SPOTLIGHT: Public Health

STATES’ NEEDS

AT THE CENTER OF

MEDICAID EXPANSION DEBATES

Making Treatment Work for Opioid Abuse

Weighing the Health Impacts of State Policies

Prioritizing Public Health Resources

Getting the Lead Out

“It’s a broken system and the costs are skyrocketing. We need to come up with ways to make it a better system, and I think we can do that.”

SPEAKER WILLIAM J. HOWELL
Virginia House of Delegates
### Congratulations!

CSG ANNOUNCES THE 2016 TOLL FELLOWS CLASS!

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Applications for the 2017 Toll Fellows Class will be accepted Oct. 3, 2016–April 1, 2017.

For more information, visit www.csg.org/TollFellows.
ON THE COVER
Virginia Speaker William J. Howell believes that providing quality systems of health care for his state’s citizens is important, but he said expanding Medicaid isn’t the answer. Calling it a “broken system,” Howell said state solutions—not a federal one—will go further in meeting the health care needs of Virginians.

Photo by Joe Mahoney

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10 IN THE KNOW: RATIONALIZING HEALTH CARE
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12 HEALTH IMPACT ASSESSMENTS
The phrase “evidence-based” has become ubiquitous in state government circles, but until recently that work has not applied to health. CSG Senior Fellows Katherine Barrett and Richard Greene explore how some states are incorporating health impact assessments to measure the implications of policies and programs to the health of state residents.

14 THE OPIOID CRISIS
Opioid overdose deaths are on the rise across the United States, with overdose rates tripling since 2000. State leaders and medical experts say the fight against drug abuse must be waged on many fronts.

18 MAKING TREATMENT WORK
Addiction is a chronic, neurobiological condition with the potential for recovery and relapse. But recovery is possible, and treatment works best if it is multi-dimensional, evidence-based, and addresses both the physiological and psychological elements of substance use disorders.

20 PUBLIC HEALTH PRIORITIES
The average life expectancy is lower in the United States than in other nations with advanced economies. What does it take to save lives—not one by one through medical treatment, but hundreds of thousands or even millions at a time? Dr. Joshua Sharfstein says three basic steps can help states do just that.

22 HEALTH CARE JOBS
Increased health care spending has an impact on the workforce landscape. In the six years after the recession, health care added 2.1 million jobs to the economy—more than the next three industries (leisure and hospitality, professional services, and education) combined.

24 10 QUESTIONS: NATIONAL DRUG CONTROL POLICY DIRECTOR MICHAEL BOTTICELLI
According to National Drug Control Policy Director Michael Botticelli, making a variety of treatment options available is key to addressing the opioid epidemic and saving lives. He said state and local governments are often closest to the problem and should be part of the solution.

26 MEDICAID EXPANSION
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30 TRAINING THE HEALTH CARE WORKFORCE
The demand for health care services in the United States is growing—a result of population growth, an aging population and federal health care reform that has increased the number of Americans with health insurance coverage. And experts estimate that the demand on the health care industry and its workforce will continue to rise for years to come.

32 PREPARING FOR ZIKA
Mosquitoes have caused problems for reasons as small as disturbing outdoor leisure and as great as transmitting viruses such as West Nile. As the summer heated up in 2016, health and mosquito control professionals across the states had one more reason to pay attention to the pesky, biting insects—Zika.

36 GETTING THE LEAD OUT
In the wake of the water crisis in Flint, Michigan, cities, states and the federal government are taking a closer look at the state of water infrastructure in the United States and its ability to deliver healthy and safe drinking water to residents.

40 STATE ABORTION LAWS
In June, the U.S. Supreme Court struck down Texas’ strict regulations on abortion clinics in the court’s most significant decision on abortion rights in decades. At issue was to what extent states can regulate abortion within their borders, which likely will have ramifications for states across the country that have passed legislation restricting abortion in recent years.

42 BEHAVIORAL HEALTH
While counties have always played a crucial role in delivering services and treatment to individuals with behavioral health needs, recent changes in the landscape have opened up even more opportunities for localities to assist these residents effectively. Medicaid, which counties help to finance, remains the largest source of funding for behavioral health services in the U.S.
It’s summer, at last. And while for many state policymakers that means the busy legislative session is over, we at CSG know that it doesn’t mean the hard work you do for the states is done. In fact, the summer offers us all a chance to roll up our sleeves and tackle the issues that continue to challenge our states. And CSG is here to help. From CSG regional meetings and leadership development programming to new policy publications, summer is ripe with opportunities to share capitol ideas.

Here’s what’s happening at CSG.

1. **CSG announces the 2016 Toll Fellows Class**
   CSG started its summer by saluting 48 emerging state leaders from across the country. Members of the Henry Toll Fellowship Program Class of 2016 represent 29 states and the U.S. territories of Guam and Puerto Rico, with 37 representing the legislative branch, three serving in the judiciary and eight hailing from the executive.

   The class will come together Aug. 26–31 in Lexington, Kentucky, for what is known as one of the nation’s premier leadership development programs for state officials. To meet the Henry Toll Fellowship Class of 2016, please visit www.csg.org/LeadershipCenter.

2. **The Book of the States hits bookstands**
   The Council of State Governments will continue a long tradition of “sharing capitol ideas” with the publication of the 2016 edition of The Book of the States, available mid-July. The 2016 volume includes 150 in-depth tables, charts and figures illustrating state government operations. It also includes 30 articles from state leaders, innovative thinkers, noted scholars and CSG policy experts on topics such as improving the absentee voting process for military and overseas voters; Americans’ health insurance coverage rates post-ACA; the impact of growing diversity on the state political landscape; and the latest on hydraulic fracturing in the states.

3. **CSG regions hold annual meetings**
   The CSG regions are gearing up for their annual meetings, which offer outstanding sessions on the most important regional issues and opportunities to work with colleagues to identify state solutions to the challenges facing each region. We hope to see you there!

   - **CSG SOUTH**
     70th Southern Legislative Conference Annual Meeting
     July 9–13 | Lexington, Kentucky

   - **CSG MIDWEST**
     71st Midwestern Legislative Conference Annual Meeting
     July 17–20 | Milwaukee, Wisconsin

   - **CSG EAST**
     56th Eastern Regional Conference Annual Meeting
     Aug. 7–10 | Québec City, Québec, Canada

   - **CSG WEST**
     69th CSG West Annual Meeting
     Sept. 6–9 | Coeur d’Alene, Idaho

4. **New CSG regional reports on research and workforce development**
   In 2015, CSG, in partnership with Elsevier, published America’s Knowledge Economy: A State-by-State Review that analyzed the research strengths of the United States and the importance of public, private and academic sector collaboration to workforce development. This year, CSG will produce four regional reports identifying case studies in each region that demonstrate successful or unique collaborative programs or policies. The regional reports also will analyze the research strengths of each region and present findings on the comparative advantages a region has across all the research institutions in the geographic area. The regional reports are scheduled to be released over several months beginning in late summer.

5. **Save the dates for CSG National Conferences**
   CSG is gearing up for the 2016 National Conference, Dec. 8-11 in Colonial Williamsburg, Virginia—the birthplace of our nation. Be sure to check out www.csg.org/2016nationalconference for the agenda, keynote speakers, and registration and travel information.

   CSG also is pleased to announce the dates of the 2017 National Conference. Mark your calendar and make plans to join the CSG family Dec. 14-17, 2017, in Las Vegas, Nevada, for the 2017 CSG National Conference!
We, together, using the tools of public health, have the power to stop the health equivalent of many earthquakes that happen around the world.”

— CDC Director Dr. Thomas Frieden on public health efforts to prevent a Zika epidemic, during a May 26 address at the National Press Club.

We are much better off if we maintain a public health system that has a higher state of preparedness.”

— James Blumenstock, who oversees health security programs for the Assn. of State and Territorial Health Officials, as quoted in the Los Angeles Times.

The first step toward recovery from addiction is to save the life.”

— Delaware Department of Health and Social Services Secretary Rita Landgraf, as quoted in a June 2 press release, on efforts to provide naloxone, an opioid overdose antidote, to law enforcement officers in the state.

When you have no providers out there, you have a public health crisis.”

— Linda Young, nursing program specialist for the South Dakota Board of Nursing, as quoted by MedCity News, on efforts to explore how telemedicine can help address growing shortages of school nurses in the rural state.

We can save lots of lives through disease prevention.”

— Kansas City, Missouri, top public health officer, Dr. Rex Archer, as quoted by KCUR Radio.

Everyone has a role to play in building a culture of physical activity & health.

#ABCDRBCHAT #STEPITUP”

— Tweeted by U.S. Surgeon General Vivek Murthy, May 24 (@surgeon_general)
COUGH SUPPRESSANTS
Delaware Gov. Jack Markell in June signed a bill that prohibits the sale of some cough suppressants containing dextromethorphan, or DXM, to anyone under age 18, according to The News Journal. The bill is an attempt to keep minors from getting high with medicines such as Robitussin and Vicks DayQuil and NyQuil. The News Journal reported that similar legislation had been considered in Florida, New York and New Jersey.

DEATH PENALTY
The Connecticut Supreme Court in May upheld an earlier ruling, declaring the state’s death penalty unconstitutional, according to the Associated Press. The court said the inmate in question must be sentenced to life in prison without the possibility of release. A law signed by Connecticut Gov. Dannel Malloy in 2012 abolished the death penalty, but the change did not apply to those already facing execution.

REDUCED TUITION
Hundreds of out-of-state students plan to attend The University of Maine under the school’s Flagship Match Program, which matches the tuition at a student’s flagship institution in Connecticut, Massachusetts, New Hampshire, New Jersey, Pennsylvania or Vermont, The Boston Globe reported. The University of Maine saw a 22 percent increase in the number of first-year students who had committed to the university as of May 1 from the same time last year. Of those students, 45 percent were out-of-state students compared to 35 percent last year.

DRUG PRICES
Vermont is the first state to require drug companies to explain price increases to prescription medications under a bill signed by Gov. Peter Shumlin. According to the Burlington Free Press, drug companies must justify price hikes to the attorney general’s office.

GAMBLING
Maryland Gov. Larry Hogan has signed a bill that legalizes some home games involving wagering if limited to mahjong or card games, according to The Washington Post. Among other restrictions, games cannot be held more than once a week and games cannot be advertised. Players must share a pre-existing social relationship. A sponsor of the bill said police should not have to use limited resources to stop home poker games.

NEW YORK TACKLES HOMELESSNESS
In June, New York state launched a $10.4 billion plan to combat homelessness over the next five years.

Phase one of the Homelessness Action Plan includes seeking proposals for 1,200 units of supportive housing, which will provide services such as employment training, counseling, and assistance in obtaining and maintaining primary and mental health care, according to a press release by the governor’s office.

“Gov. (Andrew) Cuomo’s historic investment in the battle against homelessness will provide thousands of New York residents with the support they need to rebuild their lives,” said Ann Sullivan, commissioner of the state Office of Mental Health. “For individuals struggling with mental illness and substance use disorders, a safe place to live with integrated services is a proven route to recovery and resilience.”

In addition, the initial phase of the plan calls for providing New York City with more than 500 beds in state facilities for the homeless, creating an Interagency Council on Homelessness to recommend best practices for reducing homelessness and completing inspections of all homeless shelters in the state.

“With unprecedented financial assistance to combating homelessness, Gov. Cuomo’s action plan is a broad, wide-reaching approach to addressing one of our society’s most troubling and intransigent problems,” Homes and Community Renewal Commissioner James S. Rubin said.
HATE CRIMES
Louisiana Gov. John Bel Edwards signed a bill that expands the state’s hate crime statute to include violence against police officers, firefighters and EMS personnel. Louisiana is the first state to add professions to the list of groups protected by hate crime legislation, which typically includes race, ethnicity, religion, gender and sexual orientation, according to CNN.

RAW MILK
According to newly signed legislation, it is now legal to drink raw milk in West Virginia through animal-sharing agreements, the Charleston Gazette-Mail reported. The law allows West Virginia residents to enter into agreements to share milk-producing animals and drink raw milk. It is still illegal to sell or distribute raw milk. Residents are required to sign a waiver acknowledging that they are aware of the health risks of drinking raw milk before entering into any agreements.

GRANDPARENT VISITATION
The Alabama Legislature passed a new law that would give some grandparents the legal right to visit their grandchildren. The new law, which repeals the 2010 Grandparent Visitation Act, creates higher standards that grandparents must meet to be eligible for visitation, according to AL.com. Grandparents must prove, by clear and convincing evidence, that they have a relationship with the grandchild and visitation is in the child’s best interests.

WOMEN AND BUSINESS
In the last nine years, women have opened new businesses at a much higher rate than the previous two decades. The 2016 State of Women-Owned Business Report finds that, between the years 2007 and 2016, women opened 1,072 new businesses on average daily. Nearly 8 in 10 businesses owned by women were located in seven of the SLC’s 15 member states.

STATE BUSINESS RANKINGS
The top four states in which to do business are Florida, North Carolina, Tennessee and Texas, according to an annual CEO opinion survey. The survey, conducted by Chief Executive, asked 513 CEOs to rank the best and worst states for business based on three primary factors: taxation and regulations, workforce quality and living environment. Texas and Florida have topped the list every year since the survey was first conducted in 2005, Fortune reported.

VIRGINIA STUDENTS TO GET MORE TECH TRAINING
Plans are underway to incorporate computer science education into K-12 classrooms in Virginia. Newly signed legislation calls for the state Board of Education to incorporate computer science, computational thinking and computer coding into the Standards of Learning curriculum. The bill, passed unanimously by both the Senate and the House of Delegates, is designed to help prepare students for technology jobs.

According to a Richmond Times-Dispatch story, Gov. Terry McAuliffe said it is critical for students to graduate prepared for a challenging job market that demands new skills. McAuliffe signed the bill into law on May 16.

“We will be sending a clear message…to all the businesses around the globe that we’re very serious about this, computer science, and what we need to do to build those skill sets of the future,” he said.

The new standards do not add requirements to the curriculum or replace any subjects, Delegate Thomas Greason, the bill’s sponsor, told the Richmond Times-Dispatch. Greason said it would take about two years to develop and implement the new standards.

The state Board of Education will be working to develop and incorporate the computer science curriculum into the state Standards of Learning at the same time that it works to meet new federal assessment and school evaluation requirements under the Every Student Succeeds Act that was passed in December, said Virginia Secretary of Education Anne Holton.

“The timing of all that is intertwined,” said Holton. “All of those things work together.”
HOT CARS
In August, an Ohio law will allow people to break into vehicles to save children and animals, according to The Plain Dealer. The bill, signed by Gov. John Kasich, protects someone from civil liability and damages if the person also calls police and believes the pet or child is in danger. Supporters of the law said it would reduce the number of heatstroke-related deaths.

ROAD FUNDING
Local governments across Indiana have received more than $500 million in funding from the state for road and bridge repairs, The Indianapolis Star reported in June. Gov. Mike Pence approved the funding earlier this year. Most of the money—$435 million—will go to counties, cities and towns. Schools and library districts will receive the remaining funds. The money was pulled from local option income taxes held in a trust by the state.

MARIJUANA
Illinois Gov. Bruce Rauner and state Republican leaders have agreed to extend Illinois’ medical marijuana pilot program to July 2020, according to the Chicago Tribune. The program was slated to end after 2017. In addition, post-traumatic stress disorder and terminal illness were added as qualifying conditions. The newspaper reported that the bill, sponsored by Rep. Lou Lang, includes several changes to the program, which lawmakers will have to vote on before it is implemented.

SENTENCING REFORM
Iowa Gov. Terry Branstad in May signed into law a bill that makes nearly 1,000 nonviolent drug offenders eligible for early release over the next five years, according to The Des Moines Register. The law, effective July 1, allows the Iowa Board of Parole to release offenders who have served at least half of their mandatory minimum sentences. Judges have some leeway in determining how much of the sentences those convicted of second-degree robbery and other nonviolent offenses must serve.

MIDWIVES
Starting next year, Kansas midwives will not be allowed to administer abortions or abortion-inducing drugs, according to the Lawrence Journal-World. Gov. Sam Brownback signed a bill that included the prohibition in May. In addition, after the law goes into effect, nurse-midwives will be permitted to practice independently within a limited scope of care instead of entering into an agreement with a physician.

MINNESOTANS URGED TO ASK ABOUT DAILY ASPIRIN
A Minnesota public health campaign launched in June encourages middle-age and older adults to consider taking a daily dose of aspirin to prevent a first cardiovascular episode. Aspirin is commonly used among people who have already had a heart attack or stroke to keep the event from occurring again.

Dr. Russell Luepker, a cardiologist and researcher with the Minnesota Heart Health Program, said more than 16,000 Minnesotans suffer a first stroke or heart attack each year, but 2,000 of those events could be prevented if most at-risk patients took aspirin every day.

Not all adults need to take aspirin and adults who have ulcers or are prone to other bleeding conditions should not take aspirin. Stan Shanedling, who supervises the cardiovascular health unit at the Minnesota Department of Health, said that’s why the campaign is called “Ask About Aspirin” and not “Just Do It.”

He said Minnesota is the first state to launch an aspirin campaign. It will take about two to three years to determine the effectiveness of the program, he said.
BREWERY LAW
Starting July 1, children will be allowed inside licensed breweries in Idaho. The law, signed by Gov. Butch Otter in April, treats breweries that do not serve food the same as breweries that do serve food, which are permitted to allow minors inside, according to the Idaho Statesman. Wineries also were already allowed to have minors on their premises. Proponents of the law said allowing children in brewery tasting rooms would support tourism.

RECOVERING STUDENTS
Oregon State University will open a dorm in the fall for students recovering from drug and alcohol addiction, according to The Oregonian. An OSU alumnus will fund the Recovery and Learning Community on campus. Nine students will live in the dorm initially, but up to 24 will eventually move into the dorm. The university is providing scholarships to help some students pay for the dorm fees.

TRANSPLANTS
Doctors in California can now perform transplants between patients who have HIV because of a bill signed by Gov. Jerry Brown in May, The Sacramento Bee reported. In November 2015, a federal regulation permitted organ transplants between individuals with HIV. A transplant surgeon in San Francisco urged lawmakers to act quickly to help a patient with a failing liver after a donor with HIV volunteered to provide part of his liver. The surgery was delayed because of a state law that made it illegal.
THINKING ABOUT HOW TO RATIONALIZE HEALTH CARE DELIVERY

We don’t need to ration health care in our country. We need to rationalize care—to rethink how we spend money.

At Camden Coalition of Healthcare Providers, our vision is to make Camden, New Jersey, the first city in the country to bend the cost curve while improving quality. For more than a decade, we have been working with all the services in Camden, New Jersey—including local hospitals, nursing homes, family doctors, behavioral health specialists and addiction services—that may come into contact with our patients.

We use data to identify “high utilizers” of emergency room and hospital services and when one of these patients is admitted to a hospital we send a staff member to their bedside. Our goal is to link those patients with non-emergency health care services as soon as possible and make sure they don’t come back to the hospital. We are in their home within three days of release and then over a 90-day period of intervention that staff member helps the patient create a treatment plan, goes with them to primary care provider visits and even coaches the patient and the doctor on how to talk with each other. Linkages are made to other services needed by patients or their families.

Here are three key things to keep in mind:

1. **Understand that services will look very different in the future.** We have an obsolete way of delivering services. The basic infrastructure that was laid down by Medicaid is 50 years old and not enough of that has changed. The service delivery models are old and the ways they are administered by state governments are old. Contracts are old. These outdated models require a major shift. The work of the next generation of state leaders is going to be a tremendous transformation of the system. It’s going to hurt; it’s going to be painful. For instance, it may be possible that the changes in service delivery required cannot be offered by mom-and-pop physician offices, but will require physicians to affiliate with bigger institutions with sophisticated infrastructure in place, including large clinics and federally qualified health care centers.

2. **Let stories lead the change.** Identify the top 10 utilizers of Medicaid services in your system. Assign staff to go meet them, to offer intensive coaching and case management services. Systems are actually good at dealing with outliers on a case-by-case basis and there is much to be learned from doing so. All the state systems of care will be called upon by this exercise. One thing that will be learned is that poor care and bad outcomes are not a poverty problem. This is a health care delivery problem exacerbated by poverty.

3. **Apply the basic lessons of economics.** If the system pays too much for a set of services, there is every reason for that service to be provided in excess. If the system pays too much for emergency room care, for instance, there is no financial reason for emergency rooms to limit the provision of care. If you don’t pay enough for primary care, it will fall apart and go away. In Camden, our data found the most common emergency room visits were for head colds. For the $1.4 million spent on this service, four primary care offices could have been opened.

We are seeing the beginning of long-term change in Camden, New Jersey. Similar innovations are underway in a number of other communities, including a number involved in the Robert W. Johnson Foundation’s Aligning Forces for Quality initiative and four hospitals receiving federal Medicaid funding in Allentown, Pennsylvania; Aurora, Colorado; Kansas City, Missouri; and San Diego, California. For more information about these efforts, visit [www.rwjf.org/en/library/collections/super-utilizers.html](http://www.rwjf.org/en/library/collections/super-utilizers.html).
Health has been called the great equalizer. Everyone—regardless of age or race or class—wants to live a healthy life. Likewise, states want to help achieve healthy communities for their citizens: communities that support healthy lifestyles for residents, where quality care can be accessed to address health care needs and where preventable diseases are just that—prevented. But the health of communities—and threats to it—are ever evolving, creating a constant challenge for states to address emerging issues and needs. Today, the opioid epidemic, chronic diseases, systems of care and even basic community infrastructure present new challenges to the public health of states, and the states are responding.
The phrase “evidence-based” has become ubiquitous in state government circles. The concept is simple: Decisions, in an evidence-based system, are made based on validated prior experiences and research, rather than just on opinions, anecdotes and ideologies.

But, “often that work hasn’t included health,” said Rebecca Morley, director of the Health Impact Project, a collaboration of the Robert Wood Johnson Foundation and the Pew Charitable Trusts. Morley’s efforts, along with others, have been to encourage and assist states and localities in developing so-called health impact assessments, or HIAs, which are “a very specific tool for bringing health issues to decision making,” she explained.

HIAs use a variety of procedures, methods and tools to evaluate the potential health effects of a policy, program or project, according to the World Health Organization.

HIAs have been around, to some extent, for decades, though using that particular name for them is a more recent phenomenon. Suzanne Condon, former associate commissioner of public health in Massachusetts, recalled an instance in 1990 when the mayor of Leominster, Massachusetts, was concerned about the health hazards in building a play area for children in an abandoned lot that contained metal contaminants. Condon helped him do a careful toxicology study, which led to laying 4 to 5 inches of gravel over the ground to protect the children’s health.
Since then, the use of health impact assessments has gathered steam, acquiring that moniker along the way. The movement really started to gain traction in the United States in 2009, when there were 62 HIAs completed, many in California. More recently, there have been closer to 400 a year, almost all in states and localities, as opposed to the federal government.

HIAs can uncover potential hazards that may not be obvious to either decision makers or the general public. For example, around 10 years ago, “there was a proposal to build a new low-income housing complex for seniors near a very busy freeway in the San Francisco area,” said Aaron Wernham, chief executive officer of the Montana Healthcare Foundation.

The idea was favorably received in most circles. But when developers began to work with health officials to create a health impact assessment, people realized the influx of moving vehicles into the neighborhood could create problems for older residents. “So, they worked with the developers to use windows that wouldn’t let the pollution in,” said Wernham, so residents wouldn’t suffer from respiratory issues. “They also made changes so there wouldn’t be as much noise. And we know that noise has impact on health in terms of sleep.”

Unlike their cousins, environmental impact statements, these HIAs aren’t generally used to stop a project but “to inform a project,” explained Morley.

“So people have said that HIAs are like birthing a baby,” said Emily Bourcier, operations and development manager at the Center for Community Health and Evaluation of the Group Health Research Institute. “Once it’s done, you’re not done.”

Bourcier’s point is that HIAs—like any kind of evaluation—haven’t delivered on their promise until actions have been taken to help alleviate any of the potential health hazards uncovered in the process. This can be complicated by the fact that, in many instances, the team that put together the HIA is disbanded after the report is disseminated, but before efforts are made to ensure the recommendations have a chance to be incorporated in decisions.

Of course, like other management tools, HIAs are not a silver bullet. There are, however, a number of ways in which they can be used to optimize the likelihood they will improve health outcomes for a state and potentially save health dollars down the line (if Medicaid costs drop, for example).

A handful of keys to success are laid out in an article titled “An Evaluation of Health Impact Assessments in the United States” that was published in 2015. It was written for the Centers for Disease Control and Prevention by Bourcier and others. They point out the importance of putting together the right team for an HIA, including “experts in the content related to the decision under consideration [and] knowledge of the decision-making process.” The article also encouraged bringing decision makers on board early on and throughout the process in addition to delivering early findings of the HIA to stakeholders even before recommendations are made.

Of course, properly done HIAs aren’t cheap. Pew and other foundations have helped subsidize many health impact assessments. But one of the major sources of funding, the CDC, has recently had its budget for underwriting HIAs cut by Congress.

This move took place in the end-of-the-year appropriations process in December 2015, said Margo Pedroso, deputy director of the Safe Routes to School National Partnership. The House of Representatives chose to cut the funding, with the rationale that the change would allow the CDC to focus on more direct public health activities. The subject may not be entirely closed, however, as a number of national, state and local organizations have written to Congress asking for a restoration of funding in fiscal year 2017.

This congressional decision is an exemplar of a phenomenon that we’ve long seen at all levels of government. Efforts that have long-term payoffs often are given second class status, while direct services are favored. In the short run, this may be a politically expedient philosophy. But in the long run, it doesn’t necessarily serve the citizens well. Without appropriate planning and a real understanding of all the costs associated with a governmental effort, additional expenses and problems will likely crop up down the line.

### Steps of HIA

1. **Screening**
   - Determine whether an HIA is needed and likely to be useful.

2. **Scoping**
   - In consultation with stakeholders, develop a plan for the HIA, including the identification of potential health risks and benefits.

3. **Assessment**
   - Describe the baseline health of affected communities and assess the potential impacts of the decision.

4. **Recommendations**
   - Develop practical solutions that can be implemented within the political, economic, or technical limitations of the project or policy being assessed.

5. **Reporting**
   - Disseminate the findings to decision makers, affected communities and other stakeholders.

6. **Monitor & Evaluate**
   - Monitor the changes in health or health risk factors and evaluate the efficacy of the measures that are implemented and the HIA process as a whole.

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**About Barrett and Greene**

CSG Senior Fellows Katherine Barrett and Richard Greene are experts on state government who work with Governing magazine, the Pew Charitable Trusts, the Volcker Alliance, the National Academy of Public Administration and others. As CSG senior fellows, Barrett and Greene serve as advisers on state government policy and programming and assist in identifying emerging trends affecting states.
Vermont Gov. Peter Shumlin attracted national attention more than two years ago when he spent his entire state-of-the-state speech describing what he called “a full-blown heroin crisis” in his state.

“In every corner of our state, heroin and opiate drug addiction threatens us,” he said. The number of overdose deaths from heroin in Vermont had doubled from the year before. Another indication of trouble in the state, Shumlin said, was the rise in the number of Vermon ters in treatment for opiate addictions—up 770 percent since 2000, numbering 4,300 people in 2012.

Fast forward to late March 2016, when President Barack Obama appeared in Atlanta before a national summit of almost 2,000 professionals, advocates and people in recovery to discuss prescription opioid abuse and heroin use. He said 28,000 people in the United States died from opioid drug overdoses in 2014.

“It’s important to recognize that today we are seeing more people killed because of opioid overdose than traffic accidents,” Obama said. “This is affecting everybody—young, old, men, women, children, rural, urban, suburban.”

Obama praised the non-partisan and cross-sector action already underway.

“We’ve got an all-hands-on-deck approach, increasingly, that says we’ve got to stop those who are trafficking and preying on people, but we also have to make sure that our medical community, that our scientific community, that individuals—all of us are working together in order to address this problem,” Obama said.
Trends Hit the States

“The increasing number of deaths from opioid overdose is alarming,” Dr. Tom Frieden, director of the Centers for Disease Control and Prevention, said in a January 2016 press release about the newest national data.

Driving the upward trajectory of overdose deaths are two interrelated trends, according to the CDC: the 15-year-long increase in deaths related to prescription pain relievers and a recent surge in illicit drugs, largely heroin and, more recently, fentanyl. Fentanyl is the powerful prescription pain reliever recently in the news as the cause of the accidental overdose death of the musician Prince. Counterfeit fentanyl is sold on the black market, often mixed into heroin to increase the high.

From 2000 to 2014, nearly half a million people died from drug overdoses, the CDC reported. Deaths from all drug overdoses numbered over 47,000 in 2014. In 2014, opioids, mainly prescription pain relievers and heroin, accounted for 61 percent of all drug overdose deaths—the 28,000 lost lives the president referred to in Atlanta earlier this year. The national rate of opioid overdoses has tripled since 2000. The other major classes of drugs associated with overdose deaths include stimulants, often used to treat attention deficit hyperactivity disorder, and central nervous system depressants for relieving anxiety, such as Valium.

States’ opioid drug overdose rates vary greatly. In 2014, West Virginia’s rate of opioid overdose deaths—31.6 deaths per 100,000—was nearly ten times that of Nebraska, the state with the lowest rate at 3.2 deaths per 100,000, according to CDC data. Besides West Virginia, the states with the highest drug overdose death rates include New Hampshire (23.4 per 100,000), New Mexico (20.2 per 100,000), Rhode Island (19.8 per 100,000) and Ohio (19.1 per 100,000).

The trend of more overdose deaths seems nearly inescapable for states. When CDC compared 2013 rates to 2014 rates, it found 34 states posted increases (12 of them statistically significant) in the one-year comparison. No state had a statistically significant decline in drug overdose death rates.

A Complex, but Preventable Disease

“Drug addiction is a preventable disease,” according to Nancy Hale, CEO of Operation Unite, a nonprofit organization started in 2003 in Kentucky to rid communities of illegal drug use through law enforcement, treatment and education. Operation Unite sponsored the fifth annual National RxDrug Abuse and Heroin Summit in Atlanta in March featuring Obama.

Hale said the summit emphasized the stigma of words like addiction and drug addict. “We are talking about a complex disease and quitting takes more than good intentions or a strong will.”

According to Hale, the National Institutes of Health have found the brain changes over time because of drugs. The change hampers the ability to resist the impulse to take the drug, despite the consequences of using drugs on the person themselves or their family.

Besides treatment for the chronic disease of drug use, Hale said, a holistic approach, including community education and outreach, is necessary.

“No one policy or program will solve the problem. Everyone is a stakeholder,” she said.

Dr. Matt Rohrbach, a medical doctor who is a member of the West Virginia House of Delegates, said his state cannot move ahead economically unless it turns around its drug abuse numbers. He agreed that the fight against drug abuse must be waged on many fronts.

“Addiction is a medical problem just like diabetes and heart disease,” he said. “Some answers are medical, some are social.”

Harm Reduction

There are a number of harm reduction policies that can reduce the negative consequences of drug use and save lives, Rohrbach said.

Opioid Overdose Death Rates, per 100,000: 2014
In 2015, West Virginia passed a law to provide the overdose antidote naloxone to first responders as well as individuals at risk of overdose and their relatives, friends or caregivers. A followup law passed this year, Rohrbach said, makes naloxone available in West Virginia “behind the counter.” Anyone can ask the pharmacist for naloxone and, after a brief training on administration, take it home. According to the Network for Public Health Law, all but five states—Arizona, Kansas, Missouri, Montana and Wyoming—have laws to improve naloxone access, but West Virginia is only 1 of 12 states that allow possession of naloxone without a prescription.

New Mexico was the first state, in 2007, to adopt a Good Samaritan law that addressed the criminal concerns of a person summoning aid in an overdose situation. Now 34 states and the District of Columbia have laws that prohibit law enforcement action against those seeking help for an overdose.

Needle, or syringe, exchange programs are another harm reduction strategy. The purpose of these programs is to prevent the spread of blood-borne diseases such as hepatitis B, hepatitis C and HIV through needle sharing.

After West Virginia began the state’s first needle-exchange program in Huntington in 2015, Rohrbach said the results were better than expected.

“If you have enough gumption to go to the exchange, you know you have a problem, and you want help,” he said. The exchange, located at the local health department, provided primary care and access to peer counselors, themselves in recovery.

“We found an amazingly high percentage—40 to 50 percent—who started to ask the peer counselors how to get clean,” Rohrbach said “They became willing participants in treatment programs.”

Two states—Florida and Utah—passed laws in 2016 explicitly allowing needle exchanges, bringing the total to 20 states. Another 13 states have changed drug paraphernalia laws to prevent law enforcement action against persons exchanging needles. Five more exchanges have been developed in West Virginia.

Judicial and Policing Policies

Drug courts are in operation in almost every state, but they differ in their design, services and the populations on which they focus. The common denominator is that judges refer defendants to treatment services in lieu of incarceration. The judge, court staff and the defendant’s family and friends provide important support during the treatment process.

“One important benefit of drug court is that the defendant has a second chance for gainful employment without a felony record,” said Rohrbach.

Prescription drug monitoring programs, or PDMPs, began in earnest in the 1990s and now every state but Missouri has one. PDMPs are databases that track prescriptions for controlled substances through entries made by pharmacies and physicians.

Hale, of Operation Unite, recommends mandating physicians to use PDMPs before writing a new prescription. Massachusetts made this change as part of a 2016 comprehensive law on drug abuse.

“All Drug Overdose Deaths (2014)

- Opioid Deaths: 28,647
- Prescription Opioid Deaths: 18,893

- Total Overdose Deaths: 47,055
dissolving pills. The new formulations are more expensive and laws have passed, for instance, in Maryland and Massachusetts to require insurers to cover abuse-deterrent formulations. Hale said in the long run savings would accrue to commercial insurers who will not bear the cost of treating opiate addiction.

**Treatment**

A growing body of evidence supports medication-assisted treatment for substance use disorders. There are three elements to MAT—medication that reduces drug-seeking behaviors, counseling, and support from family and friends—according to the federal Substance Abuse and Mental Health Services Administration, or SAMHSA. MAT differs from most methadone clinics that often include little or no counseling and from detoxification programs that are short term and don’t use medications to reduce drug cravings.

According to SAMHSA, MAT is greatly underused. SAMHSA data show only 28 percent of heroin admission plans listed MAT therapy in 2010, down from 35 percent in 2000. The reluctance to use MAT treatment may be related to the misconception of substituting one drug for another.

States such as Massachusetts and West Virginia have increased funding for treatment, including MAT, and Obama has requested federal funds. And states that have expanded Medicaid eligibility under the Affordable Care Act have access to new resources to put toward treatment.

**Education and Prevention**

“The easiest drug addict to treat is the one you prevented,” Rohrbach said, emphasizing the importance of education and prevention activities. He also urged states to develop education programs for health professionals on treatment of chronic pain and opiate prescribing.

“I will be honest, a lot gets back to the fifth vital sign, and how doctors control pain,” he said.

Hale said the National Institute of Drug Addiction has shown that prevention programs are effective and that for each dollar spent on research-based programs, up to $10 can be saved in treatment for alcohol and other substance abuse.

“We can’t arrest our way out of the [drug] problem,” she said. “We can’t treat our way out of the problem. Education holds the key.”

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**FINDING AN ALTERNATIVE**

Left: Angelique Chacon, photographed in October at her home in Wilmington, California, had prepared to spend six years behind bars for selling methamphetamine, but a new rehabilitation program in U.S. District Court in Los Angeles allowed her to take a plea deal, get a part-time job, take classes at a technical school and graduate from rehab with a sentence of probation instead of prison. Drug courts provide an alternative judicial approach to drug crimes, offering defendants with treatment options in lieu of incarceration, often accompanied by community supervision. © AP Photo / Ringo H.W. Chiu

**A SECOND CHANCE**

Above: Kylee Moriarty receives a hug from a volunteer on July 10, 2015, at the Gloucester, Massachusetts, police station. Moriarty is participating in a new program of the Gloucester Police Department that helps heroin addicts to access treatment. © AP Photo / Elise Amendola, File
Addiction is a chronic, neurobiological condition with the potential for recovery and relapse. We know that recovery is possible and that treatment works best if it is multi-dimensional, evidence-based, and addresses both the physiological and psychological elements of substance use disorders. When coupled with appropriate psychosocial supports, medication-assisted treatment can provide one of the best paths to long-term recovery.

Medication-assisted treatment, also known as MAT, is one of the most powerful tools in the behavioral health toolbox for responding to heroin and opioid use disorders. Methadone, buprenorphine and extended-release injectable naltrexone all reduce opioid use, opioid use disorder-related symptoms, risk of infectious disease and crime, according to The American Society of Addiction Medicine’s 2003 report, Advancing Access to Addiction Medications.

Substance use disorders are often chronic, so medications may need to be administered for a long period of time, possibly for a lifetime. However, particularly in the early stages of recovery, medication alone is not considered best practice in treating opioid use disorders. Buprenorphine, methadone and naltrexone reduce physical cravings but do not address the psychosocial aspects of substance use disorders.

Too few people who are diagnosed with an opioid use disorder have received appropriate treatment for their condition. Therefore, expanding access to MAT is a primary focus for the Substance Abuse and Mental Health Services Administration, or SAMHSA. As part of a comprehensive effort to improve access to treatment, SAMHSA is proposing a change to the Drug Addiction Treatment Act of 2000 regulation to increase the number of patients that providers can treat for opioid use disorders. Currently, physicians can be approved to prescribe buprenorphine to 30 patients or, after a year of treating 30 or fewer patients, may apply for a waiver to treat up to 100 patients. SAMHSA has proposed regulations that would increase the waiver limit to 200 after additional requirements have been met. Realizing the urgency of the opioid public health crisis, we expedited the timeline for the rulemaking.

While the increased limit is intended to make MAT available to more people, it...
States also express frustration with the slow pace of uptake of evidence-based practices by specialty-care programs. Programs have a hard time incorporating more than one of the rather complex evidence-based practices. Some of these issues can be addressed via technical assistance that SAMHSA can provide to states and their providers. Others, such as the complexity of the available evidence-based practices, require a longer-term solution that involves working with researchers to conduct studies that identify the essential elements of effective practices and programs and to conduct systemic reviews to identify the common elements that cut across specific evidence-based practices that can be incorporated into psychosocial interventions.

People for whom substance use disorders are chronic will need long-term care, which may include peer supports as well as medication and psychosocial interventions by trained professionals. Peer support workers fill in gaps in the treatment continuum and offer the particular perspective of a person who has been through the disease and is coping effectively. In addition to their support role, peer support staff can serve as a resource to link patients to needed social supports such as housing, job seeking or training programs, family supports, and other essential services. SAMHSA has grants available to states to help them enhance their peer support efforts.

With its grants programs and training/technical assistance services, SAMHSA is working with states to move the treatment of substance use disorders from a short-term counseling model to a model of treatment that includes the use of medications, counseling and peer supports over an extended period of time for some patients, as well as being able to address the needs of people who have a diagnosis of mild substance use disorders—in accordance with the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition—who may need shorter-term, less intense interventions.

Unfortunately, states have reported challenges in finding physicians willing to offer office-based opioid treatment; therefore, locating opiate treatment programs is an ongoing issue. Patients may be reluctant to use antagonists such as extended-release injectable naltrexone because of withdrawal fears, and physicians lack experience with treating withdrawal symptoms in non-specialty care settings. States also express frustration with the slow pace of uptake of evidence-based practices by specialty-care programs. Programs have a hard time incorporating more than one of the rather complex evidence-based practices. Some of these issues can be addressed via technical assistance that SAMHSA can provide to states and their providers. Others, such as the complexity of the available evidence-based practices, require a longer-term solution that involves working with researchers to conduct studies that identify the essential elements of effective practices and programs and to conduct systemic reviews to identify the common elements that cut across specific evidence-based practices that can be incorporated into psychosocial interventions.

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Kana Enomoto serves as principal deputy administrator for the Substance Abuse and Mental Health Services Administration, or SAMHSA, where she has been delegated the functions, duties and authorities of the administrator to oversee an agency with four centers, four offices, over 600 employees and a budget of $3.7 billion. Through data, policy, public education and grants, Ms. Enomoto and the SAMHSA team advance the agency’s mission to reduce the impact of substance abuse and mental illness on America’s communities.

Dr. Kimberly A. Johnson, director of the Center for Substance Abuse Treatment, has an extensive career in behavioral health that has earned her numerous awards, including the federal Department of Health and Human Services Commissioner’s Award for Child Welfare Efforts and the National Association of State Alcohol and Drug Abuse Directors’ Recognition for Service to the field of Substance Abuse Treatment and Prevention.
With these famous words, Thomas Jefferson established that life itself could be a core measure of the trajectory of our nation. And indeed, over the course of U.S. history, ever-increasing numbers of Americans have been able to experience longer and healthier lives. In 1776, average life expectancy was about 40 years. Today, it is 79.

Yet, alarm bells are ringing. According to the National Academy of Sciences, the average life expectancy is lower in the United States than in other nations with advanced economies. Within our borders, African-Americans, rural Americans and poor Americans on average die years earlier than others. In fact, for some groups—including poor, white Americans—as a result of suicide, drug addiction and chronic illness, life expectancy is now actually falling.

It is no surprise that political leaders across the ideological spectrum increasingly are asking what can be done to protect and promote the health of their communities. In many areas, county and state governments are calling on state and local public health departments to deliver major improvements in health.

What does it take to save lives—not one by one through medical treatment, but hundreds of thousands or even millions at a time? This may sound like a crazy question, but it’s the right one to ask. Public health campaigns have in fact saved the lives of millions of people in the United States and around the world from malnutrition, infectious disease, unclean water and air, and other preventable conditions. In the United States, even today, up to half of all premature deaths are preventable.

Opportunities to Save Lives, Many at a Time

by Joshua Sharfstein
Step 1 is to know your numbers. It all starts with understanding the problem. Health departments can determine which specific diseases and conditions that lead to premature death are affecting local residents at the highest rates. Mapping health data can pinpoint geographic hot spots in need of extra attention. Over time, governments can use information to figure out which responses are working and which are not. Effective use of data has been a key element of successful efforts to reduce infant mortality, lower the number of deaths from overdose, and reduce the toll of cardiovascular disease, diabetes and cancer.

Step 2 is to convene your public and private partners around common goals. Maryland established 39 health goals for the state in five strategic areas—healthy beginnings, healthy living, healthy communities, access to health care and quality preventive care—and charged 18 local health coalitions with the responsibility to pick key targets and establish strategies for progress. Local hospitals, doctors, business leaders, school officials and others joined health officials in rolling up their sleeves and developing innovative projects.

State policymakers can support local initiatives in many ways. These include convening expert teams to provide input on strategy, such as Rhode Island recently did around an epidemic of overdoses. The state is now moving forward to expand access to life-saving addiction treatment. Similarly, states can adopt laws, regulations and policies that prevent asthma outbreaks from happening, for example, by modernizing housing standards and promoting reductions in tobacco use.

By coordinating with private employers and insurers, states also can seek more value from health care spending. Oregon, Tennessee, Maryland and Utah have all been leaders in paying for health care differently—paying more for improved health results and higher quality care, rather than for increasing volumes of services alone. Private and federal funding can be used to supplement many of these efforts.

Step 3 is to empower your citizens with new and creative tools to improve their own health. This means seeking out those efforts that are likely to create the most opportunities for health and wellness, even if they do not look like traditional health projects.

For example, it might on first glance seem like a good idea to expand an educational campaign to help doctors tell their patients about the benefits of exercise. Yet for the same amount of money, a state or locality may have greater impact by creating attractive walkways, parks and athletic programs that draw people to participate. Similarly, efforts to expand access to fresh food, reduce housing hazards such as lead poisoning, address trauma and violence, and enhance educational opportunities for children will allow many more individuals and families to enhance their own health and well-being.

Improving and extending life is not just any policy goal. It was the first. Making progress is very much part of renewing and revitalizing the American dream.

About the Author

Joshua M. Sharfstein, M.D. is associate dean for Public Health Practice and Training at the Johns Hopkins Bloomberg School of Public Health, where the mission is Protecting Health, Saving Lives – Millions at a Time.
The United States spends more on health care than any other country.

According to the Centers for Medicare and Medicaid Services, the U.S. spent $3 TRILLION in 2014, up 5.3 percent over 2013 levels.

In the six years after the recession, health care added 2.1 million jobs to the economy, more than the next 3 industries combined—leisure and hospitality, professional services, and education.


Employment in health care is projected to grow by 19% from 2014 to 2024, much faster than the average occupation—adding about 2.3 million new jobs.

2014–2024: The health care and social assistance industry will produce 1 in 3 net new jobs in the U.S.

Nearly one in eleven jobs is in the health care field—12.2 million jobs in 2014.
“Bottom” 5 States with the Highest Percentage of Counties Declared Medically Underserved¹

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<th>State</th>
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“Top” 5 States with the Highest Percentage of Jobs Classified as Health Care Jobs, May 2014²

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<td>Massachusetts</td>
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¹An area is considered “medically underserved” by the U.S. Department of Health and Human Services, Health Resources and Services Administration when the area has a low ratio of primary medical care physicians per 1,000 population along with elevated infant mortality and poverty and/or a high percentage of the population age 65+.

More Americans die every year from drug overdoses than in car crashes. What are some of the factors that have helped fuel the crisis?

“The primary contributing factor to the rise in drug overdose deaths since 1999 is the increase in prescribing of prescription opioid pain medications; opioids are powerful drugs that carry a risk of addiction. As a result, opioid-involved overdose deaths tripled in 15 years. In 2014 alone, this epidemic claimed 28,000 lives across the U.S. It’s a real crisis, and we’re working to expand treatment so that everyone who needs it can access it.”

Fentanyl, a synthetic opioid, seems to be taking on a leading role in the epidemic. Why is it so dangerous?

“Fentanyl is much more potent than heroin, so we’ve seen a surge in overdose deaths involving fentanyl in recent years. It’s also sometimes mixed with heroin, so people may not realize they are using fentanyl. The Obama administration has been working closely with the international community to disrupt and dismantle criminal organizations trafficking heroin, reduce poppy cultivation, and enhance efforts at the border to decrease the flow of heroin. We’ve also focused on making sure that anyone in a position to witness an overdose is equipped with naloxone to help reverse overdoses and give people a chance to enter treatment and, eventually, long-term recovery.”

You’ve hosted community forums across the country on the opioid epidemic in recent months. What have you learned from the communities you’ve visited?

“First, we have a treatment gap that’s preventing us from saving lives. It’s estimated that only 12 percent of people who need treatment are actually getting it. … Too many (family members of those lost to overdoses) shared similar stories about long waits for treatment or a lack of good treatment options in their communities. … It’s critical that people can access treatment, including medication-assisted treatment, which is unavailable in many places. And we need more treatment providers, especially in underserved areas. The president’s $1.1-billion budget request would help expand access to treatment in areas that need it.”

In October 2015, President Obama announced a number of new public and private-sector efforts to address the epidemic, such as health care prescriber training. How does the administration hope to help stem the tide of overdoses with these efforts?

“Ensuring prescribers and patients understand the risks involved with prescription opioid pain medications will go a long way toward ending this crisis. In March, the CDC released its new...
Guideline for Prescribing Opioids for Chronic Pain so prescribers can safely treat their patients’ pain, while also recognizing the risks of opioid prescribing. The Obama administration has also trained more than 75 percent of federal prescribers in safe and responsible prescribing practices. It’s a start, but we need every prescriber of opioids to get the training they need. This will go a long way toward preventing future opioid use disorders—and deaths.”

5 What role are state prescription drug monitoring programs and other state initiatives playing in larger efforts to prevent and respond to substance abuse?

“The opioid epidemic affects the whole country, but it’s often state and local governments that are closest to the problem. … While 49 states and the District of Columbia have prescription drug monitoring programs, too few prescribers check these systems before prescribing. States can enhance these prescription drug monitoring systems, allow syringe service programs, expand access to the opioid overdose-reversal drug naloxone, pass Good Samaritan laws that encourage people to call 911 or seek other medical aid without the fear of arrest when witnessing an overdose, and make treatment more widely available. They can also require prescriber education so the prescribers in their states are trained to safely and responsibly prescribe opioid pain medications.”

6 How are state and federal programs expanding access to treatment for addiction?

“There’s a huge treatment gap right now all across the country. … As I’ve traveled the country, I’ve heard heartbreaking stories from parents unable to access treatment for their children, some of these children have died as a result. This is unacceptable to the president, it’s unacceptable to me. We need Congress to pass the president’s budget request that includes $1.1 billion to expand treatment so we can help people reach recovery and regain control of their lives.”

7 What are some of the evidence-based treatment options that have promise to help reduce overdoses?

“People need to have access to every form of treatment because there’s no single path to recovery and what works for one person may not work for another. Medication-assisted treatment is the standard of care for opioid use disorder, but it’s unavailable in many places, partly because of the stigma surrounding addiction and treatment. Yet it’s generally accepted by the public that medication is a useful tool—if not the primary tool—to quit smoking. People with substance use disorders should have the same access to medication.”

8 For many years, drug addiction has been approached as a criminal issue, but leaders are increasingly referring to addiction as a public health issue. Why is this so critical?

“In 2014 alone, drug overdoses killed more than 47,000 people. This is a real public health crisis, and we recognize that we can’t incarcerate our way out of this problem. It’s past time for our country to both reform the criminal justice system and to make sure that people with substance use disorders get the treatment they need. We need to be diverting more people to treatment, including through drug courts. President Obama often says ‘America is a nation of second chances.’ Our country celebrates people who take the steps to overcome adversity. Our policies should reflect this.”

9 How has your personal success story of long-term substance use recovery informed your efforts to help communities across the nation?

“I hope that my story of recovery inspires people with substance use disorders—and their loved ones—to see that recovery is possible, and that you can have a life after substance use. But my story is not unique—there are millions of Americans in recovery across the country. We didn’t all take the same path to recovery, and that’s why it’s so important that people can access every form of treatment.”

10 What role does the medical community play in combating prescription drug abuse?

“The medical community has a huge role to play in preventing, identifying and treating substance use disorders. Prescribers can prevent the misuse of prescription opioid pain medications by following the CDC’s Guideline on Prescribing for Chronic Pain, suggesting alternative treatments to manage their patients’ pain and checking their state prescription drug monitoring program. They can intervene if they think a patient is at risk for overdose or developing an opioid use disorder by co-prescribing naloxone and referring the patient to substance use treatment. They have a tremendous role to play in our efforts to move our country from crisis to recovery.”
The June 2012 U.S. Supreme Court ruling upholding the constitutionality of the Affordable Care Act, or ACA, one of President Barack Obama’s signature domestic policy initiatives, included a bit of a surprise for states.

Writing the majority opinion of the court, Chief Justice John Roberts acknowledged Congress’ ability to incentivize states’ participation in programs under the ACA, such as Medicaid expansion, but with a limit. “What Congress is not free to do is to penalize states that choose not to participate in that new program by taking away their existing Medicaid funding,” he wrote.

And with that, a major component of the health care reform legislation became an option for the states, leading to a series of new debates in statehouses across the country.

While the Supreme Court’s decision removed the federal stick in the law to help enforce Medicaid expansion, a sizeable carrot for states choosing to expand Medicaid to individuals whose income falls below 138 percent of the federal poverty rate remained—full federal coverage of the cost of expansion for three years, after which the state match would gradually increase to 10 percent.

Four years later, 31 states and the District of Columbia have expanded Medicaid, according to the Henry J. Kaiser Family Foundation, which monitors health policy at the national and state levels. While most states adopted expansion as laid out in the ACA, a few states such as Arkansas and Indiana have expanded the program under the 1115 waiver process, which allows for demonstration programs that give states more flexibility in program design.

For the 19 states that have not expanded Medicaid, the question of whether or not to expand remains, while the clock continues to tick in the countdown to the end of full federal coverage of the program in December.

While the debates among state and federal lawmakers have been politically charged at times, state lawmakers contend that the decision to expand or not centers around the unique needs of states and their constituents—and how best to meet
those needs—rather than around the politics of the issue. And those debates are leading to a variety of solutions in the states.

A High Price

Originally designed to cover young children, the elderly, and blind and disabled people with low incomes, Medicaid expansion under the ACA effectively eliminated the program’s categorical eligibility requirements other than income level, which significantly expanded the scope of the program and its cost.

According to the 2015 State Expenditure Report by the National Association of State Budget Officers, or NASBO, “Medicaid spending accounted for 25.6 percent of total state spending in fiscal 2014, the single largest component of total state expenditures,” and was expected to grow to 27.4 percent by fiscal year 2015. This rise in Medicaid spending represents an increase of 4.8 percent in state expenditures from 2014 to 2015, and an increase of 22.5 percent in federal Medicaid spending. Total Medicaid spending in fiscal 2015 is estimated to be $512.3 billion, according to the report, up 15 percent from fiscal 2014.

For some state legislators, the price of expanding Medicaid eligibility is simply too great.

In Virginia, Gov. Terry McAuliffe has called to expand the program, but the state’s General Assembly has blocked the plan, citing costs as a principal reason.

According to Virginia Speaker Bill Howell, Medicaid accounts for 23 percent of state general fund expenditures to cover the state’s match for nearly a million program recipients. “The cost of the existing Medicaid program over the next two years is going up close to $950 million,” said Howell. “Every additional dollar that we put into Medicaid is one less dollar that is available for K-12 or higher education or public safety.”

Expanding Medicaid would add 400,000 members to Virginia’s rolls.

“It’s just unsustainable,” said Howell.

Costs were also a concern to lawmakers in South Dakota. Soon after the 2012 Supreme Court ACA decision, South Dakota Gov. Dennis Daugaard established a Medicaid Opportunities and Challenges Task Force charged with evaluating the advantages and disadvantages of pursuing expansion. In its final report released in 2013, the task force noted the “considerable” cost of expansion to the state general fund, which it estimated would rise from $1.5 million in fiscal year 2014 to $36.8 million by fiscal year 2020.

But new developments between the state and federal government have changed the fiscal implications of expansion for the state. The Centers for Medicare and Medicaid Services, or CMS, agreed in February to fully cover the cost of certain types of care for Native Americans who seek services outside of Indian Health Service, or IHS, the federal agency responsible for providing health care to Native Americans. Previously, costs for Native American health care provided at IHS facilities were fully covered, but the cost of care provided to Medicaid-eligible Native Americans at non-IHS facilities were shared between the state and federal government.

The savings to the state from the new agreement address initial cost concerns related to expansion, said South Dakota state Sen. Craig Tieszen, who was a member of the governor’s Medicaid Task Force.
“(Gov. Daugaard) has calculated very conservatively that South Dakota will actually benefit from this expansion,” said Tieszen, “because what we will save on Medicaid-eligible Indian health care will exceed what the eventual cost of expansion would be.”

Although the state Legislature did not take up the plan during the regular legislative session, news reports suggest that Daugaard may call a special session to consider the plan this summer.

Indiana also found a way to reduce the fiscal impact of Medicaid expansion when it pursued its plan to expand Medicaid under the Section 1115 waiver process. Under its expanded program, called the Healthy Indiana Plan 2.0—or HIP 2.0—that began in early 2015, Indiana nearly doubled Medicaid rolls in the state, which now covers 400,000 Hoosiers.

According to Indiana state Rep. Ed Clere, former chairman of the Indiana House Health Committee and co-chair of the CSG Health Public Policy Committee, the state was able to fund expansion by leveraging the hospital assessment fee—a payment imposed on health care providers by the state—authorized under the ACA, which made expansion budget-neutral for the state. “Had it not been for the (Indiana) Hospital Association, I don’t think expansion would have happened,” said Clere. “They came to the table with the hospital assessment fee as a funding mechanism.”

For Clere, the benefits of Indiana’s program—both direct and indirect—outweigh the costs. “It has major fiscal implications for the state and it also has major implications for the state in terms of workforce and site selection and job creation,” said Clere. “Other states have talked a lot about how they’re going to save money … and keep a focus on cost. That’s important, but that can’t be the sole focus.”

**The Need for Reform**

Beyond costs, state leaders have also pointed to the need for reform of Medicaid.

A recent report by the Virginia Joint Legislative Audit and Review Commission, or JLARC, found the state spent as much as $38 million over a two-year period on ineligible Medicaid enrollees due to delays in reviewing renewals.

“IT’s a broken system and the costs are skyrocketing,” said Howell. “We need to come up with ways to make it a better system, and I think we can do that.”

Howell said the JLARC report identified opportunities to curb Medicaid fraud and abuse, and the House of Delegates has formed a Medicaid Improvement Reform Commission to identify options to streamline the program. “We’ve come up with some good ideas over the last couple of years, but we’re just at the beginning of the process,” said Howell. “But there’s got to be a better way to treat these people who can’t help themselves.”

Clere said Indiana’s unique path to Medicaid expansion through HIP 2.0 addressed some of these concerns that could be used as a model for other states. HIP 2.0, which uses managed care services, is modeled after commercial coverage, offering HIP Basic and HIP Plus options for recipients. HIP Plus participants pay premiums in the form of monthly contributions to a Personal Wellness and Responsibility account designed to function much like a health savings account, and they receive expanded benefits and pay co-payments only for non-emergency use of the ER. HIP Plus members above the federal poverty level who fail to pay their premiums can be barred from coverage for six months.
It’s a broken system and the costs are skyrocketing. We need to come up with ways to make it a better system, and I think we can do that.”

» Speaker Bill Howell, Virginia House of Delegates

“(Gov. Daugaard) has calculated very conservatively that South Dakota will actually benefit from this expansion, because what we will save on Medicaid-eligible Indian health care will exceed what the eventual cost of expansion would be.”

» South Dakota state Sen. Craig Tieszen

It’s Medicaid expansion, it’s just that we did it in a different and, many of us would argue, more innovative way than traditional Medicaid.”

» Indiana state Rep. Ed Clere

An Uncertain Future
In an election year that has been full of surprises, the issue of uncertainty also resonates among state lawmakers as they consider Medicaid expansion.

And, according to Clere, this applies even in his state that already has expanded Medicaid. In states like Indiana that have an 1115 waiver for Medicaid expansion, which are considered demonstration programs, the waiver is renegotiated bilaterally between the state and federal governments every three years. But in March, Gov. Mike Pence signed Senate Enrolled Act 165, which codifies the program into law, limiting the ability to change the program’s provisions.

Clere said that may create obstacles down the road.

“HIP 2.0 provided a politically acceptable pathway for expansion, and I think SEA 165 maybe fences in that pathway in a way that allows very little room to maneuver,” said Clere. “I’m concerned that we may find ourselves in a situation where the whole program may be in jeopardy.”

“It’s a volatile time, politically, and we don’t need any more uncertainty with coverage,” Clere added.

Concerns related to uncertainty extend also to future costs of the program—even those not covered by the state.

“If I were in a state that had expanded Medicaid, I’d be very concerned about the federal government’s promise to pay 90 percent of costs forever,” Howell said. “The country just can’t afford this rapid growth in entitlements.”

But future uncertainty may make action now a bit more likely in South Dakota as it considers its deal with the current administration for federal coverage of Native American health care.

“There’s a hesitation as to what the future may bring and what direction is the federal government going to take under different leadership,” said Tieszen. “But this is an issue that probably the window of opportunity could close after the November election. Who knows? Things can change.”

while those at or under the federal poverty level who fail to pay premiums are moved to HIP Basic coverage, with fewer benefits.

“It’s Medicaid expansion, it’s just that we did it in a different and, many of us would argue, more innovative way than traditional Medicaid,” said Clere. “It was a major milestone, not only for Indiana but for the country in that it is unique in its features.”

South Dakota, should it move forward with Medicaid expansion, would add a much smaller number of recipients to its rolls than either Indiana or Virginia—50,000—which Tieszen said would add “a very limited exposure to fraud.” But he said there are inefficiencies in the ways these individuals currently receive health care services, as well.

“The manner in which these Medicaid expansion-eligible people are getting health care now is about as expensive and inefficient as it can be—it’s emergency room type of care,” said Tieszen. “Medicaid, despite what flaws it might have, is a better delivery system than what we’re currently utilizing.”
The demand for health care services in the United States is growing—a result of population growth, an aging population and federal health care reform that has increased the number of Americans with health insurance coverage. And experts estimate that the demand on the health care industry and its workforce will continue to rise for years to come. According to the Georgetown University Center on Education and the Workforce, or CEW, demand for health care services will grow twice as fast as the national economy over the next decade.

That means the nation will require more health care professionals in the years to come, but the question for many is whether there are enough future workers in the health care education pipeline to meet these rising needs.

According to the Association of American Medical Colleges, demand for physicians will exceed supply by 60,000 to 90,000, with a shortfall of primary care physicians of between 15,000 and 35,000, by 2025.

But the supply of primary care nurse practitioners and physician assistants over the same timeframe is expected to increase more rapidly. The U.S. Health Resources and Services Administration projects that the supply of primary care nurse practitioners could increase from 55,400 in 2010 to 72,100 in 2020—a growth of 30 percent. Meanwhile the supply of primary care physician assistants is estimated to increase by 58 percent—from 27,700 in 2010 to 43,900 in 2020.

In health care, there are really two labor markets: Professional and Support. Professional jobs demand postsecondary training and advanced degrees, while support jobs demand high school and some college. According to Dr. Nicole Smith of Georgetown University CEW, there is “minimal mobility” between the two, and the pay gap is enormous. The average professional worker makes 2.5 times as much as the average support worker.

A 2012 study by Georgetown University’s CEW found that demand for postsecondary education in health care will rise faster than in all other fields with the exception of science, technology, engineering and mathematics—or STEM—and education occupations. Of an estimated 5.6 million new health care jobs created by 2020, 82 percent will require postsecondary education and training.
NURSING & HEALTH CARE SUPPORT

With 3 million registered nurses in the U.S., nursing makes up the largest component of the health care profession. According to the Institute of Medicine, there has been significant progress made in training future nursing professionals needed to meet the nation’s growing health care demands. Between 2010 and 2015:

- **Enrollment** in entry-level Bachelor of Science in Nursing, or BSN, programs increased by 21 percent from 161,540 to 195,704 students.
- Schools have expanded capacity in RN-to-baccalaureate degree completion programs with enrollment increasing by 76 percent from 77,259 to 135,999 students.
- The percentage of employers requiring new RN hires to hold a baccalaureate increased from 30 percent to 47 percent. Within that same timeframe, the percentage of employers preferring nurses with a BSN increased from 76 percent to 84 percent.
- Since fall 2010, enrollment in Doctor of Nursing Practice programs has more than tripled, from 7,037 to 21,995 students (213 percent increase). Enrollment in Ph.D. nursing programs has also increased by almost 10 percent over the last six years with 5,035 now pursuing the research-focused doctorate.
- According to the Georgetown University CEW, health care support professions—such as home health aides, nursing assistants and athletic trainers—are expected to grow at the second fastest rate by 2020 within the health care industry, behind only nursing. These types of jobs offer the lowest wages among all health care jobs, and typically require a high school education or some college.

PHYSICIANS AND OTHER DOCTORS

According to data from the Association of American Medical Colleges, the number of students enrolled in M.D.-granting and D.O.-granting schools rose by 33 percent between the 2004-2005 and 2014-2015 academic years.

- M.D. enrollment increased 22 percent from the 2004-2005 to 2014-2015 academic years.
- In the 2014–2015 academic year, more than 60 percent of new students in M.D.-granting schools enrolled in their home state. Puerto Rico and Louisiana had the highest rates of in-state matriculation—at more than 90 percent of new medical students—while New Hampshire had the lowest in-state matriculation rate at 8.7 percent.
- According to Georgetown University’s CEW, the pipeline of future doctors in America typically comes from high-income families. More than half of all medical school students come from families in the top income quintile in the country, with a combined annual family income of more than $115,000.
- More than 85 percent of all medical students have at least one parent who has earned a college degree. At least half of all medical students have at least one parent with a graduate degree.

WORKING WHILE LEARNING

Working while learning, or learning while earning, is not uncommon for health care workers.

- Close to **15 PERCENT** of all working learners over 30 are enrolled in baccalaureate health care programs.
- Of all workers who are also currently enrolled in colleges and universities are over the age of 30.

JULY/AUG 2016 | CAPITOL IDEAS
Mosquitoes have caused problems for reasons as small as disturbing outdoor leisure and as great as transmitting viruses such as West Nile. As the summer heated up in 2016, health and mosquito control professionals across the states had one more reason to pay attention to the pesky, biting insects.
Scientists discovered Zika virus in 1947. But for decades it was rare and “we just thought it was a relatively mild disease, and for most people, it is,” said Janet McAllister, a research entomologist with the Centers for Disease Control and Prevention. Most people infected never even experience symptoms bad enough to see a doctor, McAllister added. “So that’s what we thought Zika virus was until the outbreak was big enough.”

Pregnant women were warned about Zika virus after an outbreak in Brazil because it was determined that the virus could cause birth defects such as microcephaly, a condition that results in babies born with undersized heads and underdeveloped brains. In addition, Zika virus can be sexually transmitted and transmitted via blood transfusion.

In early June, as the first official day of summer approached, the virus had overwhelmed South and Central America. No locally transmitted cases had been reported in the United States although cases had been confirmed in the U.S. territories of Puerto Rico, the Virgin Islands and American Samoa.

State and local health departments with limited resources have scrambled to prepare for the virus’ arrival. “State health departments and state vector control—or county vector control—programs run on shoestring budgets, and now they’re being asked to do a lot more work,” McAllister said.

Mosquito control programs vary across jurisdictions, from programs “run by one or two employees to multimillion dollar programs with multiple aircraft,” McAllister said. Vector control, however, usually doesn’t start with spraying chemicals; rather, vector control starts with surveillance, collection and research to make the best decisions about where and how to abate mosquitoes.

“I think the general public thinks they just jump in the truck and spray everything because that’s what’s visible to the public,” McAllister said. “The public doesn’t see all of the work that goes into that decision to run that spray truck.”

The CDC has worked with states on lab training, McAllister said. The agency also has worked with blood centers to get a system in place for testing donated blood, and the CDC has developed guidelines for health care professionals who treat pregnant women infected with Zika.

“There’s a lot of guidance that we’ve actually put into place in a very short time because this was not an issue anywhere in the world this time last year,” McAllister said.

In some areas, universities have provided research and awareness assistance. Lee Townsend, an entomologist with the University of Kentucky College of Agriculture, Food and Environment, said the university collaborates with the state Public Health Department and the state Agriculture Department, which handles mosquito control. Townsend manages a website that consolidates pertinent Zika news and information for the community.

“We’ve been working with both groups—the Public Health department and the Department of Agriculture—to try to get together a unified effort, getting information out, training people to do some extra mosquito control if that becomes necessary and just having a number of things ready to go when the problem shows up,” Townsend said.
In May, there had already been five cases of travel-related Zika virus in Kentucky, said Townsend. “I think the chances are that we’ll have some locally transmitted cases,” he said. “It seems like that’s a good possibility.”

In cities such as New Orleans, some of the tools to monitor mosquito-transmitted viruses were established before the Zika outbreak, allowing vector control agencies to make evidence-based decisions about abatement, instead of simply spraying on a schedule, said Claudia Riegel, director of the New Orleans Mosquito, Termite and Rodent Control Board, during a webcast in June presented by the CSG South office.

But that’s not the case in every city and county.

“It’s a very uneven picture because different health departments are resourced differently, and there’s a number of states that don’t even have mosquito control programs because the funding has been so limited over the last five to eight years or so,” said LaMar Hasbrouck, executive director of the National Association of County and City Health Officials, or NACCHO.

Hasbrouck said health departments have to start their Zika efforts by analyzing their own capacities. Small health departments may be able to enhance efforts in information and education of the general public and health care professionals, while larger departments with more resources may be able to develop monitoring and research programs.

The CDC has awarded grants to some districts for Zika response efforts, including mosquito control. In early June, Congress continued to debate the amount to spend on emergency funding for Zika. In February, President Barack Obama asked Congress for $1.8 billion in emergency funding.

In the meantime, money has shifted from other areas to Zika, limiting the ability of health departments to respond to other issues, Hasbrouck said. In May 2016, NACCHO—in partnership with the Association of State and Territorial Health Officials, the Council of State and Territorial Epidemiologists and the Association of Public Health Laboratories—released a report about the impact of the CDC’s redirection of $44 million in public health and emergency preparedness funds away from local and state health departments to the national Zika response. Some health departments reported a possible reduction in staff because of the cuts, and departments reported that the cuts would harm local efforts to respond to Zika and emerging threats, the report said.

Although Zika preparation has been hurried and many jurisdictions need more financial support, much has been established from past public health emergencies. In New Orleans, agencies have had practice coordinating response efforts during emergencies such as the Ebola outbreak. “So there’s a lot of infrastructure there that’s established,” Riegel said.

She added that coordination between agencies is key during a public health emergency. Hasbrouck had similar views and said partnerships and communication processes between agencies have been refined during past health crises.

“Every single time you have a public health emergency, you’re building that up, increasing the capacity, increasing the networks and the know-how,” he said.

**ESTIMATED RANGE OF Aedes aegypti MOSQUITO IN THE UNITED STATES, APRIL 1, 2016**


Aedes aegypti mosquitoes are more likely to spread viruses like Zika, dengue, chikungunya and additional viruses than other types of mosquitoes such as Aedes albopictus mosquitoes.

Map does not show exact locations or numbers of mosquitoes living in areas or the risk/likelihood the mosquitoes will spread viruses, but rather CDC’s best estimate of the mosquito’s potential range, based on areas where mosquitoes are or previously have been found.
Thank you!

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In the wake of the water crisis in Flint, Michigan, cities, states and the federal government are taking a closer look at the status of water infrastructure in the United States and its ability to deliver healthy and safe drinking water to residents.

A recent USA Today report analyzing data from the U.S. Environmental Protection Agency, or EPA, found that over the past four years, close to 2,000 water systems in all 50 states showed excessive levels of lead in water testing results. Some of the highest levels of lead were found at schools and day cares.

In order to prevent lead contained in these pipes and fixtures from leaching into drinking water, water system operators are required by the EPA’s Lead and Copper Rule to treat the finished water to ensure that when the water leaves a treatment plant it is not corrosive.

“What happened in Flint is when they switched to the Flint River as their source, it was a much more corrosive water and they didn’t apply the proper corrosion control for the leaching of lead in the distribution system,” said Peter Grevatt, director of the EPA’s Office of Groundwater and Drinking Water. “That’s what caused the elevated levels of lead in the community.”

According to Jim Taft, executive director of the Association of State Drinking Water Administrators, getting the lead out of the nation’s drinking water infrastructure is the ultimate solution.

“If I don’t think anybody that’s looked at the problem for any length of time has come to any other conclusion,” he said. “You can apply corrosion control, but obviously there are things that can go wrong. In Flint, you have what many would probably consider to be a perfect storm of bad stars aligning that...
caused the problem. You can optimize and do the best job possible, but we need to be working to get the lead out.”

But ridding the country’s drinking water infrastructure of lead is no small task.

The biggest obstacle is that lead service lines run from the water main in the street to the home. Typically, these lines are privately owned where the property line begins and the responsibility for replacing them resides with the property owner, said both Taft and Grevatt.

“There are millions, we aren’t sure how many, (of) service lines that are pure lead,” said Grevatt. In addition, said Taft, plumbing fittings and fixtures installed in homes prior to 2014 were allowed to contain up to 8 percent lead.

And updating water infrastructure is costly. According to the EPA, over the next 20 years it will cost approximately $384 billion to upgrade the nation’s drinking water system. While this number includes replacing aging treatment plants and older water lines that do not contain lead, removing lead service lines from the nation’s water system will be expensive.

Addressing these challenges is “a big task,” said Taft—one that cannot be accomplished by any one agency or government. “It’s a federal, state and local partnership. It’s a shared responsibility.”

On the federal level, Congress makes funds available to the EPA through the Drinking Water State Revolving Fund ($863 million in fiscal year 2016), a program created by the 1996 amendments to the Safe Drinking Water Act. Grevatt’s office administers the fund by awarding capitalization grants to states based on need; the states in turn provide loans and other financial assistance to local communities or water systems for infrastructure projects.

Taft said that Michigan has made some of its surplus state funding available to replace lead service lines on private property in Flint. A recent letter from EPA Region 5 to Michigan explained how the Drinking Water State Revolving Fund also can be used in this manner—an option for other states, as well. Similarly, the state of Wisconsin recently announced the Lead Service Line Replacement Funding program, which would provide $11.8 million to municipalities to replace lead service lines running to homes, schools and daycares.

Communities can also make funds available for lead service line replacement through rate structures, sinking funds and other creative financing, said Taft. Madison, Wisconsin, launched one of the first lead service replacement programs in the country in 2001 and has largely completed the replacement of the more than 8,000 known lead service lines in the city.

In light of Flint, the federal government, states and other organizations have redoubled their efforts to ensure safe drinking water.

“EPA is working with all of the states to make sure they are taking all the proper steps that they need to be taking to work with local communities to ensure that the Lead and Copper Rule is being properly implemented,” said Taft.

The EPA is working on revisions to the rule and states are working to explore innovative solutions. Ultimately, said Taft, “I think the faster we can get the lead out, I think the better we will all be from a public health standpoint.”
Rep. Kelley Packer wears many hats in her life. “Every weekday morning, I start my day wearing my favorite hat—that of wife and mother. I wake up my youngest son for school and make sure the rest of my household is ready for the day before leaving for work.”

As a full-time working mom and state leader, days are often spent juggling multiple responsibilities, something Packer does with ease. “I work full time as an office manager for a medical facility in Pocatello, Idaho,” said Packer. “I arrived a little before 8 a.m. and worked until I had a radio phone interview with my opponent for the upcoming primary from 9-10 a.m., then it was back to work.”
For Packer and her family, being outside and staying active is part of their daily lives. While her son pitches a baseball game, Packer served treats at the concession stand, “fulfilling my duty as a team mom,” she said.

Although the Idaho House of Representatives had already adjourned by May 10, Packer looks forward to the opportunity to return to carry out the important business of legislating. Here, she speaks with a colleague before a State Affairs Committee meeting begins. “I love committee meetings, where we hear debate and work through the meat of each bill, making the final decision on whether it gets to go to the House floor,” said Packer.

Soon after the game, Packer headed to a candidate forum in American Falls, Idaho, in the lead up to the primary election the following week. Just getting there was a whole different sort of race. “The game was in Arimo, Idaho, 68 miles away from American Falls,” she said. “My district is a large area that takes in two counties in my state.”

Did You Know?

Packer is an avid outdoorswoman and loves water sports. “I love to try new things and have even bungee jumped as one of my adventures,” she said. Packer also enjoys singing and has sung professionally for many years.
On June 27, the U.S. Supreme Court struck down Texas’ strict regulations on abortion clinics, in the court’s most significant decision on abortion rights in decades. At issue in the case, Whole Woman’s Health v. Hellerstedt, is to what extent states can regulate abortion within their borders, and the ruling likely will have ramifications for states across the country that have passed similar legislation restricting abortion in recent years.

Lisa Soronen, director of the State and Local Legal Center, describes the case as the “most significant abortion case since Planned Parenthood v. Casey,” the 1992 Supreme Court case that held that state lawmakers could restrict abortion rights as long as they do not provide an “undue burden” to women seeking an abortion. In the Casey decision, the court defined an undue burden as a “substantial obstacle in the path of a woman’s fundamental right to choice.”

“Since the case was decided in 1992, states have passed a large number of restrictions on abortion, testing the limits of undue burden and making it inevitable that the court would have to revisit it,” said Soronen. “It’s been a long time coming.”

At the center of Hellerstedt is a 2013 Texas law that banned abortions after 20 weeks and required doctors at abortion clinics to obtain admitting privileges at a hospital located within 30 miles. It also required clinics to meet the same standards as hospital-style surgical centers, although this provision had previously been on hold pending resolution by the Supreme Court.

Writing for the 5-3 majority, Justice Stephen Breyer wrote, “We conclude that neither of these provisions offers medical benefits sufficient to justify the burdens upon access that each imposes. Each places a substantial obstacle in the path of women seeking a previability abortion, each constitutes an undue burden on abortion access, and each violates the Federal Constitution.”

Supporters of the Texas bill had argued the requirements were put in place to improve the quality of medical care for women.
There was a “renewed focus at the state level around abortion restrictions beginning in 2011,” said Nash.

Between 2010 and 2015, 288 abortion restrictions were enacted by the states—the largest number in a five-year period since the 1973 Roe v. Wade decision that legalized abortion. An additional 21 laws restricting abortion have been passed by states so far in 2016, such as bills banning a second-trimester abortion procedure known as dilation and evacuation and legislation prohibiting abortions due to the fetus’ sex, race, national origin or ancestry, or because of a diagnosis of a genetic anomaly.

Looking Ahead

Now that the Texas provisions have been struck down, the court’s decision could open the door for challenges to restrictions in other states.

According to Soronen, “although the court’s ruling applied only to Texas, any state laws requiring admitting privileges and surgical-center regulations are mostly likely unconstitutional.”

Soronen said the ruling may also provide a framework by which other state restrictions on abortion will be judged. “While all abortion restrictions are different and will have to be judged individually, it is clear that the court was concerned about the large number of clinics that would be closed as a result of the Texas law,” she said.

“State lawmakers have needed more information on the court’s definition of undue burden to better understand the outer boundary of what actions states can legally take,” said Soronen. “The Supreme Court has now ruled that Texas went too far.”

Some state restrictions, such as waiting periods up to 72 hours, parental consent for minors 17 and under, mandatory ultrasounds and required counseling, have mostly been upheld by lower courts. State lawmakers also have sought to set limits on how late abortions can be performed, with 14 states now banning abortions at 20 weeks of pregnancy. Two state laws banning abortion after six weeks (North Dakota) and 12 weeks (Arkansas), however, have been blocked by federal courts.

Almost half of states have passed additional regulations on abortion clinics, requiring that they meet the licensing standards for hospital-style ambulatory surgical centers, often requiring renovations such as widening hallways and installing sophisticated air filtration systems. Of these, 17 states have regulations that apply to sites where medication-induced abortions are provided even if surgical abortions are not.
COUNTIES KEY TO ADDRESSING BEHAVIORAL HEALTH NEEDS ON THE GROUND

by Sallie Clark

Counties are at the forefront of assisting individuals with behavioral health needs, annually investing $83 billion in community health systems, including behavioral health services. Through 750 behavioral health authorities and community providers, county governments plan and operate community-based services for people with mental illnesses and substance abuse conditions. County-based behavioral health services exist in 23 states that collectively represent 75 percent of the U.S. population. Counties also help to finance Medicaid, the largest source of funding for behavioral health services in the U.S., and serve as the local safety net, administering wrap-around human services support.

These services are critical, as 1 in 5 adults in the U.S. experience a mental illness, with less than half receiving treatment in the past year. One in 10 experience a substance use disorder, with only approximately 10 percent receiving treatment in the past year. An estimated 8.5 million adults in the U.S. have both a mental health and substance abuse disorder.

While counties have always played a crucial role in delivering services and treatment to individuals with behavioral health needs, recent changes in the landscape have opened up even more opportunities for localities to assist these residents effectively. While much of the attention related to Medicaid expansion revolves around increased coverage for basic health care needs to a new category of low-income people, many states and localities have also realized opportunities to increase the availability and quality of behavioral health services, according to the Government Accountability Office. In the 26 states and the District of Columbia that expanded Medicaid in 2014, an additional 350,000 adults with mental health care concerns received care, according to the Pew Research Center.

As the entry point into the criminal justice system, counties are uniquely positioned to make the most of Medicaid to improve outcomes for justice-involved individuals—a population with numerous behavioral health needs. Nearly 2 million adults with serious mental illnesses such as bipolar disorder and schizophrenia are booked into county jails every year, and the prevalence of people with mental illnesses in jails is three to six times higher than that of the general population.

Once incarcerated, people with mental illnesses tend to stay longer in jail and upon release are at a higher risk of returning than justice-involved individuals without these illnesses. We also know that only about 4 percent of jail admissions result in prison sentences—in other words, 96 percent of jail detainees and inmates return directly to the community from jail. These statistics highlight the critical need for expanded access to mental health and addiction services for justice-involved individuals, which can help reduce recidivism and provide a return on investment for local taxpayers.

Despite individual counties’ tremendous efforts to address this problem, we often run into significant obstacles, such as
The National Association of Counties, or NACo, The Council of State Governments’ Justice Center and the American Psychiatric Association Foundation have come together to lead a national initiative to help advance counties’ efforts to reduce the number of adults with mental illnesses in jails.

About the Author
Sallie Clark is the president of the National Association of Counties and an El Paso County, Colorado, commissioner.
It would be no surprise if a young person whose perception of public service has been formed through the lens of cable news and its 30-second sound bites was forever dissuaded from choosing a career in the public arena. So much of what we see today involves the negative attacks and divisive rhetoric that have fueled increased polarization in this nation.

But an innovative program in Lexington, Kentucky, offers an opportunity for a select group of future leaders to see public leadership in a far different and much more positive way.

THE HENRY CLAY CENTER FOR STATESMANKHIP is a nonprofit dedicated to educating a new generation of leaders in the essential skills of diplomacy, negotiation and conflict resolution.
The Henry Clay Center for Statesmanship was formed in 2007 as an innovative youth leadership program inspired by HENRY CLAY, Kentucky’s revered native son, whose estate still stands as a public museum in Lexington. Clay served with distinction as secretary of state, U.S. senator and speaker of the U.S. House of Representatives, leaving a profound legacy as our nation’s “Great Compromiser.”

For more information on nominating a student for a Student Congress in 2017, please contact:

Dr. Michael Vetter
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859-233-8777
www.henryclaycenter.org

Thanks to a collaborative partnership that includes The Council of State Governments, the Martin School of Public Policy and Administration at the University of Kentucky, and Transylvania University, the Henry Clay Center expanded in 2016 to hold both a high school and college-level Student Congress in the same year for the first time.

The week-long summer programs gather competitively chosen students from every region of the U.S. During the week, they have the opportunity to meet with lawmakers, academics, journalists and civic leaders to discuss the practical importance of compromise and constructive engagement and dialogue to resolve conflict and competing interests in a democracy.

The Council of State Governments assists in recruiting qualified applicants from across the country for both programs. The University of Kentucky’s Martin School faculty directs the college-level curriculum, including taking student teams through a participatory case study in compromise on a major public policy issue.

The Student Congress programs are funded entirely by donations and are completely free of cost, including travel and lodging, to those students selected.

As a new board member of the Henry Clay Center for Statesmanship, I have been inspired by the mission of the organization and the passion of its board and staff leadership.

Having served seven Kentucky governors, and held statewide office as Kentucky’s lieutenant governor and state auditor, I know the value of strong public leaders. And I am keenly interested in the future of public leadership. I have watched with dismay as increased polarization and gridlock have too often hampered our progress. But, I have also been in the room when effective compromises were reached by enlightened leaders willing to respect opposing viewpoints and find common ground.

The need has never been greater to impart the skills of statesmanship to those who will take up the torch as it is passed to their generation.

At a time when it is so easy to become discouraged about the political process, it gives me great hope to see the inspired and gifted young leaders who assemble for these Student Congress sessions.

The Henry Clay Center imparts the skills of statesmanship to bring about change in an increasingly polarized public and civic environment. It is a mission vital to our future and one that we hope will draw increasing engagement and support as we seek to build a new generation of inspired leaders.

About the Author

Crit Luallen is a former Kentucky lieutenant governor and state auditor. She serves on the board of directors at the Henry Clay Center for Statesmanship.
SHARES COST/NOT EQUALLY

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JULY/AUG 2016 | CAPITOL IDEAS

/CSG Education and Workforce Director Addresses Teacher Educators

CSG Director of Education and Workforce Development Elizabeth Whitehouse spoke at the American Association of Colleges for Teacher Education, or AACTE, State Leaders Institute on June 6 in Washington, D.C. Whitehouse was part of a panel of representatives from state policy organizations including The Aspen Institute, National Association of State Boards of Education, Education Commission of the States, National Governors Association and The Council of State Governments. The session focused on strategies for AACTE’s state affiliates to partner and build relationships with state policymakers, principally in the context of the Every Student Succeeds Act.

/CSG Hosts Cybersecurity Policy Academy

More than 50 state policymakers, federal experts and private-sector representatives convened May 23–25 in Seattle for the CSG second annual Cybersecurity and Privacy Policy Academy. Attendees heard from public and private-sector experts on the growing threat of cyber crime to state governments and what they can do about it. Attendees took a tour of Microsoft’s cybercrime unit to see how cutting-edge technology and big data analytics can help protect both data and people.

/CSG Releases 2016 Biennial Report

Public health outbreaks such as Ebola and the avian flu are resulting in emergency declarations outside of “traditional” disasters. More states are creating emergency support functions to help combat the growing cyber threat. And while mitigation is tried and true in reducing hazards, many states are stymied in their efforts by lack of staff, insufficient expertise, lack of buy-in from elected officials and insufficient funding support. These are just a few of the findings in the new National Emergency Management Association 2016 Biennial Report. This year is the 20th anniversary of the report, which is the most comprehensive compilation of state emergency management data available today. The report is available for purchase at www.nemaweb.org.
The subcommittees of a national workforce development task force created by The Council of State Governments met April 30–May 1 in Washington, D.C., to develop and review policy options that states could consider to improve workforce development for people with disabilities. The meeting featured Jerry Abramson, deputy assistant to the president and director of intergovernmental affairs at the White House, as the plenary speaker.

CSG, in partnership with the National Conference of State Legislatures, organized the National Task Force on Workforce Development for People with Disabilities to help state leaders identify barriers to employment at the state level and provide them with policy recommendations to address those barriers. The task force consists of four subcommittees: Career Readiness and Employability; Hiring, Retention and Re-entry; Entrepreneurship and Tax Incentives; and Technology, Transportation and Other Employment Supports.
RON STOLLINGS
West Virginia State Senator and Physician

West Virginia state Sen. Ron Stollings, or Dr. Stollings to his patients, used his experience as a physician to inform his policy decisions while representing his constituents for the last 10 years and serving as the chair of the Senate Health and Human Resources Committee for four years. “I have boots on the ground,” said Stollings. “I see up to 20 patients a day. I see what is troubling them and what issues they are having and, frequently, I can take those issues to the statehouse and try to implement changes that might positively impact people.” Only about 20 percent of health outcomes are attributable to the traditional medical care system, Stollings said, so he concentrated on public health issues such as obesity, vaccinations and tobacco use during his time as the Health Committee chair. Stollings also is focused on the opioid abuse epidemic. Stollings and his colleagues in the Legislature have combated this by trying to help physicians make smart, conservative decisions about when to prescribe opioids. They set up a review panel to monitor pharmacy data for outliers and identify and eliminate “pill mill” doctors. West Virginia also expanded access to the opioid overdose antidote naloxone by making it available at pharmacies without a prescription. However, focusing too much on access to one class of drug, and not the larger causes of drug abuse such as unemployment, isn’t a long-term solution, according to Stollings. “Heroin use started (increasing) after ratcheting down of prescription opioids,” he said. “You push in that balloon in one area and it comes out another area. On a bigger level, it is a societal problem.” Stollings’ experiences in hospital and primary care settings also led him to support Medicaid expansion under the Affordable Care Act in West Virginia. “People without insurance put off care,” he said. “I’ve seen it a lot of times—they never enter the health care system until it is already high cost…when they need dialysis or are nearly blind if they are diabetic. Getting people into a primary care setting, a medical home, is one of the things that does improve health outcomes.”
COMING IN *CAPITOL IDEAS’ NEXT ISSUE!*

**JUSTICE IN THE STATES**