

Expert Panel Meeting on Systems-Level Change: Behavioral Health and Public Health Interconnection

Executive Summary

On June 18, 2018, ASTHO and CDC hosted the “Expert Panel Meeting on Systems-Level Change: Behavioral Health and Public Health Interconnection” in Atlanta, Georgia. The purpose of the meeting was to bring together public health leaders at the local, state, tribal, and national levels to discuss successes and lessons learned in connecting behavioral and public health systems. Some key lessons learned centered on the need for shared definitions; addressing the social determinants of health and upstream factors for behavioral health issues; and building the financing and data infrastructure to support behavioral health integration.

Introduction

ASTHO strives to engage state, tribal, local, and territorial health officials in addressing and preventing behavioral health issues by building capacity throughout the governmental public health system. Through the *Interconnecting Behavioral Health and Public Health* project, ASTHO is identifying and analyzing evidence-based, evidence-informed, and experience-based policies and programs that address behavioral health. ASTHO is also analyzing practices impacting state interagency coordination and cooperation to address the social determinants of health and other behavioral health issues. Through this expert panel meeting, ASTHO gathered recommendations for interconnecting behavioral health across sectors.

During the meeting, participants identified the need for shared definitions of behavioral health interconnection as a key theme:

- Broadly, **behavioral health** refers to the impact behaviors have on the well-being of the mind and body. Behavioral health includes topics such as mental health, substance use disorder, suicide, adverse childhood experiences, injury violence prevention, and tobacco use.
- **Interconnections** between behavioral health, public health, and healthcare systems lie along a continuum of integration which can range from collaboration between state agencies to fully integrated behavioral and public health systems.

During this panel meeting, public health leaders representing different levels in their organizations shared their experiences collaborating across agencies to address various behavioral health issues. ASTHO and CDC selected these public health leaders to participate based on their expertise related to how systems lever approaches and interventions have been utilized to interconnect behavioral and public health systems in their jurisdictions. Systems change levers are essential elements for making lasting changes and systems-level improvements, as well as for building the infrastructure for behavioral

health integration. Public health leaders spoke about their experiences related to four systems levers: (1) financing and structure, (2) complementary sectors and partnerships, (3) policy change, and (4) data-driven action.

Having a shared vision and open lines of communication are essential to state health agencies working to integrate behavioral and public health. Developing a financing structure includes identifying funding across sectors and leveraging existing resources and reimbursement for behavioral health services—two critical components for integrating behavioral health systems. Complementary sectors and partnerships entails involving a variety of stakeholders in the decision-making process and thereby increasing collaboration across state agencies. Policy change allows officials to identify and implement organizational, regulatory, and legislative polices—including upstream policy measures—that can have an impact on both behavioral and physical health. Lastly, data-driven action depends on improving surveillance data, addressing data gaps, and sharing data across sectors to educate and empower stakeholders.

Financing and Structure Panel

Panelists

- **Douglas Fish**; (state representative) medical director, New York State Health Department Division of Program Development and Management, Office of Health Insurance Programs
- **Jami Snyder**; (state representative) deputy director, Arizona Health Care Cost Containment System
- **Katherine Neuhausen**; (state representative) chief medical officer, Virginia Medicaid

Summary

During this panel, three public health experts discussed practical examples of behavioral health and public health interconnection from a systems-level perspective that focused on structure and finance, including barriers and facilitators to this interconnection in their communities. Douglas Fish discussed New York state's Delivery System Reform Incentive Payment (DSRIP) program and the patient-centered medical home developed in coordination with the National Committee for Quality Assurance. Fish also spoke about incorporating principles of behavioral health coordination and integration, which combines efforts of the DSRIP program and the Advanced Primary Care initiative, developed as part of the State Innovation Model grant program.

Resources:

- [Arizona Health Care Cost Containment System](#)
- [New York State DSRIP Program: Frequently Asked Questions](#)
- [Virginia Addiction and Recovery Treatment](#)

Jami Snyder highlighted Arizona's work to create an integrated care environment across multiple levels (regulatory, payer, and provider) that addresses topics, such as care coordination and maximizing payer responsibilities. Katherine Neuhausen focused her presentation on Virginia's addiction and recovery treatment services (ARTS) and Virginia's Medicaid coverage of substance use disorder services before ARTS. Other discussion topics highlighted the need for service integration, the social determinants of health, and opportunities for a more holistic approach to the service array.

Challenges

- Provider payment and reimbursement for services can be difficult since providers struggle to understand whom to bill for services.
- Developing a system that captures data from community and stakeholder partnerships.
- Telehealth coverage expansion and expanding it beyond clinical settings. Understanding how telehealth can be adapted to meet the members and patients where they are.
- Same-day billing in Medicaid can delay or limit the full integration of behavioral health into the medical home model or federally qualified health centers. Reimbursement can also be delayed for managed care plans that contract with a behavioral health organization for same-day billing.
- Healthcare providers recognize that many patients have multiple physical and behavioral health care needs, yet services have traditionally been provided separately.

Successes and Recommendations

- There is a need for a sustainable financing structure that leverages financing streams. Financing for behavioral health services is often siloed between agencies and there are key opportunities to leverage funding streams. Expert panelists indicated there was a growing opportunity for developing tools to improve the financing infrastructure of behavioral health services.
- Community and stakeholder outreach and engagement is vital. In Virginia, the Medicaid program partnered with professionals at the health department to increase coverage of non-pharmacologic, evidence-based treatment for chronic pain.
- Integrating physical and behavioral health services can help improve the overall quality of care for individuals with multiple health conditions by treating the whole person in a more comprehensive manner. New York state's DSRIP program focuses on providing high quality, integrated primary, specialty, and behavioral healthcare in a community setting with hospitals used primarily for emergent and tertiary levels of services.
- To fully integrate physical and behavioral health services for individuals with substance use disorders (SUD) and expand access to the full continuum of services, Virginia's Department of Medical Assistance Services plans to "carve in" non-traditional SUD services into managed care for members who are already enrolled in plans. The only service currently covered by managed care in Virginia is inpatient detoxification.
- On April 1, 2017, Virginia's Medicaid program launched an enhanced substance use disorder treatment benefit: Addiction and Recovery Treatment Services (ARTS). The ARTS benefit provides treatment for those with substance use disorders across the state. The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid and the Governor's Access Plan, including expanded community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment. After the first year of implementing ARTS, more members are receiving treatment for all SUD and opioid use disorder.
- When establishing shared space, practices must be mindful of the following issues: provider accountability for meeting regulatory standards and dividing responsibility among other providers; care coordination and ensuring that patients are aware that they are being seen by varying providers; and ensuring federal requirements are met.

Complementary Sectors and Partnerships Panel

Panelists

- **Karen Meyer**; (local representative) health promotion coordinator III - community assessment, Office of Assessment, Planning and Improvement, Tacoma-Pierce County Health Department, Washington State
- **Julie Morita**; (local representative) commissioner, Chicago Department of Public Health
- **Kara Hickel**; (state/tribal representative) health communications and equity specialist, Division of Community and Health Systems, North Dakota Department of Health
- **Lacy Fehrenbach**; (state representative) director, Office of Healthy Communities, Division of Prevention and Community Health, Washington State Department of Health
- **Kaye Bender**; (national representative) president and CEO, Public Health Accreditation Board (PHAB)
- **Tassy Parker**; (tribal/academia representative) professor, family and community medicine; professor, nursing; director, Center for Native American Health, University of New Mexico Health Sciences Center

Summary

During this panel, six public health experts representing local, state, tribal, and national perspectives discussed their experiences working with partners to integrate behavioral health into public health. Four panelists presented on ways to integrate behavioral health through public health policy, programs, and health improvement plans.

Karen Meyer discussed the development of the Tacoma-Pierce County health improvement plan, which integrated behavioral health as part of three priorities, including chronic disease prevention, mental health and increasing access to quality healthcare. Julie Morita presented on Chicago's new health improvement plan which includes a focus on addressing the social determinants of health and prioritizes mental health, substance use, and violence prevention. Kara Hickel focused on an innovative tribal structure which funds tribal coordinators to work with local and state coalitions to address tobacco and substance misuse. Lacy Fehrenbach discussed state policies which mandated the primary care and financing integration of behavioral health through accountable communities of health.

Kaye Bender spoke about a recent PHAB meeting that highlighted several key themes, including the definition of behavioral health from a systems-level and the complexity of discussing behavioral health and shared language. Following Kaye's discussion, Tassy Parker presented a digital story developed in partnership with the Urban Group in Albuquerque, NM. The story focused on the integration of mental health into primary care

Resources:

- [Tacoma-Pierce County Health Improvement Plan](#)
- [Making Connections Initiative](#)
- [Healthy Chicago 2.0](#)
- [Chicago Health Atlas](#)
- [Chicago Connects](#)
- [Overcome Opioids](#)
- [North Dakota Engages American Indian Tribes](#)
- [Washington Essentials for Childhood Initiative](#)
- [Washington Senate Bill 6312](#)
- [Washington Accountable Communities of Health](#)

Challenges

- Stigma associated with behavioral health services and the full range of social determinants of health can be difficult to address.
- One challenge in Chicago is funding for behavioral health services in FQHCs due to limited Medicaid reimbursement for community health workers for navigation services. In addition, community mental health service providers receive limited reimbursement for psychiatry services.
- In Chicago, a barrier for clients accessing behavioral health services was navigating the system and identifying available resources.
- The additional time needed to respectfully work within the processes established by individual tribal sovereign governments.
- Ensuring that agreements for data sharing and research dissemination are agreed upon with tribes prior to data collection or research initiation.

Successes and Recommendations

- Health improvement plans provide an opportunity to incorporate behavioral health at a systems-level. Tacoma Pierce County included mental health as an integrated strategy, while Chicago included mental health as a priority health topic.
- Community level education can reduce stigma associated with behavioral health and assist with client navigation. Tacoma Pierce County hired two coordinators to conduct community level education about social determinants of health and available resources. Chicago is working with other organizations to expand access to their helpline and assist clients in navigating available resources in Chicago. North Dakota is disseminating education about tobacco and substance misuse to tribal communities through coordinators for each tribe.
- When developing health improvement plans or engaging communities, public health should include a health equity and social determinants of health lens.
- Community needs assessments are a good tool for identifying existing resources, developing baseline data, and engaging local agencies and organizations.
- Comprehensive collaborations for behavioral health integration could include: city, county, and tribal agencies; department of corrections; criminal justice system; law enforcement; EMS; primary care; FQHCs; Medicaid; departments of transportation and labor; payers; other social services; and local coalitions.
- To engage tribal communities, identify the preferred protocol first, which may include contacting respected community members, such as the elders program directors, or elected or appointed tribal leaders. Understand that they will consider the engagement within their own communities in their own ways and time.
- Legislative action to integrate behavioral health could improve reimbursement for behavioral health services. Washington state has a legislative mandate through Senate Bill 6312 to integrate behavioral health in financing and preventive services by 2020. The state also has a goal of converting 90 percent of Medicaid provider payments to value-based care.
- An accountable community of health (ACH) is one way to interconnect behavioral health by bringing together leaders from multiple sectors to align resources and integrate behavioral health. In Washington state through the 115 Medicaid waiver, ACHs are tasked with integrating behavioral and physical health through five-year projects that include bidirectional integration, community-based care coordination, opioids crisis, reproductive and maternal child health, and chronic disease prevention.

- Care coordination that includes whole person health can address social determinants of health along with physical health. In Washington state, the Pathways Hub Model involves community health workers who coordinate among 20 potential pathways such as family planning, screenings, housing, employment, and education.

Policy Change Panel

Panelists

- **Jay Butler**; (state representative) chief medical officer, Alaska Department of Health and Social Services
- **Myra Parker**; (tribal representative) CEO, Seven Directions and Assistant Professor, University of Washington
- **Rahul Gupta**; (state representative) health officer and commissioner, West Virginia Department of Health and Human Resources, Bureau for Public Health

Summary

During this panel, three representatives from state and tribal levels discussed practical examples of behavioral health and public health interconnection from a systems-level perspective that focused on law, legal, and policy opportunities, including barriers and facilitators to this interconnection in their communities.

The panel helped to inform how different systems-level issues contributed to their state's successes and failures. Jay Butler discussed the ASTHO 2017 President's Challenge, which was driven by the opioid epidemic but expands broader on the substance misuse and prevention framework.

Myra Parker presented on behavioral health disparities that continue to represent major public health issues among American Indian and Alaskan Native communities and the need to include tribes in national initiatives, frameworks, and investments to drive policy change. Rahul Gupta shared West Virginia's overdose response video and discussed how West Virginia is addressing the opioid crisis. Gupta emphasized the need for a comprehensive, science-driven approach that combines the efforts of federal, state, and local agencies, along with other organizations and industries to implement solutions to address the opioid epidemic. Collectively, all three presenters discussed how they work in their communities

Resources:

- [Keepin' It REAL](#)
- [ASTHO 2017 President's Challenge – Public Health Approaches to Preventing Substance Misuse and Addictions](#)
- [The National Tribal Behavioral Health Agenda](#)
- [Behavioral Health Barometer](#)
- [West Virginia Overdose Response Video](#)

Challenges

- In Washington state, policies are not always able to integrate best practices for assessment while simultaneously taking into account both cultural humility and trauma-informed care.
- Tribal serving organizations can encounter challenges in promoting policy innovation and communication among state legislatures due to self-government, tribal and state government policies, regulations, and communication mechanisms.
- Tribal, state, and local agreements for data sharing, collaboration, and referral processes vary widely with perceived legal challenges, which presents a significant barrier.

- The integration of various public health departments and agencies responsible for the care and coordination of physical, behavioral, and mental health can support the broader interconnection of behavioral health and public health. However, the differing agency structures and values can present challenges in implementing a fully integrated framework.
- State regulations, provider licensing and certifications, billing requirements, and health information exchanges can delay the delivery of integrated care models.

Successes and Recommendations

- Partnerships with FQHCs and tribal organizations are important. Partnering with tribal serving organizations is beneficial because they are informed about the tribal infrastructure and culture and are able to provide managed care.
- Take a systems approach to improving health outcomes.
- By recognizing workforce competencies, guiding principles, and existing resources that support state and tribal relationships, tribes and states can continue building on efforts to improve governmental services, policies, and federal regulations for both communities.
- In most states, telehealth is only covered for clinical appointments. States should explore ways to expand telehealth coverage to meet the clients' needs.
- Care coordination agreements are critical tools that outline key tasks and responsibilities of providers, facilities, and services. These agreements should be utilized often to support the development of new policies and to foster patient and provider relationships and improve transitions of care.
- Ensure public health organizations and their stakeholders analyze upstream determinants of public health to include: adverse childhood experiences and other factors that increase infant exposure to toxic stress.

Data-Driven Action Panel

Panelists

- **Bevin Croft**; (national representative) research associate, Human Services Research Institute (HSRI), Cambridge, MA
- **Greg Holzman**; (state representative) state medical officer, Montana Department of Public Health and Human Services
- **Marian Arledge**; (local representative) executive director, Western North Carolina Health Network, Asheville, NC

Summary

During this panel, three experts from the national, state, and local levels discussed their experiences in collecting and using data for action. Bevin Croft, representing HSRI, a national non-profit that provides technical assistance on research evaluation, discussed best practices for collecting and utilizing needs assessments. Greg Holzman described his state's efforts collaborating and sharing opioid data among agencies, including an epidemiology group comprised of experts from many state agencies. Marian Arledge described how a

Resources:

- [HSRI Behavioral Health Projects](#)
- [Montana Substance Use Disorder Strategic Plan](#)
- [WNC Healthy Impact Partnership](#)

partnership between 17 hospitals and 19 public health agencies is working toward a vision of improved community health through data driven action.

Challenges

- One challenge with using data are the vast gaps between the prevalence of data and use of services. HSRI described the difference between population prevalence of mental health disorders and penetration rate of people using available services.
- There are limited metrics that capture outcomes of behavioral health interventions at the population level. Outcome measures are often driven by grant requirements and collected for compliance with grants.
- Electronic health records are designed for billing and patient care coordination, but do not currently capture systems-level data.
- Behavioral health providers do not regularly conduct assessments at consistent intervals; a client may have an initial assessment without a repeat assessment for years. This may be attributed to the limitations of telehealth coverage and varying billing requirements across private and public insurers.
- Due to a system that is often siloed, different agencies often hold different pieces of information about a patient.
- Needs assessments are often focused on what is currently happening, versus the intended outcomes.
- State agencies often have competing priorities based on siloed requirements and develop specialized data which can contradict each other. For example, in Montana, public health data on opioids do not indicate an increase in opioid overdoses deaths (actually decreased since 2009) and emergency department data related to non-heroin opioid overdoses has been mostly stable 2010-2014 (small number of heroin overdoses); however, data from the Division of Criminal Investigation show increasing illicit opioid activity in Montana, and anecdotally Montana healthcare providers are seeing more complications secondary to IV drug use.
- According to Western NC Health Network, large datasets can be overwhelming for local and county level jurisdictions to analyze and disseminate.

Successes and Recommendations

- HSRI recommends that community needs assessments be outcome driven and focus on the guiding principle of what the optimal outcome will be. They recommend a set of four aims: engage with the community to understand intended outcome; analyze outcome data and service utilization; provide actionable recommendations; and establish strategies for implementation.
- Data collection could include qualitative data and the voice of the service user. Qualitative analysis examples include: in-depth interviews with service users, providers, family members, advocates and administrators, as well as community listening sessions.
- It is important to have data that is accessible and easy to disseminate for local and county-level jurisdictions. Data interpretation and dissemination should not be a barrier to local organizations.
- Western NC Health Network recommends that results-based accountability is key to data driven action. Goals should be outcome driven and data collection should have clear measurable indicators.

- Successful data collection can occur by using a combination of publicly available data, de-identified data, and data sharing agreements.

Key Themes

- Effective public health and behavioral health interconnection requires shared definitions and vision.
- More education is needed on how successful systems are leveraging unique ways to finance and braid or blend funding to address behavioral health issues in their communities.
- Public health agencies can play a critical role in analyzing the impact of the social determinants of health and upstream factors for behavioral health issues.
- Stigma toward behavioral health issues, such as mental illness and substance misuse, must be addressed in order to improve access and quality of care provided to individuals who seek care.
- Care coordination should include a whole-person approach addressing the social and physical well-being of clients.
- Behavioral health can be integrated at a systems-level through health improvement plans and shared state agency plans.
- Community needs assessments that are outcome driven are a good tool for engaging community stakeholders in identifying gaps and recommendations for behavioral health services.
- Engaging tribal communities requires an understanding of their sovereignty, forms of government, and cultural differences.
- Legislative action can help integrate behavioral and public health at a systems-level by supporting data sharing agreements, financing of behavioral health services, and addressing upstream factors.
- Data-driven action should be based on quality data that is accessible and easy to disseminate to state and local stakeholders.

Conclusion and Next Steps

Behavioral and public health interconnection requires a systems-level approach that includes elements, such as legislative action, data-driven action, effective collaboration and leveraging financing structures. Key themes from this meeting indicate the need for a shared definition of behavioral health interconnection, addressing upstream factors (such as the social determinants of health and stigma associated with behavioral health issues), and additional education on how successful systems are leveraging different finance streams to address behavioral health issues in their communities.

As a result of this initial expert panel meeting, next year ASTHO will:

- Distribute this report through multiple channels and audiences (e.g., expert panel meeting panelists and observers, state health officials, leadership designees, and newsletters). The National Council on Behavioral Health (NCBH) will also send this report to its members. This aligns with ASTHO's strategic priority to develop strong and effective state and territorial health officials by providing them with opportunities to connect, share knowledge on topics that advance their positions, and align with emerging trends and issues.
- Convene a learning collaborative composed of five state teams through ASTHO's Learning Opportunities. ASTHO will utilize the lessons learned from this meeting and the state learning

collaborative members to provide tailored technical assistance to participating state health officials and leadership designees. ASTHO will help state learning collaborative members develop a formal workplan on identifying gaps and outcomes to interconnect, sustain, and pay for behavioral health and public health interconnection activities. This will also support one of ASTHO's strategic priorities to build capacity to identify emerging trends and issues and provide related support to state and territorial health officials.

- In coordination with ASTHO, NCBH will provide a Mental Health First Aid training and extend ASTHO's Learning Opportunities to all state health officials or leadership designees participating in the learning collaborative.
- ASTHO will also synthesize and disseminate multiple *ASTHOBriefs* on promising practices to help local and state health departments address prevention of behavioral health issues using a systems-level approach.
- Lastly, ASTHO, in coordination with NCBH, will be producing an *ASTHOExperts* deliverable on a promising practice that uses data to tell a unique story of behavioral health and public health interconnection.