braided funding. On the other hand, braided funding allows for better tracking and accountability of resources from each contributing agency, which may be needed to comply with current state or federal reporting requirements.[84] States may also choose to implement both methods of combined funds, depending on the legal authorization of usage of funds for certain programs.

These funding mechanisms also promote collaboration among state agencies. By allowing more efficient access to funds, agencies are able to fund cross-cutting projects and initiatives and efficiently redirect carryover funds to other programs as needed—making it easier to develop a cohesive system to address addiction.[85] For example, Douglas County, Kansas passed a sales tax to fund crisis care. The county blended these dollars with a small amount of Medicaid, as well as state and federal dollars for crisis care, to develop a crisis stabilization center that integrated mental health and SUD services.[86]

As a result of a better integrated system of funding, individuals may be provided with access to evidence-based treatment, and social determinants of health, such as stable housing and transportation, can be targeted.[87] In turn, individuals can find the support and treatment they need without sorting through unnecessary hurdles.

BRAIDED AND BLENDED FUNDING SYSTEMS

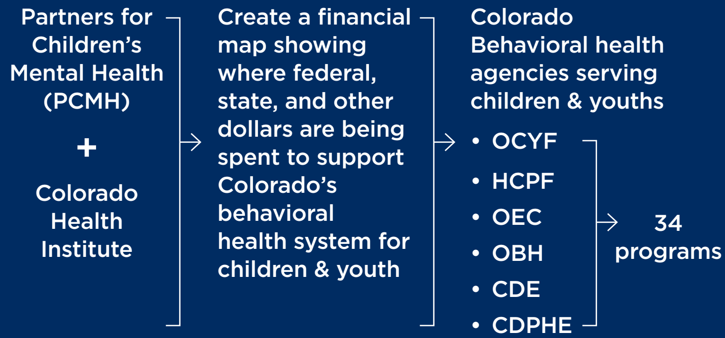


Adapted from the National Academy for State Health Policy, December 2017. https://nashp.org/wp-content/uploads/2017/12/deBeaumont.pdf

Adapted from the National Academy for State Health policy, June 2016. https://nashp.org/wp-content/uploads/2016/06/CSA-Virginia-Brief-1.pdf

SPOTLIGHT ON...
COLORADO'S BEHAVIORAL HEALTH TASK FORCE CHILDREN'S SUBCOMMITTEE

PLAYERS



FUNDING

- Between $404 - $810 million spent annually
- State funds accounted for 60% of total funds spent, similar to national tends
- 54% of all funds could not be tied to the 10 key behavioral health service areas
- 41% of identifiable allocation of funds went to outpatient care, similar to national trends
- 9% of funds went to community- and home-based services
- Only 3% of funds went to residential care, compared to 25% nationally
- Funding came in multiple forms:
  - — Block grants as lump sums
  - — Federal match (ex:, Medicaid matches at 53%)
- Findings hindered by incomplete data collection and reporting, as well as delayed Medicaid claim data

WHO IS BEING SERVED

- Use of behavioral health system by children and youth in Colorado is lower (5%) than national trend (11%)
- 14% of Colorado children and youth reported that they did not get the care they needed
  - — 58% of those who did receive needed services were female
- Colorado served approximately 1.5 million children, though reporting methods did not allow report to identify users of multiple systems
- 40% of state agencies could not report age data
- 80% of state agencies could not report race/ethnicity data
- 50% of state agencies could not report sex/gender data

RECOMMENDATIONS

1. CONSOLIDATE FUNDING STREAMS & SERVICE DELIVERY
- Eligibility criteria
- Program size
- Funding flexibility
- Services provided

2. MAXIMIZE FEDERAL DOLLARS
- Identify opportunities to increase federal matching funds (e.g., Medicaid)

3. PROMOTE EQUITY IN BEHAVIORAL HEALTH FUNDING
- Equitable distribution of services
- Education on what services are available to youth
- Targeted outreach to racial & ethnic groups that experience disparity

4. FOCUS ON SUBSTANCE USE TREATMENT
- Consolidated funding stream that promotes access to SUD treatment

5. INVEST IN DATA
- Increase efficiency
- Greater understanding of demographic and service gaps
- Comprehensive service array information
- Individualized service provision

In response to consistently cited uncoordinated care, Colorado's Department of Health and Human Services Office of Behavioral Health, supported through a federal grant from SAMHSA, developed a comprehensive and strategic plan after an evaluation of the funding of its 6 child-serving agencies.[88] The evaluation, which began with comprehensive fiscal and programmatic mapping, found that resource allocation was unclear, collection of demographic data was sparse, and unnecessary duplication of services existed across systems. Further, clients who experienced high service utilization were accounting for a disproportionate amount of spending and resource expenditure, as well as multiple system usage. Researchers also found that the youths who required high levels of public resources were often complex cases, had greater clinical severity, and experienced poorer outcomes, all of which could be better understood and addressed with a coordinated, collaborative approach to the delivery of services across systems.[89] A system of care grounded in programmatic alignment and coordinated funding streams would lessen system involvement and improve mental health outcomes.[90]

LEVERAGING FEDERAL PROGRAMS TO BLEND AND BRAID FUNDING ACROSS SYSTEMS

Waivers across multiple federal agencies are available to states to implement innovative programs with collaborative funding. For example, Section 1115 of the Social Security Act provides states the opportunity to pilot innovative programs that align with the objectives of Medicaid, including "flexibilities to improve the continuum of care for beneficiaries with substance use disorders (SUDs) including Opioid Use Disorder."[91]

Currently, 33 states and the District of Columbia have been granted Section 1115 waivers that allow for flexible administration of services that support people with SUD.[92]

Some states have used 1115 waivers to incorporate Medicaid coverage for social determinants of health. Arkansas' Medicaid waiver provides medically necessary housing and nutrition support services.[93] North Carolina's 1115 waiver addresses unmet nonmedical needs—including food, housing, and transportation insecurity—through Medicaid.[94] Maryland has leveraged its Section 1115 waiver program, called HealthChoice, to expand services and coordinate care as part of its comprehensive SUD strategy.[95] For example, Maryland's waiver renewal allowed implementation of the Maternal Opioid Misuse (MOM) Model, a comprehensive, pilot program for pregnant individuals with OUD in an effort to improve maternal health outcomes and reduce the burden of neonatal abstinence syndrome (NAS) and its associated costs.[96]

States can use Medicaid to encourage the development of innovative "Value Based Payment" and "Pay for Performance" models as a vehicle to spur reform. For example, the "Addiction Recovery Medical Home" model includes a bundled payment for integrated treatment, care management, and recovery supports.[97] States can require or encourage managed care organizations to adopt these types of models to fund services which historically have been neglected through traditional Fee for Service payment mechanisms in statute and contracts.

In addition to innovations in Medicaid, the federal government can put structures in place to assist with blending disparate funding streams to achieve outcomes. For example, some federal agencies, such as the Departments of Education (ED), Labor (DOL), Health and Human Services (HHS), and Justice (DOJ), have the authority to enter into Performance

Partnership Pilots (P3) for Disconnected Youth, a funding opportunity that allows state, local, or tribal governments to blend discretionary funds from specified federal agencies to implement goal-focused programs serving disconnected youth.[98] In these pilots, the Office of Management and Budget (OMB) designates a federal agency to steward the pilot program on behalf of all participating agencies, thus reducing the administrative burden and generating a more efficient funding stream.[99] Lessons from the P3 program and others should be adopted in the SUD space to identify and scale the successful aspects of these approaches based on the evaluation of these programs.

States can also maximize established enforcement mechanisms in Federal law, such as implementation of the Mental Health Parity and Addiction Equity Act and subsequent regulations, to increase access to treatment across systems. New York State, for example, implemented a robust parity enforcement strategy that included legislation limiting utilization management by managed care organizations (MCOs) for mental health and SUD services, ensuring the use of transparent medical necessity criteria by MCOs, a state Ombudsman to assist people and families to navigate denials of insurance claims, and significant investments in state oversight staff.[100]

IMPLEMENT MODELS TO MAP FUNDING ACROSS GOVERNMENT AGENCIES AND ALIGN GOALS, MISSIONS, & OUTCOMES

State and local governments have also been innovative in developing regional, trans-agency programs to provide a more efficient and sustainable SUD treatment system through the implementation of braided or blended funding systems to unify their different funding streams.

The state of Washington operates nine local collaboratives, called Accountable Communities of Health (ACHs), which braid federal grant money with state funds and private contributions to encourage cross-sector investments in healthcare that focus on equity and expanding access in the community.[101] As of 2021, ACHs in Washington devoted $150 million to integrating physical and behavioral health care for patients with complex care needs and increasing access to SUD treatment.[102] One of Washington's ACHs, Better Health Together, awarded $150,000 across 15 partners to support providers of SUD and mental health services and has coordinated and funded peer and SUD counselor training and certification through the Community Colleges of Spokane.[103] Another ACH, Cascade Pacific Action Alliance (CPAA), provides services to whole person care, including safe and stable housing, transportation, education, and other issues that create barriers to overall well-being.[104]

Rhode Island's Department of Health launched the Health Equity Zone (HEZ) initiative in 2015 that uses a braided system of federal, state, and local funds to support a comprehensive, community-based approach to address the root causes of health inequity.[105] The OneCranston HEZ partnered with Anchor Recovery and Project Weber/RENEW, local organizations in the SUD space, to provide expanded access to SUD clinical support for community members. Further, OneCranston HEZ collaborated with the Cranston Fire Department to train its members in overdose intervention and supply the department with the opioid overdose antidote, naloxone. In 2021, over 100 firefighters were trained, and 500 packets of naloxone were distributed to six fire stations.[106] OneCranston HEZ also strives to strengthen community well-being with a focus on racial equity and

trauma-informed care. Book clubs and cooking classes are hosted as opportunities for residents to share each other's cultures, and choir workshops allow residents to engage in trauma-informed performance art, culminating in a community concert.[107]

Other initiatives have taken the lead in integrating traditional SUD services with common ancillary programs that touch upon SUD, such as economic development. Recognizing that SUD is more than a healthcare issue, the Appalachian Regional Commission established the Investments Supporting Partnerships In Recovery Ecosystems (INSPIRE) Initiative to support holistic recovery-focused programs to enable workforce participation while continuing to access their SUD treatment.[108] Since 2021, INSPIRE has invested over $28 million into workplace initiatives across Appalachia and aided over 6500 individuals in locating and training for workplace opportunities.[109] Additionally, states, such as New Hampshire,[110] Massachusetts,[111] Kentucky[112], and Indiana,[113] have developed Recovery Ready Workplace initiatives to incentivize and empower employers to address and support employees in recovery, through its policies, practices, and benefits.

Justice Reinvestment is a data-driven criminal justice strategy that aims to improve public safety by enacting legislation and policies that reduce the size and costs associated with incarcerated populations and divert a portion of those saved funds to community-based, high-performing public safety programs.[114] A key component of justice reinvestment is investing in whole person, integrated services in local communities, including housing, employment, educational or vocational training, and SUD treatment.[115] In Albany County, New York, implementation of MOUD for people incarcerated in the jail resulted in the Sheriff decommissioning at least 100 unoccupied jail cells and converting these spaces into transitional housing for those experiencing homelessness with social supports, job training, and other services to aid reentry and recovery.[116]

The Justice Reinvestment Initiative (JRI) is a collaboration among the Bureau of Justice Assistance (BJA), The Pew Charitable Trusts (Pew), and Arnold Ventures to address the drivers of prison and jail admissions, recidivism, and corrections costs and pivot focus to increasing community capacity for supervision and whole person resources in an effort to improve public safety.[117] By developing programs that expedite lower-level criminal cases, the JRI program in Delaware County, Ohio, is expected to redirect almost $600,000 annually to expanding critical mental health and SUD treatment services.[118] Similarly, JRI strategies in Mecklenburg County, North Carolina, include a policy that promotes citations rather than arrest, allowing the jurisdiction to reinvest over $4,000,000 in mental health and SUD crisis support and prisoner reentry services.[119]

Another method of budgeting that addresses siloed agency structures and promotes data sharing is outcomes budgeting. Outcomes budgeting typically involves the city, county, or state identifying its priorities, then interdepartmental teams, also referred to as priority teams, draft "requests for results" (RFRs) addressing the various priorities. Agencies (or Departments) then submit budget requests that specify the outcomes expected to achieve with the funding and the priorities and results that the outcomes address.[120] The interdepartmental teams review the budget requests and make recommendations. Evaluations of outcome based budgeting have found that outcomes-based budgeting leads to a culture shift within the agencies, leads to more data sharing, and improves outcomes for participants and the community.[121]

Traditional outcomes budgeting focuses on community priorities and measurable outcomes, but in considering their budgeting, government entities should consider how to further racial equity. Further, governments should develop community priorities in line with

the components of a whole person model and tailor priorities to reflect the communities served by engaging in equitable and meaningful community engagement.

The City of Baltimore enacted an outcomes budgeting model in an effort to enhance its effective programming and services.[122] From 2009 to 2015, the implementation of this model in Baltimore resulted in a 38% reduction in infant mortality, an 11.6% increase in employment, and a 50% reduction in frequent 911 callers by assigning nurses to assess and treat underlying causes.[123] The switch to an outcomes budgeting model also highlights low-performing programs, where additional funds can be directed to support efforts.[124] Increasing use of data and evidence in the budgetary process enables cities like Baltimore to promote greater success in service delivery and outcomes. ***See SPOTLIGHT ON: City of Baltimore Outcome Budgeting Model.***

While changes in budgeting processes may incentivize government coordination, for the SUD system redesign to be successful, there must be accompanying changes in governance.

SPOTLIGHT ON...
CITY OF BALTIMORE OUTCOMES BUDGETING MODEL

1

IDENTIFY
PRIORITY OUTCOMES
FOR FUTURE

2

IDENTIFY
COMMUNITY INDICATORS
OF SUCCESS

3

ESTABLISH
RESULTS-BASED ACCOUNTABILITY

- How are we doing? What is causing this result?
- Who can help? What would work?
- What action should we take now for future budget proposals?

4

ALIGN
RESOURCES WITH DESIRED OUTCOMES

- Allocate funding to outcomes instead of agencies, where Programs/Services are the units of analysis for budgeting
- Encourages trans-agency collaboration
- Re-define work to make services more relatable to citizens

5

DEVELOP SET OF
PERFORMANCE MEASURES

- OUTPUT: How much did we do?
- EFFECTIVENESS/EFFICIENCY: How well did we do it?
- OUTCOME: Is anyone or EVERYONE better off?

6

SHIFT THE
BUDGET DEBATE

- Raise the outcome quotient & encourage decisions based on data, rather than politics
- Establish teams of employees & community members to gauge results:
  - — Requests for Results (RFRs)
  - — Review & rank budget offers across agencies
  - — Recommend investment portfolio
  - — Engage community as policymakers
  - — Set product-performance priorities to guide purchases

RECOMMENDATIONS

- **Ensure transparency in funding to facilitate coordination**
- **Map funding across agencies touching on SUD to determine how resources are being allocated and how to address gaps in care**
- **Align goals, missions, and outcomes for agencies across the whole of government to facilitate collaborative funding models, such as braided, blended, or outcome budgeting**
- **Leverage federal waivers to allow for blended funding opportunities**
- **Prioritize data infrastructure development and maintenance in funding opportunities**

4. GOVERNING FOR AN ECOSYSTEM OF CARE

GOVERNANCE CHANGES NECESSARY TO ACTUALIZE A REDESIGNED SYSTEM of care include improving the coordination of siloed agencies (e.g., health, treatment, criminal justice, child welfare, etc.) and governments (local and state) that provide services for people with SUD. It also includes the development of standardized data collection strategies and regularly sharing among agencies to facilitate data-driven policies. This all requires coordinated governance.

COORDINATED GOVERNANCE THAT TRANSCENDS LEADERSHIP CHANGES

Leadership will drive coordination and cooperation across and among agencies. This can be best accomplished through a centralized entity in the Governor's office that is provided with sufficient funding and authority to coordinate budgets and policies across government agencies, as well as a focus on reviewing outcomes.[125] It also requires leadership at the highest level of each agency to prioritize such coordination.[126] To be effective, governance infrastructure must be able to transcend and survive political leadership shifts.

Coordination must be both horizontal and vertical, with government agencies collaborating locally, regionally, and statewide. Key components of such an approach include the establishment of shared outcomes, information sharing, including disseminating successful practices and pilots, and providing logistical support.[127] If appropriate, inter-agency or inter-

governmental agencies can be formed to coordinate efforts, house information, and build trust. Regional or state-wide centers for excellence can also be formed to provide technical assistance and support.

Kentucky, despite state leadership changes over time, has established centralized structures and initiatives to ensure consistency in a "whole person, whole government" approach to SUD. The Kentucky Office of Drug Control Policy leads and coordinates Kentucky's response to substance misuse across state government agencies.[128] Recently, this office worked with various sectors of the community, including the Chamber of Commerce and counties, to establish recovery ready communities, an initiative designed to provide a quality measure of a city or county's SUD recovery efforts through offering "local officials, recovery advocates, and concerned citizens the opportunity to evaluate their community's current SUD treatment programs and interventions in a framework that is designed to maximize positive public health outcomes among Kentuckians suffering from SUD."[129]

COORDINATED DATA COLLECTION & DATA SHARING TO SUPPORT ALIGNED FUNDING AND OUTCOMES

A key element to developing an aligned system is strengthening the capacity for data integration, analysis, and evaluation of important decisions on how to target and coordinate services. Data sharing between agencies is crucial to data systems as they must be adequate to meet record-keeping requirements for the different sources of funding.[130]

States like Washington and Pennsylvania have created institutes, the Research and Data Analysis Division within the Department of Social and Health Services (DSHS)[131] and Actionable Intelligence for Social Policy (AISP),[132] respectively, that work on cross-sector analysis to improve policymaking and link administrative data across agencies.

Meaningful and equitable community engagement practices should be used to assist government agencies in developing measures of success. Moreover, agencies should come to an agreement on how measures will be defined and agree to collect standardized measures to enable data sharing. Data collection and sharing should be at regular intervals and data lags minimized to the extent possible, so programs and agencies can adjust their practices based on the data as timely as possible. All efforts should be taken to de-identify and protect data, and investments should be made in data and infrastructure support.

Data collected should reflect the funding priorities and outcomes identified when budgeting and should align with the components of the system, including by focusing on developing measures that capture the well-being of the whole person.

RECOMMENDATIONS

- Identify a top-level champion to prioritize action and reform
- Establish a centralized coordinating entity with sufficient authority, funding, and logistical support
- Develop effective, implementable mechanisms for coordination and establishment of shared data and outcomes
- Mechanisms for regular and comprehensive data analysis and sharing
- Align goals, missions, and outcomes across agencies without "MET" (Money, Ego, Turf) influence on system redesign

CONCLUDING THOUGHTS

TO ADEQUATELY STRENGTHEN MULTIPLE SYSTEMS OF CARE and protective factors for people who have a SUD or are at risk of developing a SUD requires rethinking the ways in which our current systems are funded and organized. In doing so, state and local governments should strive to create a system of care that encompasses services and care across the lifespan and prioritizes treatment on demand and connection to trauma-informed and compassionate support services that address the needs of the whole person. For such a system to be successful, budgets must be blended, braided, and/or aligned with outcomes that reflect community priorities and needs. Government leadership can facilitate agency collaboration to encourage integration and the development, standardization, and sharing of data to inform program implementation. These coordinated systems not only reduce administrative burden, but support individuals, families, and communities in receiving the care that they need to improve outcomes without encountering barriers in the form of siloed services.

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