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Rethinking the Opioid Crisis

Using Seven Pay for Success Principles to Better Understand and Address the Crisis

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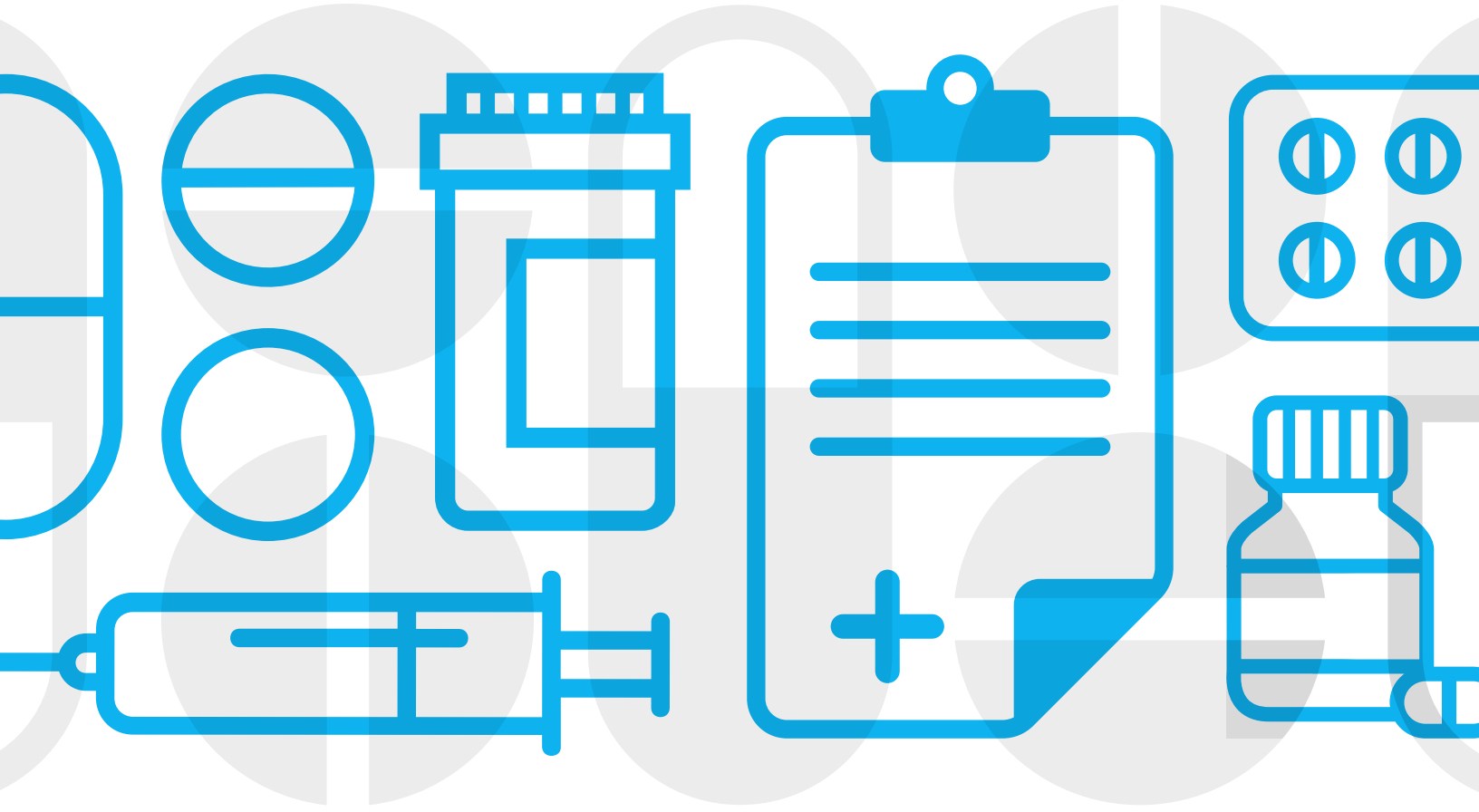

Introduction

Decisionmakers recognize the opioid crisis is a difficult policy challenge. But *why* the opioid crisis is so difficult and how to overcome those difficulties are not as clearly recognized, leading even the best efforts to address the crisis to risk spending limited public resources on potentially ineffective or even counterproductive efforts. To mitigate these risks, adopting the perspective of pay for success (PFS) facilitates the application of sound public policy and administration principles in a manner that can help decisionmakers clarify challenges and implement more effective solutions to the opioid crisis. Decisionmakers can use these principles to enhance new or existing efforts to address the opioid crisis, regardless of whether the PFS financing mechanism is used to fund those efforts.

The insights presented in this brief are the result of a community of practice composed of public officials, practitioners, experts, and other stakeholders, which provided a platform to interpret the opioid crisis through a PFS perspective. This brief is not a guide for implementing PFS projects to address the opioid crisis but rather a summary of public policy insights about the opioid crisis that arise from applying a PFS perspective to the issues. The first part of this brief explains why the opioid crisis is such a difficult public policy challenge and provides examples of efforts that did not fully consider these difficulties. The second part describes how seven principles underlying the PFS model can help decisionmakers overcome these challenges in their new or existing efforts to address the opioid crisis.

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Why Is Addressing the Opioid Crisis So Difficult?

Before turning to the policy challenge of the opioid crisis, it is useful to consider an analogous physiological problem: fevers. Two hundred years ago, physicians viewed a fever itself as an illness[1] rather than a common symptom of several possible underlying conditions. Those physicians also lacked precise instruments for measurement, the ability to evaluate a patient's symptoms across his or her entire body, a reliable evidence base to aid in diagnosis, and a catalog of effective treatments for specific diagnoses. Without these understandings and resources, eighteenth-century medical decisionmakers focused on treating the most visible problems as they understood them, which meant reducing the patient's fever. As a result, patients continued to suffer from the underlying conditions that caused the fever in the first place as well as from the additional consequences of misguided treatment.

Consider three people with different conditions that can each produce a fever: Willis has a common cold, Kelly has a chronic bacterial infection, and John has an emerging malignant tumor. Based on eighteenth-century constraints, all three patients would have received similar treatments focused on reducing their fevers, such as cold baths (Currie 1805). This could have successfully reduced the fevers for all three, but the treatment probably would have prolonged Willis's cold and made Kelly's infection and John's tumor worse.

Today's policy decisionmakers seeking to address the opioid crisis face constraints analogous to those faced by eighteenth-century medical decisionmakers. As with fevers, opioid use disorder (OUD) in and of itself is a recognizable and significant problem with serious inherent consequences (box 1) and is a common symptom of several possible underlying and overlapping conditions. Adding further complexity, the underlying conditions that can lead or contribute to OUD extend beyond physiological and psychological factors (e.g., chronic pain and genetic factors affecting addiction) and other individual characteristics (e.g., socioeconomic status and strength of personal support systems). OUD can also be the result of individual or concurrent societal factors (e.g., local cultural norms, economic conditions, or prescriber practices). These factors span the purview and responsibility of many different and often siloed public agencies and other organizations (e.g., police departments, departments of health, and prescribers).

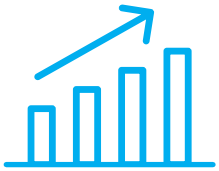
Further, the escalating rates of fatal opioid overdoses[2] set an expectation for decisionmakers to take urgent actions that fall within the scope of their individual agencies. Such urgency can lead to prompt but uncoordinated and ineffective (or even counter-effective) efforts.

Minimal data integration across agencies and a limited evidence base to help identify problems and develop effective solutions can make it difficult for decisionmakers to accurately understand and effectively address the underlying problems. Just as with fevers, decisionmakers risk taking actions that are ineffective (as in the case of Willis's cold) or even harmful (as in the cases of Kelly's infection or John's tumor) when they base their decisions on a narrow view of readily apparent symptoms instead of a more comprehensive understanding of the overall problem.

Based on this view, the challenges of addressing the opioid crisis can be better understood through three key difficulties:

1. **The opioid crisis is more than the total number of fatal overdoses or people with OUD.**
2. **Siloed agencies make the full scope of the problem difficult to recognize and address.**
3. **A small but growing evidence base offers little guidance on identifying and addressing problems.**

Although there is overlap between these three difficulties, understanding each individually clarifies different aspects of the public policy challenges the opioid crisis poses.



DIFFICULTY 1
The Opioid Crisis Is More Than the Total Number of Fatal Overdoses or People with OUD

A dramatic quadrupling in opioid-related deaths since 1999 has turned drug overdoses into the most common cause of accidental death. In just one year, opioid-related fatal overdoses in the US jumped more than 28 percent from 33,091 in 2015 to 42,429 in 2016.[3] Among people younger than 50, drug overdoses, primarily driven by opioids, are now the leading overall cause of death, surpassing heart disease and cancer.[4] Public health researchers estimate that the death toll over the next decade could be as high as 650,000.

Such alarming statistics have led to a view of the problem as an *opioid* crisis. But the scope of the crisis extends beyond individual cases of OUD or fatal overdoses. OUD itself represents a significant and tragic problem (box 1), but it also represents a common symptom of many underlying factors (e.g., economic conditions, education levels, and availability of health

care options) that can contribute to the conditions where OUD proliferates (CASA 2012). Understanding and addressing the overall opioid crisis requires an appreciation of the confluence of these underlying factors, how they affect different groups in different ways, and their implications for crafting effective public policy efforts for each of these groups. Consider the stories of a new John, Kelly, and Willis. Their real stories exemplify how their shared diagnosis of OUD can be the result of different underlying circumstances that necessitate different interventions.

For John Pickiney, from Vancouver, Canada, addiction began at age 6 with a Ritalin prescription.[5] After running away from home to escape a violent upbringing, John turned to heroin and other drugs. He served time in prison for robberies committed to support a drug habit costing more than $500 a day. For John, typical treatment approaches such as Narcotics Anonymous and methadone clinics did not work. John's life changed when he found a program at the Providence Crosstown Clinic that provides safe injections of heroin to the roughly 15 percent of those with OUD who do not respond to other treatments. Although he must go the clinic three times a day for a supervised dose, John now has secure housing with furniture, a part-time job, and peace of mind in knowing that he is not injecting himself with dangerous street chemicals.

In Ashtabula, Ohio, Kelly McLaughlin is a mother and former Head Start caseworker.[6] After becoming addicted to OxyContin following neck surgery, Kelly began sleeping all day, leaving the home for long stretches of time with no explanation, and letting the house fall into disarray. After a neighbor called County Children Services, her children were removed from her home and Kelly returned to treatment after several failed prior attempts. Kelly continues to struggle with her cycle of recovery and relapse in her social circles, where drug use is common.

Across the border in West Virginia, Willis Hatcher was working at a motel in a small coal town.[7] After being injured at work from a fall, he was referred to a pain clinic and immediately prescribed opioids by a doctor who was fighting to keep her medical license because of ethical violations. Although Willis had fears about the opioids' addictive properties, he trusted his doctor and followed her advice, even as she began increasing his dose substantially. After six months, he was addicted to the drugs and suffered from anxiety, cramps, and headaches if he stopped using them. Unable to get the dose he needed from prescriptions alone, he turned to the black market and bought painkillers from the growing number of dealers in his town. Addiction took up more and more of his money and time, and he quit a well-paid job as a manager at Walmart for a lower-paid but less taxing position at an auto parts store.

BOX 1

The Trap of Opioid Use Disorder—OUD as a Significant Problem In and of Itself

Opioids are more addictive and deadly than illicit drugs that have led to past "epidemics," such as crack cocaine and crystal meth. Opioids are also different from other illicit drugs in that there is such prominent use of the legal forms of the drugs. In 2014, 81 million Americans had been prescribed an opioid, and nearly 2 million Americans abused or were dependent on those prescriptions. Doctors prescribe opioids to relieve a patient's physical pain, but opioids can also produce a highly euphoric sensation that "individuals describe [as] feeling warm, cozy, and relaxed with a profound sense of fulfillment and satisfaction."[a] Regardless of whether a person is seeking relief from physical pain or relief from other forms of distress through the drug's euphoric effects, once a person begins taking opioids, he or she is at risk of falling into a trap of opioid addiction, often referred to as OUD. One study found that almost 30 percent of adults initially prescribed an opioid for more than 30 days were still using prescription opioids one year later.[b]

As an opioid user's tolerance increases, the user's target dose for experiencing the desired effect increases. Users taking less than the target dose for their tolerance at that specific time can begin experiencing the symptoms of opioid withdrawal as soon as six hours after their last dose.[c] Users taking more than their target dose (i.e., overdoses) can lose consciousness, potentially to the point that they stop breathing. Using morphine milligram equivalents (MME) as a standard measure of potency for different opioids, it is clear how the risk of a fatal overdose increases as tolerance increases. Compared with doses of 1 to 19 MME per day, the risk of a fatal overdose is two to five times greater for doses of 50 to 99 MME per day and up to nine times greater for doses of 100 MME or more per day.[d]

Although highly regulated prescription opioids can be as fatal as other forms of opioids, their MMEs are reliable and knowable. This is not true of nonprescription or counterfeit prescription opioids purchased on the street. Nonprescription opioids, such as heroin and fentanyl, are cheaper and more readily available for people without a prescription.[e] But it is virtually impossible for a user to know the MME of these drugs, which can vary widely in their potency while still appearing identical.

If John, Kelly, and Willis all purchased 30 milligrams of heroin from their dealers, John's

heroin might be so diluted by a cutting agent that it cannot stave off his withdrawal, Kelly might get exactly what she expected, and Willis might get a dose laced with fentanyl 20 times more potent than he expected that would cause a fatal overdose. Laid next to one another, it would be nearly impossible to visually distinguish John's, Kelly's, and Willis's doses.

Regardless of the reasons for using opioids, people can enter the same trap if they become addicted, which can be understood as a cycle spiraling toward overdose:

1. **As soon as every six hours, I'll start feeling withdrawal if I don't use a sufficient dose again.**
2. **But if the dose I take is too large, I'll overdose, and I might die.**
3. **I can't tell if this dose is too large or too small because it's from a totally unregulated market.**
4. **Every time I manage to take another dose without overdosing, I need to take more the next time.**
5. **As I need to take more, it's harder to get my target dose just right, and it's easier to overdose.**
6. **I'm still suffering from the problems that caused me to seek relief from opioids in the first place.**

Beyond these circumstances for people with OUD, widespread opioid addiction is linked to negative outcomes for society. These include reduced labor force participation, low productivity, increased property crime, neonatal abstinence syndrome, the spread of HIV and hepatitis through intravenous drug use, and added strain to families and the state foster and child welfare systems.[f]

[a] "Heroin High," Heroin.net, accessed July 19, 2018, https://heroin.net/heroin-effects/heroin-high/.

[b] Anuj Shah, Corey J. Hayes, and Bradley C. Martin, "Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use—United States, 2006–2015," Centers for Disease Control and Prevention, last updated August 1, 2017, https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm.

[c] "Opiate Withdrawal Timelines, Symptoms and Treatment," American Addiction Centers, accessed July 19, 2018, https://americanaddictioncenters.org/withdrawal-timelines-treatments/opiate/.

[d] "Opioid Overdose Frequently Asked Questions," Centers for Disease Control and Prevention, last updated August 31, 2017, https://www.cdc.gov/drugoverdose/prescribing/faq.html.

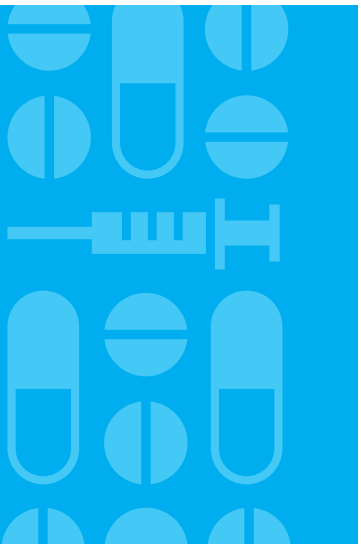
[e] Wilson M. Compton, Christopher M. Jones, and Grant T. Baldwin, "Relationship between Nonmedical Prescription-Opioid Use and Heroin Use," *New England Journal of Medicine* 374, no. 2 (January 2016): 154–63.

[f] Brennan Hoban, "The Far-Reaching Effects of the US Opioid Crisis," *Brookings Now* (blog), Brookings Institution, October 25, 2017, https://www.brookings.edu/blog/brookings-now/2017/10/25/the-far-reaching-effects-of-the-us-opioid-crisis/.

John, Kelly, and Willis all sought relief through opioids and became trapped by OUD (box 1). But different situations and conditions led them to use opioids in the first place. Just as a cold bath was not a sufficient solution for the conditions producing their fevers, a single solution is unlikely to be effective in addressing OUD for all three. Different interventions will be necessary to address different OUD cases, and determining which interventions are required will depend on understanding more than an appraisal that they all have OUD.

The opioid crisis is much larger than a problem of OUD and fatal overdoses.

Many completely different sources of human pain lead people to seek relief through opioids. These underlying sources of pain are central elements of the larger opioid crisis.



Opioids can provide temporary relief from physical pain as well as powerful sensations of euphoria and deep satisfaction, a temporary relief from many forms of distress. Whether it is relief from physical pain; mental or emotional distress; a difficult, stressful, or depressing life course; chemical dependence; or something else, understanding how one or more of these drivers leads a person into the spiral of OUD is important for understanding the necessary approach to addressing the problem. Without appreciating the underlying conditions leading people to seek relief from opioids, any effort to address the problem will be incomplete at best and counterproductive at worst.

The diversity of the underlying problems that can contribute to OUD also indicate that the opioid crisis spans across the domains of many public agencies and other stakeholder organizations with a scope that touches on those different issues. Many of these agencies do not routinely coordinate or collaborate with one another, which creates another problem for decisionmakers seeking to address the opioid crisis.

BOX 2

Misunderstanding the Problem Can Lead to Stigma, Which Is a Barrier to Implementing Solutions

Just as mistaken or narrow understandings of the opioid crisis can threaten decisionmakers' efforts to address the problem, such limited understandings of the problem can also develop into stigma about opioid use that can threaten the implementation of those efforts. Stigma can operate on many levels. Shame can prevent someone struggling with OUD from seeking treatment. When people do seek help, the high dropout rates of OUD treatment programs and the potential for patients to sell their medication has created provider bias that results in refusal of treatment.[a] Such stigma can also constrain the possible solutions decisionmakers deem viable or pragmatic, including rejection of more effective options. For example, community members might object to having a methadone clinic in their neighborhood because of their negative perception of people with OUD. This could limit the availability of treatment providers or treatment programs in a region and inhibit the amount of funding dedicated to OUD treatment.

[a] Maia Szalavitz, "Doctors Who Hate Drug Users Are Fueling the Opioid Crisis," *Vice*, November 22, 2017, https://www.vice.com/en_us/article/43nzyq/doctors-who-hate-drug-users-are-fueling-the-opioid-crisis; and Christine Vestal, "Deadly Bias: Why Medication Isn't Reaching the Addicts Who Need It," *Stateline* (blog), Pew Charitable Trusts, January 11, 2016, http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/01/11/deadly-bias-why-medication-isnt-reaching-the-addicts-who-need-it.

DIFFICULTY 2
Siloed Agencies Make the Full Problem Difficult to Recognize and Address

The scope of the opioid crisis is not limited to a single government agency's domain. It is not exclusively a public health issue, law enforcement issue, or human services issue. The scope of the opioid crisis is spread across the core responsibilities of many government agencies and nongovernmental stakeholders. Decisionmakers face the challenge of recognizing and engaging with the different manifestations of the problem across these different entities. For example, properly understanding John's case requires information from child protective services, corrections, law enforcement, housing officials and homeless shelters, treatment providers, and the public health system. Each of these agencies might have had their own interpretations

of John's case based on their own interactions with him. At best, each interpretation would be incomplete without access to information from other the other agencies. At worst, a given agency's interpretation of John's case could be wrong, and its solution could be harmful.

Government agencies and other organizations responsible for these interconnected social domains are typically siloed, making it difficult for decisionmakers to assemble a complete understanding and to identify opportunities for collaborative problem solving. These diverse agencies can be structurally siloed simply because they do not routinely collaborate with one another or can be culturally siloed based on differences in perspectives, priorities, approaches, funding, or chains of accountability, as well as different standards for confidentiality and privacy. For example, the police department that arrested John and the prison that incarcerated him might prioritize public safety and order; the heroin maintenance program might prioritize John's individual health outcomes. Although these are not necessarily conflicting priorities, they are far from a common basis of understanding to facilitate collaborations.

In addition to making it difficult for decisionmakers to see the different aspects of the opioid crisis from across siloed agencies, agencies can be blind to the consequences of their own efforts on other agencies. For example, there is an active debate about the unanticipated crime-related consequences of public health departments broadening access to naloxone,[8] a drug that can temporarily reverse the uptake of opioids in the brain to almost instantly revive a person at risk of a fatal overdose. Proponents focus on naloxone programs to achieve the public health department's goal of reversing fatal overdoses, but opponents have expressed concern that these programs might increase opioid-related thefts and other problems for police departments. The research on naloxone and other opioid-related interventions is still being developed and currently represents part of a limited evidence base on effective solutions, which is the basis of the third difficulty.

DIFFICULTY 3

A Small Evidence Base Offers Little Guidance on Identifying and Addressing Problems

Decisionmakers seeking to address the opioid crisis face challenges in looking past OUD as the sole source of the problem, identifying underlying problems from across siloed agencies, and grasping the ways one agency's actions can affect another agency. This endeavor is made more challenging by a limited evidence base of rigorous research on identifying a jurisdiction's

underlying problems as well as on solutions that have proved most effective in addressing similar problems in the past.

Many of the reasons it is difficult for decisionmakers to identify problems and implement solutions to the opioid crisis are the same reasons it is difficult for researchers to evaluate opioid-focused interventions. The outcomes of interest and the relevant data required to measure these efforts are spread across agencies and community organizations. The logic models of the causal connections between the intervention and expected outcomes can be complex and difficult to follow or understand. Further, factors separate from a given program effort can influence the impacts of that effort, making it difficult to identify any change in outcomes attributable to the intervention.

Despite the challenges of evaluating opioid-related interventions, a growing evidence base on effective forms of treatment exists. The opioid agonist treatment forms of medication-assisted treatment (MAT) have a strong evidence base. But the strength of the evidence for the intervention is not the same thing as evidence of the strength of that intervention, and MAT is not 100 percent effective. Recall that John had tried and failed on multiple forms of OUD treatment, including MAT, before he found success with a last-resort option through a heroin maintenance program. MAT might represent the best available solution, but that does not mean it is a necessary, sufficient, or appropriate solution for every problem that might arise in the opioid crisis. In fact, MAT and other forms of treatment can be dangerous when implemented incorrectly. Several jurisdictions have found that brief inpatient treatment or incarceration can increase a person's risk of fatal overdose, as time spent not using opioids reduces their tolerance, and any relapse to their prior dose will be more than they can tolerate (Strang et al. 2003).

How Can Pay for Success Improve Opioid Policy Efforts?

The difficulties of the opioid crisis make it a challenging problem for decisionmakers to address, partly because it makes essential principles of public policy and public administration difficult to apply and dangerously easy to ignore. Fortunately, these same elements of good policymaking have been embedded within the essential structure of an innovative form of program financing known as PFS (box 3), which offers a framework for ensuring that these principles can be applied in various public program efforts, including those related to the opioid crisis.

BOX 3

What Is the Pay for Success Model?

Pay for success (PFS) is an innovative financing mechanism in which a third party provides the capital to implement an evidence-based program. If the program successfully meets or surpasses its outcome targets (as verified by a rigorous evaluation), the government will repay investors, with a potential positive return.

PFS can help decisionmakers avoid political and financial risks associated with program underperformance while giving providers capital to implement evidence-based services. In a successful PFS project, the government pays only for effective social programs, families and society benefit from better outcomes, and service providers strengthen the case for funding their model. These immediate consequences can spur long-term policymaking consequences.

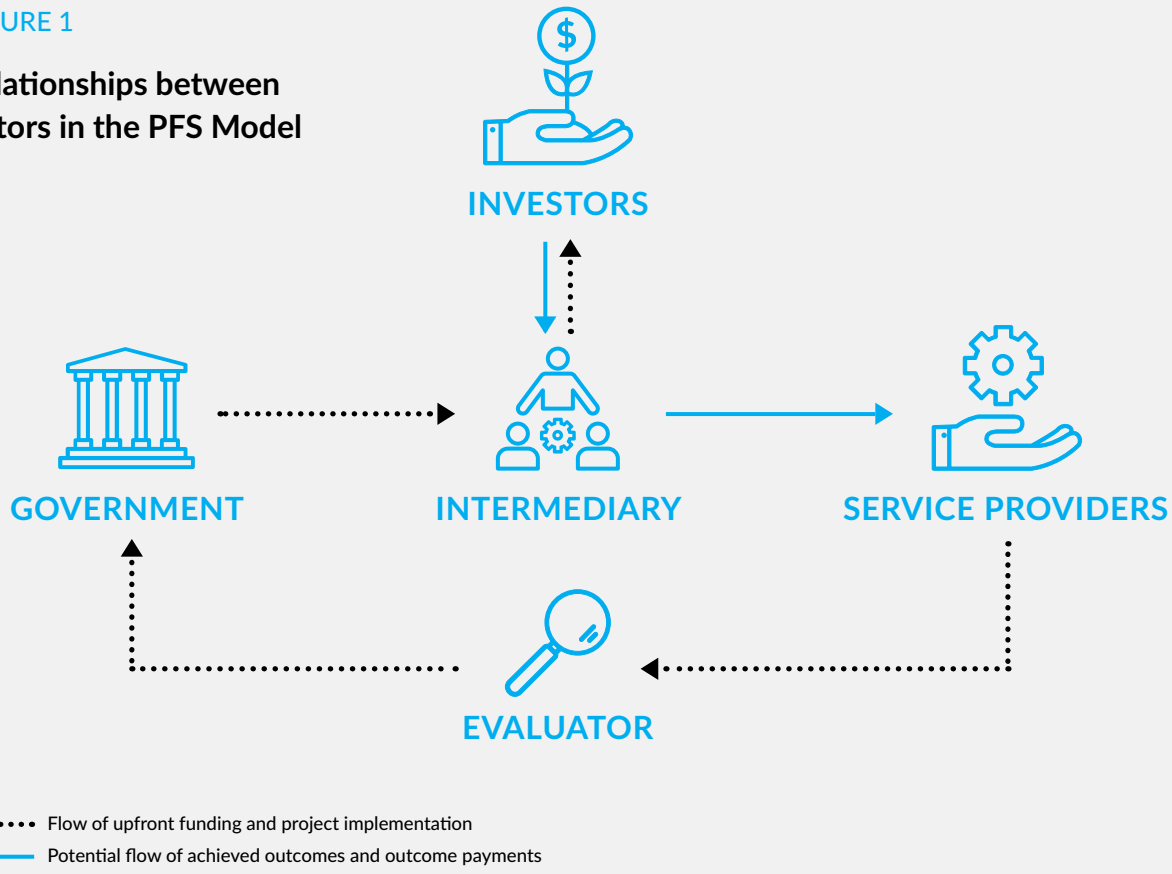
There are typically six actors involved in a PFS project:

- **Governments** identify problems to target with the PFS project and pay for the successful attainment of project goals.
- **Knowledge intermediaries** use evidence to find high-performing programs, price the PFS instrument, inform rigorous evaluation, or oversee implementation.
- **Financial intermediaries** structure the financial deal and solicit investors to provide the up-front capital.
- **Funders** (philanthropic or private) provide up-front capital to launch or expand the program on the promise of a return if the program meets agreed-upon goals.
- **Service providers** provide the evidence-based social program for the project.
- **Independent evaluators** determine if the results of the social program meet its targets.

The PFS model's emphasis on meaningful outcomes over outputs, using and generating evidence, active program monitoring and evaluation, and intense stakeholder engagement can spur systems change in how social services are procured, delivered, and evaluated.

FIGURE 1

Relationships between Actors in the PFS Model



Source: Government Accountability Office. For more information on PFS, visit https://pfs.urban.org/.

Although PFS is a public program financing mechanism, the framework for exercising that mechanism emphasizes the same principles of effective policymaking and public administration that are compromised by the characteristics of the opioid crisis. Even where PFS is not used to finance an opioid-related program, there is still great value in applying the following seven PFS principles to the crisis.

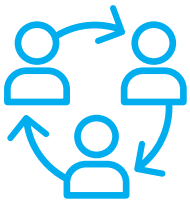
1. **Target a specific problem across multiple agencies.**
2. **Leverage the impacts of one agency's actions on other agencies.**
3. **Specify a comprehensive and pragmatic definition of "success."**
4. **Review the evidence base for possible solutions.**
5. **Support solutions through better understandings and cross-agency context.**
6. **Empower an outcomes orientation for providers.**
7. **Contribute to an evidence base that other decisionmakers can use.**

This section describes each of these PFS principles, which decisionmakers can use to develop and enhance their public policy and administration efforts to address the opioid crisis.

PRINCIPLE 1
Target a Specific Problem across Multiple Agencies

A critical aspect of any PFS project is whether the intervention successfully achieves its intended outcomes. This determines whether the jurisdiction will repay the investors who supported the intervention. Decisionmakers in the jurisdiction have a vested interest in making sure the specific problem the PFS project aims to solve is one they are willing to spend their limited public resources on solving. Similarly, investors have an interest in fully understanding the specific problem and solution they are risking their capital to support. Further, the process of negotiating the project's contract, which outlines the project's assumptions and design considerations, reinforces the incentive for all project stakeholders to share a clear and evidence-based understanding of the problem the project aims to address and the population the project intends to serve.

This emphasis on thoroughly understanding and defining specific problems for specific populations is ideal for addressing the opioid crisis. Absent PFS, decisionmakers could support overly broad and insufficiently targeted efforts to treat OUD in their jurisdiction. But it is unlikely that investors would risk capital to support a project that adopts an overly broad approach to treatment that would treat John's, Kelly's, and Willis's cases as if they were the same. Instead, negotiations between all relevant stakeholders would differentiate between these different cases and provide significant incentives to draw data from across agencies to develop as thorough an understanding as possible of these populations, their needs, and their size (i.e., number of people likely to benefit from the specific intervention). Once PFS stakeholders identify populations and problems to address from across multiple agencies' data, they can appreciate more of the implications of one agency's actions across agencies, which is the basis of the next principle.



PRINCIPLE 2
Leverage the Impacts of One Agency's Actions on Other Agencies

Many high-needs populations, including people with OUD, touch multiple social sectors, leading to costs for several agencies or departments within a jurisdiction. An effective, evidence-based program that improves outcomes and reduces the use of public services can save money for

multiple departments. And yet, any single department might be unwilling to fully finance the program if the savings and benefits for their specific department are outweighed by the costs that individual agency would bear. This is called "the wrong pockets problem" (Roman 2015). It describes a situation in which the entity that can pay for the program will not receive the full benefit in the near term. This cost-benefit analysis can sometimes persuade agencies not to fund a potentially effective program, leading to continued poor outcomes and high costs. PFS is well-suited to addressing the wrong pockets problem because it provides an avenue for the intensive collaboration needed to overcome these obstacles. PFS provides flexibility for the implementing agency to deliver an evidence-based intervention with the commitment of multiple end payers to cover its costs if successful. In this way, PFS can make more transparent the costs of services and to whom and can promote cross-departmental collaboration in financing effective services. In other words, a PFS approach encourages agencies to think about the improvements they can create outside their silos.

Given the connections across agencies that exist within the opioid crisis, there are many opportunities for one agency to take actions that could improve conditions for another agency. John, for example, was chronically homeless and cycling through the criminal justice system because of the crimes he committed to support his OUD. He was accumulating costs across the system. The Providence Crosstown Clinic (which provided John safe injections of heroin) stabilized John's life, allowing him to maintain housing and a part-time job. Multiple agencies avoided the costs of services that would have otherwise been spent on John. In a PFS project, those agencies could have contributed to a pool of resources to support repayments to investors, confident that they would pay only if the program reduced the amount they spent on John and people like him.

The Providence Crosstown Clinic was funded without a PFS solution to its potential wrong pockets problem, but the opioid crisis presents other such situations where the wrong pockets problem might be a significant hurdle that PFS could help resolve. Similarly, PFS also provides a valuable opportunity to prevent one agency's actions from harming another agency, which is the basis of the next principle.

PRINCIPLE 3
Specify a Comprehensive and Pragmatic Definition of "Success"

Effective policy requires a clear and appropriate definition of success. By linking the financial success of a PFS project to successful achievement of chosen outcomes, PFS guides

decisionmakers to carefully define which outcomes are most important for a given effort. This approach is valuable for addressing the opioid crisis, as there are many possible outcomes that agencies could prioritize (figure 2).

In addition to varying in scope and degree, definitions of success can combine multiple outcomes. Focusing on one definition of success without considering other outcomes might lead to unintended consequences. For example, Kelly's treatment providers might focus on a certain number of days she has been drug free as a definition of success. But the county's Child Protective Services might be concerned that after making some short-term progress toward recovery, she might try to reengage with her kids in a manner detrimental to their well-being. To balance different agencies' priorities, the definition of success for a PFS project targeting Kelly and people like her could include a threshold of days without a positive drug test and no reduction in the well-being of her children.

FIGURE 2

Elements of Success

Outcomes that might be considered part of successfully addressing the opioid crisis

- Emergency room visits
- Overdoses
- Reversals
- Fatalities
- Family well-being
- Property crime
- Relapse
- Rates of addiction
- Opioid prescribing
- Comparable pain management
- Housing status
- Employability
- Violence
- Trajectory of addiction
- Compassion fatigue
- Stress on frontline workers
- Levels of stigma
- Adverse childhood experiences
- Illegal drug market activity
- Community blight
- Spread of diseases

Note: This list contains potential outcomes suggested during one-on-one interviews with 10 experts. This is not an exhaustive list, but it provides initial ideas about how success might be measured.

As another example, a program to increase naloxone access (difficulty 2) might define success as reducing fatal overdoses overall *and* reducing (or at least not increasing) opioid-related thefts. Such a definition of success guards against the possible collateral consequence of a public health agency broadly distributing naloxone inadvertently leading to potential increases in property crimes, which would create or amplify a problem for the police department. Whether a relationship actually exists between reducing fatal overdoses and increases in property crime, including both outcomes in the definition of success can alleviate concerns about perceived issues that research has not yet fully addressed.

How success is defined has a significant impact on program or intervention design. In Kelly's case, the intervention is not only about OUD treatment; it is also about parenting and child well-being. For a naloxone program, the selected outcomes defining success suggest an intervention might need to include treatment and diversion programming following overdose reversal. The nature of the PFS model means decisionmakers and other PFS stakeholders will want to find interventions they believe can accomplish this definition of success, which is the basis of the next principle.

PRINCIPLE 4
Review the Evidence Base for Possible Solutions

By tying payment directly to successful achievement of predefined outcomes, PFS emphasizes the importance of evidence that a program will produce those outcomes. Expending resources to implement a program within the PFS framework requires sufficient evidence of the prospects for success to convince investors to stake their capital on those results.

An investor considering supporting either an abstinence-only or medication-assisted treatment to end opioid use for a certain number of people would need to assess the research to make their decision (Srivastava, Kahan, and Nader 2017). In this case, the evidence-base would show abstinence-only programs have little or no effect, while specific forms of MAT have been between 40 and 71 percent successful (ICER 2014).[9] Other studies have shown that increasing the availability of methadone and buprenorphine correlates to a 50 percent reduction in fatal overdoses (PDAS, n.d.). Evidence also shows that MAT can decrease opioid use, criminal behavior, and the spread of infectious disease while increasing social functioning and participation in treatment. In this case, a strong evidence base indicates a MAT form of treatment is preferable to an abstinence-only program. But such a strong evidence base for other interventions affecting aspects of the opioid crisis are not as apparent. Investors might need to consider evidence-based research from different tiers of methodological rigor[10] or seek out research from unexpected sources to weigh their confidence in a given program (box 4).

BOX 4

Effective Interventions Can Come in Unexpected Forms

For nearly 30 years, George Washington faced unstable living situations.[a] Like many people struggling with addiction, mental illness, and chronic homelessness, Washington has had many encounters with public agencies, including 13 jail visits, 40 stays in homeless shelters, and several emergency department visits, all at a high cost to the city of New York. During a stint in a shelter in 2015, Washington was approached by a social worker with a solution to end this destructive and expensive cycle of homelessness and incarceration: supportive housing, a policy that involves the city paying for permanent housing and social supports for vulnerable citizens. Although some might fear the high cost of such a program, if successful (as evidence suggests it might be), it is less expensive than the jail-to-street cycle. Washington moved into an apartment and used the drug addiction treatment, mental health counseling, and case management included in the program. The program operated with a Housing First philosophy, so sobriety was not a requirement for admission, allowing vulnerable people to have stable housing during periods of addiction and relapse.

Supportive housing might not be thought of as an intervention to address the opioid crisis, but it has one of the strongest evidence bases of any program serving a population that overlaps with those with OUD: challenging, chronically homeless people. Although few studies have examined the impact of permanent supportive housing as it relates to OUD and addiction outcomes, the policies have been shown to improve outcomes such as housing stability and incarceration rates for people with high levels of substance use and mental illness.[b]

[a] Christie Thompson, "A Fresh Take on Ending the Jail-to-Street-to-Jail Cycle," Marshall Project, May 10, 2017, https://www.themarshallproject.org/2017/05/10/a-fresh-take-on-ending-the-jail-to-street-to-jail-cycle.

[b] Anna Spier, "Strategies to Combat the Opioid Epidemic" (Cambridge, MA: Abdul Latif Jameel Poverty Action Lab North America, 2016).

By allowing decisionmakers to focus on various outcomes and providing incentives for an approach focused on evidence, PFS can allow for the selection of effective interventions that do not fit into the traditional addiction toolkit. For George, this approach has allowed him to stay in stable housing for nearly two years, get into a drug addiction treatment program, reconnect with his family, and begin pursuing his high school equivalency credential. Although the policy did not

focus on his substance use disorder, it allowed him to make progress in recovery and improve his life across a wide range of outcomes.

Sometimes, the evidence base indicates an unpopular solution is the best means of addressing a given problem. In those cases, PFS can provide an avenue for doing what works best, even if it is not what is most popular or intuitive.

PRINCIPLE 5
Support Solutions through Better Understandings and Cross-Agency Context

A key feature of PFS is that public resources are spent only if the program successfully achieves the intended outcomes. For controversial interventions that have proven effective, the emphasis on spending public resources only on what works might be enough to change the dialogue around the intervention.

Although the evidence base is limited, the opioid crisis includes several controversial interventions with some evidence of success, such as MAT, needle exchanges, and safe injection sites. PFS can provide an opportunity to build consensus around outcomes rather than the intervention where stigma can limit a program. In the face of tight budgets, elected officials might be wary of funding controversial programs for a stigmatized population like people with OUD. They might fear political backlash from the community for spending money on what the community perceives as a "troublesome" population, especially if there is a risk the program will not be effective. This can impede efforts to implement evidence-based programs that can improve outcomes for people with OUD, which could lead to cost savings and other benefits.

Although people might disagree on the means, most would agree that fewer people addicted to opioids is a good thing. Similarly, most would agree that the secondary consequences of effectively treating people with OUD, such as reduced crime and cost savings, benefit the entire community. A 2016 study found that each person who enrolled in a MAT program instead of detoxification saved California nearly $18,000 worth of crime costs over two years (Krebs et al. 2016). Reframing the debate in terms of criminal justice savings, as opposed to a debate about whether to provide opioids to people with OUD as part of their treatment (i.e., MAT) might make the opportunity to implement an effective program more viable.

In addition to emphasizing program outcomes over the program itself as a pathway for potentially gaining greater public support, PFS also allows providers to emphasize their pursuit of those outcomes over their adherence to procedures or processes that could get in the way of achieving those outcomes, which is the basis of the next principle.

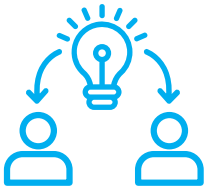
PRINCIPLE 6
Empower an Outcomes Orientation for Providers

The PFS model's emphasis on outcomes encourages project partners to be discerning when selecting a service provider. Jurisdictions typically choose to contract with providers they have worked with in the past or whose services are inexpensive. The government will pay the provider based on the provisions of their agreement, which are naturally oriented toward clearly demonstrating outputs (e.g., seeing a certain number of clients or opening a certain number of facilities). But PFS provides incentives for achieving outcomes, not providing services. As such, the PFS model challenges jurisdictions to think about which outcomes to prioritize and then procure the provider best able to achieve these outcomes, rather than the provider best able to demonstrate outputs.

Furthermore, a shared focus on achieving the targeted outcomes allows for greater flexibility during implementation, enabling partners to modify program procedures to maximize the chances of achieving positive outcomes. Unlike other programs, where periodic check-ins on standard metrics are the norm, PFS project management entails ongoing discussions on project progress. This iterative process allows partners to address issues as they arise: Which intake locations are enrolling fewer participants than projected, and why? Should we hire more provider staff in response to the higher-than-expected workload? Are the data systems communicating effectively, and if not, how can we address that?

This active performance management allows partners to determine if a project is working. If data show the project is not working and that services are not effective, early-termination clauses often permit project partners to end a project before more resources are spent on an unproductive effort. Active performance management builds provider capacity to use real-time data to inform service delivery, facilitates course corrections to increase the project's chances of improving outcomes for participants, and helps ensure that limited resources are being spent only on effective social programs.

Focusing on outcomes and monitoring performance data are valuable for an agency or service provider to guide improvements in its efforts, but they can also be critical for developing an evidence base to guide decisionmakers' efforts in other jurisdictions.



PRINCIPLE 7
Contribute to an Evidence Base That Other Decisionmakers Can Use

A PFS project evaluation aims to determine whether outcomes were achieved and whether, and how much, investors will be repaid. By proving through an evaluation that program participants experienced improvements in the target outcomes, governments can clarify the value received in exchange for their constituents' tax dollars and can contribute new research to the evidence base on programs and interventions. Increasing the evidence base on opioid-related interventions, especially effective opioid-related interventions, is important because the current evidence base is limited. There is even value in an evaluation showing the program was not effective because it can help other decisionmakers reconsider using that same approach in their jurisdiction.

Furthermore, the PFS model's emphasis on the importance of rigorous evaluation can encourage project partners to build up infrastructure, such as data-storage systems and data-collection capacities needed to evaluate results in a transparent manner. Context can significantly affect whether a particular program translates neatly from one community to another. A program that performed well in Los Angeles, for example, might not perform similarly well in rural Ohio. Factors separate from the program design or delivery can significantly influence program success. Rigorous evaluations that can capture this information enhance the generalizability of their findings.

Conclusion

Today, medical decisionmakers recognize fevers as an early symptom of several underlying illnesses and can reliably diagnose and treat (or prevent) many of those conditions. This modern state of medical care developed over more than 200 years of incremental improvements in identifying and measuring symptoms across the body's systems, understanding the relationships

between those systems, and growing an evidence base of the best treatments for specific problems. These same developments are necessary for public policy and administration efforts to address the opioid crisis. But decisionmakers addressing the opioid crisis do not have two centuries to improve understandings and responses. This brief describes how the PFS model offers a framework decisionmakers can use to accelerate progress in overcoming the policy challenges of the opioid crisis and improve new or existing efforts to address the problem. Regardless of whether decisionmakers' efforts are financed by PFS, simply considering how those efforts might be constructed as a PFS project leads to a valuable framework for rethinking the opioid crisis.

What's Next?

The Urban Institute has several resources that can help decisionmakers explore PFS and implement its broader principles, regardless of the funding mechanism.

Procuring for Success

Rayanne Hawkins and Brian Bieretz, "Procuring for Success: Lessons to Support a Shift toward Procuring Outcomes" (Washington, DC: Urban Institute, 2017).

This brief provides government stakeholders interested in PFS important lessons on how a strong procurement process can improve PFS projects. It discusses how government stakeholders should identify and define outcomes for payment; solicit public input through requests for information, resources, or proposals; engage other stakeholders, including intermediaries, service providers, investors, and evaluators; and consider passing special legislation to enable contracts based on paying for outcomes.

PFS Project Assessment Tool

Justin Milner, Matthew Eldridge, Kelly Walsh, and John K. Roman, *Pay for Success Project Assessment Tool* (Washington, DC: Urban Institute, 2016).

The PFS Project Assessment Tool (PAT) helps people answer a fundamental question: What

makes for a strong PFS project? It describes core elements of PFS projects, explains why those elements are important, provides a scoring system to help distinguish the strengths and weaknesses of a proposed project, and generates recommendations for improving those weak areas. The PAT is designed for individuals, governments, and organizations working through PFS projects or considering engagement with PFS. Broadly termed "stakeholders," PAT users include government officials and advisers, public agency leadership, program managers, service providers, and others interested in learning whether PFS might work for their community. Completing the PAT also helps build the business case for a proposed project if that project scores well in each area.

An Introduction to Evaluation Designs in Pay for Success Projects

Kelly Walsh, Rebecca TeKolste, Ben Holston, and John Roman, "An Introduction to Evaluation Designs in Pay for Success Projects" (Washington, DC: Urban Institute, 2016).

This brief provides a basic overview of evaluation designs to assist PFS stakeholders engaged in deal development. It focuses on comparison and its relation to various designs, and it presents key questions that PFS planners should address as they participate in evaluation design discussions. In PFS projects, strong evaluations are tasked with determining what happened, whether the program caused these outcomes, and whether outcome payments are triggered.

From Evidence to Outcomes: Using Evidence to Inform Pay for Success Project Design

Justin Milner and Matthew Eldridge, "From Evidence to Outcomes: Using Evidence to Inform Pay for Success Project Design" (Washington, DC: Urban Institute, 2016).

This brief offers policymakers and PFS stakeholders principles to help them understand and interpret evidence and lay the groundwork for incorporating evidence into broader public decisionmaking. It explores the following questions:

- What is evidence?
- Why does evidence matter for PFS projects?
- How do you assess the quality of existing evidence and program evaluations?

- What do you do when the evidence base is limited?

Although the brief looks retrospectively at the evidence base for social programs, two accompanying briefs look prospectively at selecting strong evaluation designs for a PFS project to determine payments and to continue building the evidence base for other programs.

Should State and Local Governments Use Pay for Success Financing to Support Medication-Assisted Treatment (MAT) for Opioid-Use Disorder?

Lisa Clemans-Cope, Don Teater, Sally Satel, Kelly Walsh, Jake Edwards, Mireille Jacobson, and Cheryl Burnett, "Should State and Local Governments Use Pay for Success Financing to Support Medication-Assisted Treatment (MAT) for Opioid-Use Disorder?" Urban Institute, October 10–13, 2017.

This debate brings together policy researchers, medical practitioners, decisionmakers, and PFS experts to discuss and debate whether state or local governments could (or should) use PFS to implement MAT to address the opioid crisis in their jurisdictions.

Using Data and Evaluation in Policy Development, Implementation, and Monitoring

Dave McClure and Ellen Paddock, "Using Data and Evaluation in Policy Development, Implementation, and Monitoring: Building Successful Policies to Reduce Prescription Opioid Misuse" (Washington, DC: Urban Institute, 2017).

Policymakers looking to reduce the abuse of prescription opioids face difficult decisions in selecting which intervention will best fit their jurisdictions. This brief outlines a five-step process decisionmakers should apply to incorporate data and evaluation into the formation and implementation of policy: create a logic model, identify data sources, collect data, analyze data to identify and solve implementation challenges, and continue to incorporate data analysis as part of the policy process.

Helping Smaller Communities Benefit from PFS through a Pooled Approach

Matthew Eldridge, "Helping smaller communities benefit from PFS through a pooled approach," *PFS Perspectives* (blog), Urban Institute, August 2, 2018.

This blog post explores how smaller communities can overcome size-related obstacles to PFS by partnering with other, similar jurisdictions through a pooled approach.

Notes

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4 Josh Katz, "Drug Deaths in America Are Rising Faster Than Ever," *New York Times*, June 5, 2017.

5 German Lopez, "The Case for Prescription Heroin," *Vox*, June 12, 2017.

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8 Richard G. Frank, Keith Humphreys, and Harold A. Pollack, "Does Naloxone Availability Increase Opioid Abuse? The Case for Skepticism," *Health Affairs*, March 19, 2018.

9 See also "Effective Treatments for Opioid Addiction," National Institute on Drug Abuse, accessed July 19, 2018, https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction.

10 Andrew Feldman and Ron Haskins, "Tiered-Evidence Grantmaking," Evidence-Based Policymaking Collaborative, September 9, 2016, https://www.evidencecollaborative.org/toolkits/tiered-evidence-grantmaking.

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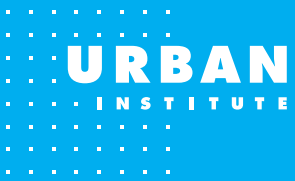

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