Bridging the Gap
Connecting Behavioral and Public Health
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- Promote policy innovation and communication among state legislatures.
- Ensure state legislatures a strong, cohesive voice in the federal system.

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Introduction

Like many other states across the country, Massachusetts has seen an alarming increase in opioid overdose deaths since 2000. In fact, opioid-related deaths in Massachusetts increased more than 350% between 2000 and 2015, spiking abruptly in 2010 and far surpassing the national average.

In response, the Massachusetts legislature passed, and the governor signed into law, Chapter 55 of the Acts of 2015. The legislation was an innovative and large-scale effort to study opioid-related deaths in the state. The legislation instructed the Massachusetts Department of Public Health to consider the available data across multiple state agencies and private partners in the public health and behavioral health sectors in order to understand what was driving the epidemic.

The result was a report that gave lawmakers a comprehensive picture of all opioid-related deaths in Massachusetts, along with a detailed description of the causes of deaths and the populations most at risk of dying. This allowed the department to recommend public health interventions to the legislature, which would not have been possible without intentional efforts to connect public health and behavioral health agencies’ information and systems.

By combining death records from the Registry of Vital Records and Statistics with death and toxicology reports from the Office of the Chief Medical Examiner, for instance, the department’s analysts were able to identify the causes of deaths. It concluded that most opioid-related deaths in the state were due to illicit opioids like heroin and not prescription opioids. This allowed the department to recommend expanding and enhancing harm reduction programs that focused on addressing heroin, fentanyl and polysubstance use. Combining the information with data from the state’s prescription drug monitoring program (PDMP), analysts also concluded that women were much more likely than men to die of an overdose related to prescription opioids. This resulted in the department recommending that providers use the PDMP database to identify any active or past prescriptions for their patients, particularly women.

In their role as policymakers, state legislators are uniquely positioned to align behavioral health and public health systems where they believe it is beneficial. They can strengthen and use statewide data systems, promote cross-sector engagement and partnerships, determine spending levels and coordinate funding sources.
By connecting behavioral health and public health systems, policymakers can better leverage resources across different sectors currently operating independently of each other. Benefits of aligning infrastructure across systems include an improved ability to address priority health problems and use limited resources more efficiently. In Massachusetts, legislative action allowed the Department of Public Health to coordinate efforts among various state and private agencies to analyze multiple population-based data sources, creating opportunities to better allocate resources and coordinate care at a systems level. The final report linked 10 different data sets together to identify the populations most at risk of overdose and the characteristics unique to different populations that informed the most effective public health intervention.

This brief explores opportunities to better connect the public and behavioral health systems. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), behavioral health involves promoting mental health, resilience and well-being; treating mental and substance use disorders; and supporting those who experience and/or are in recovery from these conditions, along with their families and communities. The Centers for Disease Control and Prevention (CDC) defines public health systems as all public, private and voluntary entities that contribute to delivering essential public health services within a jurisdiction.

For the purposes of this brief, interconnected behavioral and public health systems is defined as a continuum of aligned activity at the state level to address behavioral health outcomes in populations. Three aspects of system interconnection and the potential role of state legislators are explored in this brief:

- **Data**: Creating an infrastructure that supports accurate, timely data can give state leaders the necessary information to predict, prevent and respond to health threats.

- **Partnerships**: Directing collaborative, cross-sector partnerships can foster the effective sharing of information and resources, more focused prevention efforts, and more comprehensive solutions to challenging health problems.

- **Financing**: Leveraging funding streams across systems and structuring collaborative partnerships can create sustainable financial mechanisms to support population health and improve system efficiencies.

### Connecting Data to Predict, Prevent and Respond to Health Threats

Population-level health data can serve as an essential tool for policymakers and public health officials in responding to health problems. Rather than describing individuals’ health, population-level health data describes the health status of groups or populations of people in terms of rates and other measurements related to illness, health behaviors or risk factors. A population can be people of a specific age, geography (e.g., county, region, state), sex, race or many other characteristics.

Such data identifies health trends in groups of people and determines which groups (e.g., rural versus urban populations) are most affected by certain health concerns. It allows policymakers to predict future health needs and distribute or prioritize resources based on need. It can also be used to evaluate the effectiveness of current policy interventions and recommend changes to policies.

The more complete the data, the more confident policymakers and health officials can be about what is occurring across an entire population. Benefits of even the most robust data collection systems can be stymied when access to the data is limited. Many state and local data sources frequently become siloed in a particular agency or sector that could support decision-making if the information was shared, linked or used with other data in another way (see Table 1). By creating the infrastructure necessary for data-sharing, states can hone in on the problems facing specific populations. Strategies states may consider include data-sharing agreements, in which multiple partners agree to share data; ensuring that information in one data system is accessible in other data systems; or using data linkage, which combines information on the same individual from multiple data sets.
Table 1: Examples of Data Sets from Public and Behavioral Health Systems

<table>
<thead>
<tr>
<th>Public Health Data</th>
<th>Behavioral Health Data</th>
<th>Health Care and Other Sector Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital statistics (e.g., death and birth certificates)</td>
<td>Mental Health Client-Level Data System (MH-CLD)</td>
<td>Emergency medical services data systems</td>
</tr>
<tr>
<td>Medical examiner and toxicology data</td>
<td>Treatment Episode Data Set</td>
<td>Hospital discharge data</td>
</tr>
<tr>
<td>Cancer, trauma and other notifiable disease registries</td>
<td>Drug Abuse Warning Network (ER crises data)</td>
<td>Medicaid and all-payer claims data</td>
</tr>
<tr>
<td>Prescription drug monitoring programs (PDMP) and prescribing databases</td>
<td>State Mental Health Agency Uniform Reporting System</td>
<td>Corrections system data</td>
</tr>
<tr>
<td>CDC Behavioral Risk Factor Surveillance System</td>
<td>National Survey on Drug Use and Health</td>
<td>Housing data</td>
</tr>
<tr>
<td>CDC Pregnancy Risk Assessment Monitoring System</td>
<td>SAMHSA treatment facility surveys</td>
<td></td>
</tr>
<tr>
<td>CDC National Health and Nutrition Examination Survey</td>
<td>Treatment provider licensure databases</td>
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State policymakers may consider several policy options to strengthen data infrastructure, including:

- Policies that promote the development of data skills in the public health workforce.
- Policies that encourage data-sharing and use agreements, in which agencies or entities establish formal agreements that describe how they will share their data with others.
- Policies that support data set interoperability, which ensures that information in one data system is formatted the same way as other data systems.
- Policies that encourage and facilitate data linkage, which connects information on the same individuals in multiple data sets to create a new, richer data set.

In Massachusetts, the Department of Public Health worked with the Massachusetts Center for Health Information and Analysis to create the data infrastructure needed to analyze information across smaller, separate data sets. By linking data from the PDMP with death records, for instance, health officials were able to determine that individuals who received prescriptions for opioids from three or more providers were three times more likely to die of an overdose. This risk increased even further when the prescriptions were filled at three or more different pharmacies. This insight helped frame the analysts’ policy recommendations moving forward.

A priority in Montana was to link data sets in its state health assessment (SHA), state health improvement plan (SHIP) and strategic plan to address substance use disorders. By linking data from multiple data sets—including the state’s hospital discharge data system, trauma registry, communicable disease registry, Behavioral Risk Factor Surveillance System and Youth Risk Behavior Survey—the state was able to create a comprehensive picture of public health threats and the populations most at risk. For instance, Montana experiences one of the highest suicide rates in the United States. By combining these various data sets, the state was able to determine that middle-aged veterans and native communities were at elevated risk of suicide compared to other populations, helping to focus prevention efforts.

The state’s plan also explicitly calls for increased data-sharing and coordination across sectors to more effectively address substance use disorders (SUD) and reduce overdose deaths. Montana’s strategic plan to achieve this includes developing a prescription drug burden document with an analysis of all major sources of available public health and justice system data related to SUD. The state will also establish data-sharing agreements between multiple partners, including the Board of Pharmacy, Montana Board of Crime Con-
Combining these data sets will help better inform prevention efforts for justice-involved populations who experience higher rates of overdose deaths. The state plan also emphasizes the importance of making this data accessible to local governments and public health agencies.

**Connecting Cross-Sector Partners to Solve Challenging Health Problems**

The value of tapping into multiple data sources underscores the importance of effective partnerships. When information and resources become siloed, efforts to address behavioral health challenges can become hampered. In an interconnected health system, leaders in the executive branch (e.g., state health departments, behavioral health agencies, state corrections facilities, and criminal justice, labor and social service agencies), local governments, and other public and private entities work together to achieve positive health outcomes. State legislators are well-positioned to provide direction to state agencies to coordinate state and federal resources and create partnerships between behavioral health and public health agencies as well as complementary sectors like housing, criminal justice and social services, among others. Partnerships between different sectors help leverage existing public health resources and evidence-based tools to improve the health of the community, generate efficiencies, minimize duplication of efforts and realign resources to address current gaps.

There are a variety of potential ways states can leverage partnerships to improve public health. States can consider seeking Medicaid waivers, such as Section 1115 waivers, to allow their state Medicaid agency to partner with local public health or human services agencies to address issues relating to homelessness, housing and SUD treatment. Policymakers may also consider approaches that enable their state’s public health agency to partner with local public health agencies and other organizations to address pressing health concerns. Minnesota’s health department, for instance, provides grant funding and technical assistance for tribal governments to address tobacco use. These resources support community-based tobacco control programs, allow systemic changes, like smoke-free policies, and provide educational and cultural awareness activities.

In another partnership model, Washington uses a high level of data aggregation and sharing across Medicaid claims, criminal justice, behavioral health and social service systems. Of the state’s relevant data-sharing partnerships, the two largest are the Analytics, Interoperability, and Measurement (AIM) initiative and the Predictive Risk Intelligence System (PRISM).
By creating a comprehensive data infrastructure bridging multiple state agencies—including the Washington State Health Care Authority, departments of health and social services, as well as other insurers—AIM provides the opportunity for shared analytics to address health disparities. By integrating information from medical, social service, behavioral health, and long-term care payment and assessment data systems, **PRISM** identifies Medicaid clients most in need of comprehensive care coordination based on risk scores developed through predictive modeling. This helps the state Medicaid agency coordinate with other agencies to provide services and predict health care costs for the most at-risk populations, allowing policymakers to allocate resources more efficiently.

Another example of a partnership connecting behavioral health, public health and other public agencies is Huntington, WV’s opioid overdose **quick response teams (QRT)**. The teams are composed of a partnership of a paramedic, law enforcement official, counselor, and pastor or other faith-based community member. The county’s emergency medical service provider notifies the QRT of every overdose that occurs in the county. The QRT tracks this information and other demographic data and attempts to contact every overdose survivor within 24 to 72 hours of the overdose with the end goal of connecting them to treatment. By partnering closely and communicating daily with treatment providers, the QRT tracks available beds and other treatment resources. This allows the QRT to provide timely referrals for opioid use disorder treatment. The QRT is supported by local, state and federal funding. Between 2017 and 2018, the QRT successfully referred roughly 30% of overdose survivors to treatment. Over the same timeframe, overdoses declined by 36%.

**Connecting Funding Streams Across Systems for Greater Impact**

Overall state spending for public health has been declining. In recent years, more than half the states have had to make cuts to their public health budgets, according to a Trust for America’s Health analysis. These changes can create challenges in responding to public health crises, particularly complex behavioral health challenges. Legislative opportunities exist to promote innovative and coordinated use of these limited dollars and multiple financing resources available to states to improve behavioral and overall health. Considering the range of federal agencies that have made behavioral health-related investments and prioritized innovative funding models, coordinating strategies across state agencies can promote more consistent and cost-effective approaches to recovery and health efforts.

**ALIGNING THROUGH SHARED GOVERNANCE AND POOLING INTERAGENCY FUNDS**

Putting some of these financial mechanisms into practice in recent years, Oregon and Virginia lawmakers passed legislation creating new governance structures and funding mechanisms. Oregon formed a joint subcommittee tasked with monitoring alignment and coordination between various areas, including public health modernization, behavioral health and oral health integration, and health care and early learning system transformation. The structure of this subcommittee has allowed a cross-section of decision-makers and stakeholders from the **Health Policy Board**, the state’s **Early Learning Council** and the Department of Human Services to transform health care systems and early learning care systems. According to the council, this connected structure “produced critical alignment” by developing a shared policy framework with combined resources, aligning goals, and recommending policies to improve service delivery, financial sustainability and access to educational supports for underserved children and their families.

Virginia’s long-standing governance structure has made it possible for “a single state pool of funds” to come together and support interagency teams and programs. Virginia has over 20 years of experience **braiding funding streams** from the departments of Social Services, Juvenile Justice, Education and Mental Health to better meet the health-related social needs of low-income and at-risk children and families. One example is **Virginia’s Family Assessment and Planning Teams**, which braid Medicaid and other funds to “assess the strengths and needs of troubled youths and families who are approved for referral to the team and identify and determine the complement of services required to meet these unique needs.”
LEVERAGING MULTIPLE STATE AND FEDERAL FUNDING STREAMS

Since 2007, Louisiana has braided and blended various federal funding streams to support housing. These efforts came about in part as a result of recent disasters (hurricanes Katrina and Rita) and recognition of housing as a health issue, according to a publication from the National Academy for State Health Policy (NASHP). Louisiana administers a program with the state's Medicaid agency and the Louisiana Housing Authority to combine housing assistance with individualized services for people with substantial physical or behavioral disabilities. The braiding of funding for this program comes from disaster funds, federal rental assistance programs, housing development support through the Low-Income Housing Tax Credit, Community Development Block Grants and the Ryan White program. These programs are funded largely by federal agencies: the Internal Revenue Service, the Department of Health and Human Services, the U.S. Department of Housing and Urban Development and the Centers for Medicare and Medicaid Services. An independent 2011-2012 study examined preliminary data that showed a reduction in emergency department use and hospitalizations. Lessons learned by Louisiana could be considered by other state leaders looking at a braiding model, including:

- Consider a centralized administrative structure with meaningful support for interagency partnerships.
- Cultivate and support these meaningful interagency partnerships.
- Allow each partner agency or community partner to have autonomy; empower them to administer the services central to them and not rely on one too heavily (e.g., do not try to have one partner administer both housing and individualized services).
- Develop a robust quality review and monitoring process.

According to NASHP, the Louisiana program reports early success in cost savings to Medicaid by leveraging a braiding of different funding sources, allowing “a measure of flexibility and resiliency that a single source of funding might not.” Louisiana also reported improving connections between different agencies providing medical care, housing and nutrition supports, beneficiary experience and health education.

Conclusion

Different demands drive legislative agendas in health policy. By directing an interconnecting public health and behavioral health system approach, policymakers can create an opportunity for communities to develop a lasting, data-driven infrastructure across multiple public and private partnerships, while streamlining different funding mechanisms to support population health.
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