Behavioral Health, Local Health Department Accreditation, and Public Health 3.0: Leveraging Opportunities for Collaboration

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📖 **See also DeSalvo and Wang, p. 1279.**

The rise of the opioid epidemic and the increasing rate of suicides have drawn attention to mental health and addiction and have highlighted the need for collaboration between public health and behavioral health. However, these 2 fields have had limited engagement with one another.

The introduction of Public Health 3.0 and population-based financing models that promote prevention and value in health care have created opportunities and incentives for local health departments and behavioral health agencies and providers to work together. New undertakings include the creation of accountable care organizations, community health needs assessment requirements for all non-profit hospitals, local health department requirements to conduct community Health Assessments (CHA), and increasing numbers of public health departments that are pursing accreditation.

We argue that by taking advantage of these opportunities and others, local health departments can play a vital role in addressing critical challenges in mental health and addiction facing their communities. (*Am J Public Health*. 2018; 108:1334–1340. doi:10.2105/AJPH.2018.304533)

Since the release of the 1988 Institute of Medicine report *The Future of Public Health* and the US surgeon general's first report on mental health in 1999, increased attention has been paid to the need for greater integration of behavioral health and public health services.[1,2] However, since the release of these landmark reports, the burden of mental health problems and substance use disorders on American communities has continued to increase, and, far too often, the behavioral health and the public health systems operate in independent silos. Patients in the public mental health system die 25 years earlier than do those in the general population.[3] Moreover, 15% of US adults have a substance use disorder, and the Centers for Disease Control and Prevention (CDC) has described prescription drug misuse as a public health epidemic.[4–6] The number of people who suffer from a substance use disorder is on par with the number of people who suffer from diabetes. Additionally, the incidence of substance use disorders is more than 1.5 times the annual prevalence of all cancers combined.[6]

In November 2016, the surgeon general released a landmark report on substance misuse and substance use disorder in the United States, which underscored the need for effective population-level strategies to tackle this issue.[6] Shortly after, the CDC's National Center for Health Statistics released a report that showed that drug overdose death and suicide have substantially increased and that life expectancy has dropped for the first time in decades.[7] The suicide rate in 2015 was about 13 per 100 000 people, the highest rate since 1986 and an increase of 24% since 1999.[8] More people now die from drug overdoses each year, approximately 64 000 in 2016, than are killed in automobile accidents.[6,9]

These statistics demonstrate that behavioral health conditions are affecting the public's health in new ways and to degrees not seen before. Many of the greatest public health challenges facing our country involve behavioral health issues, including the opioid epidemic, the increasing burden of suicide, and the rising rates of alcohol and illicit drug use. These behavioral health problems affect the public's health, and recognizing the contribution that unhealthy environments make is crucial to understanding the need for public health involvement. Shern et al. argue that genetics is not the only factor in health and illness: exposure to toxic stress and traumatic events also affect individual and population health, including behavioral health conditions.[10] Public health interventions are effective in preventing the incidence of toxic stress and in reducing its effects by strengthening protective factors.[10]

Yet, using public health approaches to address behavioral health in communities is uncommon, and the 2 fields often exist in silos. Recognizing the need for greater collaboration between public health and behavioral health, the American Public Health Association's Mental Health and Alcohol,

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This article was accepted May 5, 2018.
doi: 10.2105/AJPH.2018.304533

Tobacco, and Other Drugs sections focused on this issue during roundtable and headliner sessions at their annual meetings in 2016 and 2017. Several of the themes in this essay, including Public Health 3.0, the Affordable Care Act (ACA), community health needs assessments (CHNA), and public health accreditation are derived from discussions at these American Public Health Association events. As communities increasingly recognize the burden of mental health and substance use, now is the time for public health, and specifically local health departments (LHDs), to collaborate effectively with the behavioral health system.

The public health system is uniquely positioned to address the behavioral health needs of communities. Several new undertakings support collaboration between public health and behavioral health, most notably, population-based health initiatives in the ACA and the Public Health 3.0 movement. Population health principles, including population-based outcomes and universal insurance coverage, provide the structure and incentives for concentrating on population-level interventions. With more Americans insured, especially in states that are nearing universal coverage, payers have an incentive to invest in population-level strategies. Rather than focusing on strategies that reduce high end-of-life or short-term costs, in populations with near universal coverage, payers have a greater incentive to address the drivers of longitudinal costs through investments in prevention and early intervention programs. Two specific initiatives, accountable care organizations (ACOs) and CHNAs, serve as a foundation for promoting collaboration between behavioral health, LHDs, and health care payers, and they

incentivize population-level solutions that include behavioral health.

Although the ACA itself is in the cross fire of political debate, it is likely that ACOs or similar population-based delivery and payment system reform arrangements will continue to be a focus of the Centers for Medicare and Medicaid Services, states, payers, and providers. Along with population health principles, the Public Health 3.0 model provides a blueprint for a new era of public health practice and leadership that will need to include behavioral health collaboration to be fully effective. This model promotes 5 key recommendations that were outlined by the Office of the Assistant Secretary for Health in 2016:

1. cross-sector community partnerships,
2. actionable data and clear metrics,
3. enhanced funding,
4. investment by LHDs to be the chief health strategist (CHS) in communities, and
5. commitment to encouraging public health accreditation, a growing movement in the field to standardize the work of LHDs.[11]

These 5 recommendations demonstrate critical insight into the status of public health in the United States and are likely to be enduring.

Although each recommendation of the Public Health 3.0 model could be followed in the behavioral health sector's collaboration with LHDs, we focus primarily on the role of the CHS and the accreditation process. We use the recent introduction of 2 population health initiatives, ACOs and CHNAs, to demonstrate the opportunities that LHDs have to address behavioral

health, and we argue that accreditation of LHDs can foster collaboration.

LOCAL HEALTH DEPARTMENTS

To support LHDs in engaging population-level behavioral health agendas, it is important to first understand LHD perceptions of behavioral health and how they are currently involved in behavioral health activities. Purtle et al. developed an empirically derived conceptual framework of LHD engagement in population mental health through interviews with LHDs. They found that LHDs unanimously perceived that mental health was a public health issue and that their communities were calling on them to prioritize mental health. However, LHD engagement in behavioral health activities was found to be the exception and not the norm.[12]

A reported challenge to LHD collaboration with behavioral health was the LHDs' limited relationship with the local behavioral health authority (LBHA). The LBHA has typically been responsible for delivering direct clinical behavioral health services, whereas the LHD tends to be involved in population-level strategies.[12,13] In their qualitative study, Purtle et al. found that challenges to partnerships between LHDs and LBHAs included divergent perspectives about how to address behavioral health, incongruent financing arrangements that do not reward population-based initiatives, and administrative boundaries.[12] Purtle et al. identified several potential solutions to these challenges, including collaborations on delivery system reform incentive payment programs, LHDs' provision of

behavioral health services to partially offset the strain on LBHAs, LHDs' behavioral health surveillance and planning to inform LBHA services, and the adoption of accountable health communities.[12,13] Collaboration could be mutually beneficial to LHDs and LBHAs.

In a separate study quantifying the number of mental health activities performed by LHDs, Purtle et al. found that 55.8% of LHDs were performing at least 1 mental health activity and 21.2% were performing at least 4.[14] However, 44.2% of LHDs were not performing any activities related to mental health.[14] According to the 2016 Profile Study of LHDs, the percentage of LHDs engaged in population-based activities related to mental health was even less (20.3%) and about half that of LHDs that were engaged in activities for physical disease.[13,15] In a separate study, Purtle et al. used 8 categories to classify the activities that LHDs are currently performing.[16] In order of frequency, these mental health activities were

1. assessing access gaps to mental health services (39.3%),
2. implementing strategies to increase access to mental health services (32.8%),
3. implementing strategies to target the mental health service needs of underserved populations (25.8%),
4. evaluating strategies to target the mental health service needs of underserved populations (23.0%),
5. being involved in policy and advocacy to address mental health (18.5%),
6. performing population-based primary prevention activities to address mental health (16.4%),
7. providing mental health services (14.0%), and

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8. addressing access gaps by providing mental health services (13.9%).[16]

Recent changes in access to insurance and health care delivery systems have led to new opportunities to promote behavioral health collaboration with LHDs. The emergence of ACOs that organize delivery of care by population and new requirements for health systems to engage in CHNAs serve as a foundation for new incentives and opportunities for payers, health systems, and providers to collaborate to improve the longitudinal health of a population. This shift, together with Public Health 3.0 recommendations, provides an opportunity for increased collaboration between LHDs, local health care systems and hospitals, and LBHAs.

ACCOUNTABLE CARE ORGANIZATIONS

ACOs are networks of providers—usually centered on 1 or more hospitals in a health system—that are organized to serve a fixed population. If the members of the system work together to improve the management of the population attributed to them while improving quality, they benefit financially. A provision in the ACA called the Medicare Shared Savings Program allows the creation of ACOs to improve health outcomes and lower health care costs. Over a period of time, if the ACO reduces the current total costs compared with historical costs, the ACO shares in the savings. Several commercial insurance plans have created opportunities for providers to organize into ACOs, and several state Medicaid programs are developing ACO structures. ACOs create incentives for provider

systems to manage the population attributed to it. A common strategy is for an ACO to stratify and effectively manage high-cost patients, especially those with avoidable utilization of expensive services.[17]

Individuals with behavioral health conditions are among the most expensive consumers of health care services because of poverty, childhood stressors, and significant comorbidity with physical illnesses.[18] ACOs facilitate care coordination and integration across community and acute care settings and are a promising care model for improving health outcomes and lowering the health care costs of individuals with behavioral health conditions.[18–20]

Data from the National Survey of ACOs has shown that most ACOs have done little to incorporate behavioral health.[20] Data demonstrate that although most ACOs are responsible for the costs of behavioral health in their cost benchmarks, more than one third of ACOs have no formal relationship with behavioral health providers. Moreover, only 14% of ACOs currently have nearly complete or fully complete integration of behavioral health into their primary care services, and 43% report little to no integration. Quality metrics for behavioral health (e.g., depression screening) have been found to be sparse, but when they are implemented, they have a significant impact on where providers focus their efforts.[20]

The relationship between ACOs and LHDs is also tenuous. Despite shared language related to population health, LHDs often do not have formal roles as ACO partners, largely because at this early stage, most ACOs are developing processes and organization to meet regulatory cost and quality requirements and become financially viable.[21]

However, there are significant advantages to incorporating public health expertise into ACOs. As partners with deep connections to community agencies and to ACOs' most vulnerable patients and with expertise providing preventive services, surveillance data, and a broader policy lens, LHDs are poised to partner with ACOs to address the behavioral health needs of the community.[22] LHDs can provide the public health infrastructure for ACOs to implement population-based interventions and address social determinants of health. LHDs are equipped to conduct assessments of the community to help identify gaps in health services and in behavioral health services to inform ACO planning.[14] LHDs can also collaborate with behavioral health service providers to assist in the planning and provision of services. In fact, Purtle et al. found that 14% of LHDs are already engaged in this activity.[14] Because of these opportunities and others, ACOs and LHDs now have reasons to collaborate to improve population-based health and to implement prevention activities.

The Trillium Community Health Plan in Oregon, a type of Medicaid ACO called a coordinated care organization, is an example of an ACO–LHD partnership. There are 16 coordinated care organizations in Oregon that integrate behavioral health and physical health providers with a public health infrastructure to promote prevention and early intervention. To prevent future smoking and substance use, Trillium partnered with Lane County Health and Human Services to implement a prevention intervention in schools that have a high penetration of Medicaid beneficiaries. The partnership between Trillium and the LHD demonstrates how LHDs can

provide the public health infrastructure ACOs need to engage in population-level prevention.[23]

COMMUNITY HEALTH NEEDS ASSESSMENTS

Nonprofit hospitals are now required to conduct a CHNA every 3 years and must demonstrate that they have responded to the identified needs. As part of the assessment, nonprofit hospitals must consult community members with expertise in public health, which can include consulting with LHDs to assess population health needs.[24–26] Similarly, the LHD accreditation process that is led by the public health accreditation board (PHAB) requires that LHDs conduct a community health assessment and prepare a community health improvement plan as a prerequisite for accreditation.[27] The process of developing a CHNA and a health improvement plan provides an opportunity for nonprofit hospitals and LHDs to collaborate to promote behavioral health agendas for the community.[14,24–26]

LHDs that have a community health assessment are more likely to have programs in place to address the behavioral health needs of underserved populations in their communities.[14,28] Additionally, LHDs that include behavioral health as a component of the community health assessment can help identify gaps in services that should also be included in a hospital's CHNA.[14] Because both the CHNA and community health assessment identify community needs, these parallel processes are great opportunities for LHDs and hospitals to collaborate for the benefit

of the health and behavioral health of the population.[14]

CHIEF HEALTH STRATEGIST

One of the central tenets of Public Health 3.0 is the recommendation that LHD leaders serve as the community's CHS. In this role, the LHD can serve as an organizational hub to "convene and collect input from partners, mobilize funding, and drive action toward shared goals."[29] One of the most important functions of a CHS with particular relevance for behavioral health is its role in assembling community partners. One of the barriers to collective actions on behavioral health is a lack of formal working partnerships. As the CHS, LHDs can facilitate structure, role identification, timelines, and concrete mechanisms to organize and deploy resources.[29]

Stakeholders often cite siloed responsibility and funding as a barrier to collaboration between behavioral health and LHDs. The mantra "We don't do behavioral health; that is (insert agency)'s responsibility" is far too common in current public health practice.[30] Similarly, public health funding is often categorical and organized by program silos (e.g., HIV/AIDS, maternal and child health, obesity).[29] The role of LHDs as CHS presents an opportunity to bridge these behavioral health silos and encourage behavioral health stakeholders to work toward having a collective impact. These collaborations ideally convene traditional and nontraditional partners in behavioral health to catalyze cross-sector partnerships. New partnerships that the CHS could facilitate include health care providers, education officials, employers, elected officials, faith-based organizations, transportation authorities, law enforcement organizations, child welfare organizations, and housing authorities.

An example of an LHD that is using a collaborative model for behavioral health is the New Orleans Health Department, in New Orleans, Louisiana, which recently formed the Behavioral Health Council, a board of public and private community partners that focuses on facilitating cross-sector partnerships and coordinating behavioral health services.[31] The council is staffed by the health department but includes members from the criminal justice, housing, education, and health care sectors. Along with fostering partnerships and coordinating services, the Behavioral Health Council works to assess the performance of the system for policy and programmatic purposes, collect and review system-level data, provide behavioral health training to community agencies, organize managed behavioral health care, and increase the leadership capacity of the behavioral health community.[31] This model demonstrates the importance of convening community partners in a formal organizational structure to develop behavioral health strategies.

PUBLIC HEALTH ACCREDITATION

The role and functions of LHDs vary considerably throughout the United States, and accreditation has been developed as a process that creates a common framework for performance and reduces inconsistency across the country.[32] Public Health 3.0's goal is to have all Americans served by an accredited LHD. According to the PHAB, accredited departments now serve more than 198 million Americans, or 64% of the population.[33]

Although the impact of accreditation on LHDs is not yet fully understood, a few studies have demonstrated promising results. LHDs that have completed accreditation report that the process—identifying strengths and areas of improvement and strengthening internal and external partnerships—acted as a stimulus for continuous quality improvement and improved management processes, improved their ability to deliver the 10 essential public health services, strengthened competitiveness for funding opportunities, and improved communication with the governing entity.[34–36] Including behavioral health in the accreditation process could facilitate applying these accreditation benefits to behavioral health systems, including helping LHDs identify behavioral health areas of strength and improvement, strengthening partnerships with community behavioral health providers and stakeholders, and improving communication with state behavioral health agencies. Along with these positive results, there is heightened interest among LHDs to pursue accreditation.

Accreditation is an important emerging trend in public health practice. Until recently, the PHAB did not accept mental health or substance use activities as supporting evidence for accreditation. However, in 2015, the PHAB announced that it would begin accepting some population-based prevention, health protection, and health promotion activities that address substance use and mental health as examples for accreditation.[37] Although the PHAB intends to allow population-based behavioral health services, as of the time of this writing, this is not reflected in the PHAB standards and measures. An updated version of the standards and measures with the inclusion of behavioral health is needed. Moreover, an update of the "Community Guide-Public Health Accreditation Board Standards Crosswalk" is needed to include more examples of how behavioral health activities can meet the standards and measures for accreditation. The National Association of County and City Health Officials and the CDC produced the Crosswalk to help LHDs identify evidence-based interventions that meet accreditation standards.[38]

There are currently few examples of behavioral health activities in this guide. An updated list of behavioral health interventions that meet PHAB standards could encourage LHDs to adopt behavioral health strategies. Finally, the PHAB has used programmatic-based think tanks or discussion meetings to bring together experts in the field to design and evaluate accreditation measures in various categories.[39] Think tanks topics have included emergency preparedness, chronic diseases, maternal and child health, environmental health, health equity, and primary care; however, to our knowledge, no think tanks have been held on behavioral health.[39] The PHAB should consider sponsoring such a meeting to evaluate the role of behavioral health promotion in accreditation.

In Table 1, we demonstrate how several behavioral health activities conducted by LHDs could count toward many of the PHAB accreditation standards. We have listed behavioral health

TABLE 1—How Behavioral Health Efforts Could Be Incorporated Into the Accreditation Process

Domain	Examples of Selected Standard	Initiative
Domain 1: Conduct and disseminate assessment focused on population health status and public health issues facing the community	Standards 1.2: Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population Standard 1.4: Provide and use the results of health data analysis to develop recommendations regarding public health policy, processes, programs, or interventions	Healthy Baltimore 2015, in Baltimore, MD, includes sections specifically focused on mental health and substance use disorders
Domain 2: Investigate health problems and environmental public health hazards to protect the community	Standard 2.1: Conduct timely investigations of health problems and environmental public health hazards	Alcohol Outlet Density Report 2011 Findings: "All the studies showed a positive association between the presence and density of alcohol outlets and violent crime in U.S. cities with > 200,000 population" (p. 1)
Domain 3: Inform and educate about public health issues and functions	Standard 3.1: Provide health education and health promotion policies, programs, processes, and interventions to support prevention and wellness Standard 3.2: Provide information on public health issues and public health functions through multiple methods to a variety of audiences	Don't Die campaign—a public education campaign designed to prevent opioid overdoses through public awareness and teaching people how to administer naloxone
Domain 4: Engage with the community to identify and address health problems	Standard 4.1: Engage with the public health system and the community in identifying and addressing health problems through collaborative processes Standard 4.2: Promote the community's understanding of and support for policies and strategies that will improve the public's health	Convened the Baltimore City Intergenerational Initiatives for Trauma and Youth (B-CIITY) Coalition, which elected a community board that will serve in a leadership and advisory capacity
Domain 6: Enforce public health laws	Standard 6.2: Educate individuals and organizations on the meaning, purpose, and benefit of public health laws and how to comply	Baltimore's synthetic drug ban
Domain 7: Promote strategies to improve access to health care	Standard 7.2: Identify and implement strategies to improve access to health care services	Launched a new, single telephone number for Baltimore City residents to use for substance use and mental health crisis calls, services and treatment, and information
Domain 9: Evaluate and continuously improve processes, programs, and interventions	Standard 9.2: Develop and implement quality improvement processes integrated into organizational practice, programs, processes, and interventions	Healthy Baltimore 2015: initial report, interim status report, and status report

Note. Domains 5, 8, 10, 11, and 12 focus on internal procedures and policies and have been excluded.

programs sponsored by the Baltimore City Health Department in Baltimore, Maryland. By reviewing programs that were publicly available on the LHD Web site, we were able to easily find examples of LHD work in behavioral health for each of the 10 programmatic domains. This demonstrates the applicability of behavioral health to every pertinent accreditation domain. Accreditation can play a significant role in encouraging LHDs to adopt behavioral health activities and in rewarding LHDs that are already engaged in these activities.

PUTTING IT ALL TOGETHER

As communities increasingly recognize the burden of mental health problems and substance abuse, now is the time for LHDs to increase their role in behavioral health prevention and promotion. Population-based behavioral health work must extend beyond traditional medical models that focus on diagnosis and treatment and adopt approaches that include epidemiological surveillance, community planning and cross-sector partnerships, disability prevention, and access to services.[2] As LHDs become increasingly involved in population behavioral health, public health practitioners and health systems researchers will need to become partners in studying the effectiveness of these efforts. Future directions for research include rigorous evaluation of the accreditation process, including its impact on behavioral health initiatives; evaluation of the impact of shared funding sources on collaboration between LHDs, LBHAs, health delivery systems, and ACOs; and evaluation of collective impact models and convening efforts by LHDs.

LHDs have considerable opportunities to engage in

population-based work in behavioral health. As the CHS in communities, LHDs have the opportunity to be behavioral health conveners by bringing community stakeholders together to identify areas of collaboration. The LHD can partner with ACOs to identify the behavioral health needs of their population and provide the public health infrastructure ACOs and other groups of providers need to engage in population-level health activities. In surveying the behavioral health landscape of communities, LHDs can provide leadership by producing epidemiological and behavioral health service utilization reports to help identify gaps in services. This process could be strengthened by partnerships with nonprofit hospitals as they conduct CHNAs. Moreover, the LHD can respond to these identified needs by implementing population-based initiatives.

Such initiatives could include a suicide-prevention campaign, a program to expand access to a full continuum of opioid addiction treatments with system-level metrics of access and quality, a project to reduce homelessness among individuals with serious mental illness by establishing assertive community treatment teams, a program to coordinate housing-first strategies, an anti-stigma campaign, a trauma-informed educational program for middle school and high school students, and a violence-prevention program aimed at intimate partner or sexual violence in communities. Although providing direct clinical services is not in the purview of most LHDs, it is important for LHDs to work with existing community providers and LBHAs to strengthen these services.

Because our nation's greatest public health challenges increasingly involve behavioral health conditions, LHDs are uniquely positioned, and must respond, to the evolving needs of their communities. Public Health 3.0 offers a critical blueprint for meeting these challenges and is likely to be enduring as it is adopted by the public health workforce, localities, and key stakeholders in an era of LHD accreditation. An LHD that embraces these initiatives and leads preventive, population-based behavioral health interventions will be positioned to address the health and wellness of their communities well into the future. AJPH

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