

Master of Public Health
Integrated Learning Experience Report

***Bridging a gap in care: An integrated public health and
Certified Community Behavioral Health Clinic (CCBHC)
model to increase access***

by

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submitted in partial fulfillment of the requirements for the degree

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Summary/Abstract

Integrated care in outpatient settings aims to address fragmentation between physical and behavioral health by coordinating services around the whole person. This Integrated Learning Experience (ILE) focused on the development and implementation of an integrated care model between Lawrence-Douglas County Public Health (LDCPH) and Bert Nash Community Mental Health Center (Bert Nash), a Certified Community Behavioral Health Clinic (CCBHC). Guided by the Comprehensive Health Integration (CHI) framework from the National Council for Mental Wellbeing, the project spanned nearly two years and moved deliberately from planning to implementation.

During 2024, the work centered on leadership engagement, workflow development, and creation of the legal infrastructure necessary for integration. Biweekly leadership meetings maintained steady momentum and culminated in the execution of a Designated Collaborating Organization (DCO) Agreement and an Organized Health Care Arrangement (OHCA). These agreements formalized LDCPH's role in providing defined outpatient primary care services on behalf of Bert Nash, established privacy and data-sharing standards compliant with the Health Insurance Portability and Accountability Act (HIPAA) and 42 Code of Federal Regulations (CFR) Part 2, and clarified billing and compensation methodologies to support sustainability.

The transition to implementation began on January 1, 2025, when LDCPH started seeing Bert Nash clients under the DCO framework. Co-location of Bert Nash staff at LDCPH facilitated warm handoffs, and LDCPH gained view-only access to the Bert Nash electronic health record (EHR), enabling better care coordination. Monthly updates to the LDCPH Health Board, ongoing leadership meetings, and the launch of an EHR/billing workgroup supported oversight and continuous quality improvement (CQI). By summer 2025, integration had extended to the front lines through twice-monthly provider meetings, the development of standard operating procedures (SOPs), creation of text macros and order sets, and additional provider training.

Early clinical outcomes underscore the model's potential. Clients disconnected from primary care were re-engaged and diagnosed with unmanaged hypertension, which was successfully treated and stabilized through structured follow-up. Registered dietitian consultations led to weight management successes, with improvements in nutrition and energy that supported overall treatment engagement. A psychiatric nurse practitioner provided street medicine in shelters and field settings, meeting clients where they were and reducing barriers to care access. These examples demonstrate how integration can improve outcomes for high-

need populations while aligning with public health goals of prevention, equity, and whole-person care.

Challenges remain in harmonizing separate EHR systems, sustaining workforce capacity, and navigating cultural differences between public health and behavioral health practice. However, the governance structure (monthly high-level meetings, twice-monthly provider forums, and workgroups dedicated to referrals and billing) provides reliable mechanisms for addressing obstacles. Financial sustainability is supported by a blended capitation and per-visit reimbursement model, with rebasing scheduled in 2026 to align with service demand.

This project illustrates how public health and behavioral health organizations can operationalize integration through deliberate planning, legal frameworks, and practical clinical tools. It demonstrates that integration is not simply a policy aspiration but a functional model capable of producing measurable health improvements. Future directions include formalizing nutrition integration, expanding linkages with family support and the Special Supplemental Program for Women, Infants, and Children (WIC) programs, exploring an embedded primary care panel at LDCPH, and assessing the feasibility of pursuing Federally Qualified Health Center (FQHC) Look-Alike status. Together, these efforts represent a sustainable path to advancing population health and equity through integrated care.

Subject Keywords: Integrated care, public health, certified community behavioral health clinic (CCBHC), primary care integration, Comprehensive Health Integration (CHI), chronic care management

Table of Contents

Summary/Abstract	iii
List of Figures	2
List of Tables	2
Chapter 1 - Literature Review	3
Chapter 2 - Learning Objectives and Project Description	14
Chapter 3 - Results	15
Chapter 4 - Discussion.....	24
Chapter 5 - Competencies	27
Student Attainment of MPH Foundational Competencies	27
Student Attainment of MPH Emphasis Area Competencies	32
References	35
Appendices	39
Appendix 1: Standard Operating Procedures (SOPs).....	39
Appendix 2: Process Map	46

List of Figures

Figure 3-1 DCO Agreement Exhibit A	16
Figure 3-2 Co-location of Services	18
Figure 3-3 Example of Health Board Update	19
Figure 3-4 DCO Agreement Exhibit B	21
Figure 3-5 DCO Agreement Exhibit C	22

List of Tables

Table 5.1 Summary of MPH Foundational Competencies	27
Table 5.2 MPH Foundational Competencies and Course Taught In	31
Table 5.3 Summary of MPH Emphasis Area Competencies.....	32

Chapter 1 - Literature Review

Integrated Learning Experience activities were completed at Lawrence-Douglas County Public Health (LDCPH), located in Lawrence, Kansas, under the mentorship of Jonathan Smith, MPH, Executive Director. LDCPH was established in 1942 through a joint resolution between the City of Lawrence and Douglas County and is one of only two city-county health departments in Kansas. The department's mission, "Creating abundant and equitable opportunities for good health," and vision, "Leading change to advance health for all," guide its commitment to advancing policies, practices, and programs that protect health, prevent disease, and promote equity.

A key focus area for LDCPH has been expanding preventive services by improving access to care. In January 2024, LDCPH joined a national learning collaborative through the National Council for Mental Wellbeing to implement the CHI Framework in partnership with Bert Nash Community Mental Health Center. Bert Nash Community Mental Health Center (Bert Nash) serves as Douglas County's Certified Community Behavioral Health Clinic (CCBHC), providing safety-net access to behavioral health services.

As part of the CCBHC model, Bert Nash is required to incorporate physical health services through integrated and coordinated care. To fulfill this requirement, LDCPH and Bert Nash established the first Designated Collaborating Organization (DCO) Agreement between a CCBHC and a local public health department in Kansas. Under this agreement, LDCPH provides physical health exams, chronic disease management, medication management, and preventive services for Bert Nash clients.

Work completed during the Integrated Learning Experience (ILE) supported the operationalization of this integrated care model through the development of procedural documents, communication tools, and program alignment with evidence-based best practices. These products demonstrated leadership, systems thinking, and applied public health management in advancing integrated care within a local public health context.

Literature Review

I. Introduction

Integrated care in outpatient settings is the deliberate coordination of physical health, behavioral health, and social care services to address comprehensive needs for individuals and populations (Goodwin, 2016). Unlike fragmented approaches where medical and behavioral health providers operate in isolation, integrated care emphasizes collaboration, shared information, and whole-person care by aligning clinical, organizational, and financing elements

to improve outcomes and experience (Valentijn et al., 2013, 2015). Outpatient contexts, such as primary care clinics, community health centers (CHCs), public health departments, community mental health centers (CMHCs), and certified community behavioral health clinics (CCBHCs) are common entry points into the health system making them important settings for integration and prevention (Valentijn et al., 2013; Goodwin, 2016; Druss et al., 2010; Breslau et al., 2018; Brown et al., 2023; Wishon et al., 2023; Allen et al., 2024).

Integration accelerated in the United States during the past two decades as policymakers recognized avoidable morbidity and costs associated with fragmented systems (Croft & Parish, 2013). The Affordable Care Act (ACA) catalyzed payment and delivery reforms, including health homes, accountable care organizations (ACOs), and Patient-Centered Medical Homes (PCMHs), that incentivized team-based care and care coordination (Croft & Parish, 2013). In parallel, behavioral health integration grew through the Collaborative Care Model (CoCM), supported by evidence and, later, Medicare billing codes that reimbursed psychiatric consultation and care management embedded in primary care (Archer et al., 2012). The Certified Community Behavioral Health Clinic (CCBHC) initiative further expanded access to comprehensive outpatient behavioral health with primary-care screening and coordination, with peer-reviewed studies linking CCBHC participation to lower behavioral health emergency department visits compared with non-CCBHC settings (Brown et al., 2023; Wishon et al., 2023).

The rationale for integration is compelling: fragmented systems contribute to undertreatment, poor coordination, and avoidable morbidity, particularly among people with co-occurring behavioral and physical health conditions (McGinty & Daumit, 2020). Adults with serious mental illness (SMI) experience 10-20 years of premature mortality primarily due to cardiometabolic disease and other chronic conditions that historically go underdiagnosed and undertreated in specialty mental health care (Fortuna et al., 2020). Integrated outpatient models address these failures by co-locating services, building multidisciplinary teams, and aligning incentives around prevention and chronic disease management, including nutrition, physical activity, and medication adherence within routine care (Possemato et al., 2018; Staab et al., 2021; Katon et al., 2010; Daumit et al., 2013; Green et al., 2015). Systematic reviews and meta-analyses consistently demonstrate better depression and anxiety outcomes with collaborative care (Archer et al., 2012) and suggest reductions in hospitalizations and costs as programs mature (Rocks et al., 2020). In behavioral health-anchored settings, embedding primary care improves monitoring and treatment initiation for diabetes, hypertension, and other physical conditions (Breslau et al., 2018; Druss et al., 2010). For conditions where nutrition is central (obesity, diabetes, dyslipidemia, etc.) integrated teams that include dietitians and behavioral

interventions show clinically meaningful benefits in SMI and primary care patient populations (Daumit et al., 2013; Green et al., 2015; Katon et al., 2010).

This literature review provides a synthesis of peer-reviewed evidence on integrated care models within outpatient settings. The analysis is framed by the Comprehensive Health Integration (CHI) framework (National Council for Mental Wellbeing, 2021) to provide a structured understanding of current practices and outcomes.

II. Conceptual Frameworks for Integrated Care

The CHI framework, developed by the National Council for Mental Wellbeing (2021) with Substance Abuse and Mental Health Services (SAMHSA) support, is a practice-oriented roadmap that specifies staged, bidirectional integration of physical and behavioral health across multiple domains: clinical delivery and care pathways; patient and family engagement; workforce and training; health information technology (HIT) and data; quality improvement; and financing/sustainability (National Council for Mental Wellbeing, 2021). The CHI framework emphasizes progression along an integration continuum, from foundational screening and referral to fully embedded services, and explicitly centers whole-person care, including routine screening and management of hypertension, diabetes, obesity, tobacco use, and nutrition-related risks within behavioral health and primary care settings (National Council for Mental Wellbeing, 2021). The framework aligns with evidence-based models (e.g., CoCM, behavioral health homes) and provides self-assessment tools that map organizational maturity across domains, making it especially actionable for outpatient programs and public health partners (National Council for Mental Wellbeing, 2021).

While the CHI framework is not a peer-reviewed model itself, its principles are consistent with the established, peer-reviewed research on effective integrated care structures and processes. Its distinctive contribution for practice is to synchronize evidence across domains, including financing and HIT, that are often omitted from clinical trial reports yet are important for sustainability in real-world outpatient systems (Goodwin, 2016; Valentijn et al., 2015; Rocks et al., 2020).

In community mental health centers, reverse integration, embedding primary care within behavioral health improves monitoring and some quality indicators for physical conditions (Breslau et al., 2018; Druss et al., 2010). Certified Community Behavioral Health Clinic (CCBHC), a federally supported certification for comprehensive behavioral health clinics, are associated with broader service arrays relative to non-CCBHC community clinics and reduced

behavioral health emergency department (ED) visits in demonstration states (Brown et al., 2023; Wishon et al., 2023).

III. Implementation in Outpatient Settings

Community Health Centers have established integration by embedding behavioral health in primary care, typically combining Primary Care Behavioral Health (PCBH) for rapid access with the CoCM for systematic follow-up of higher-acuity patients (Archer et al., 2012; Possemato et al., 2018). Implementation research describes a staged trajectory: initiating with co-location and shared screening workflows; progressing to shared EHR documentation and team huddles; and maturing into measurement-based care with registries and quality dashboards (Staab et al., 2021). Nutrition and chronic disease management are often integrated through medical nutrition therapy (MNT) provided by registered dietitians, group visits for diabetes/weight management, tobacco cessation services, and collaborative goal-setting that links mental health symptom trajectories with behavior-change plans (Buchanan et al., 2024; Daumit et al., 2013). For example, CHC teams use Patient Health Questionnaire-9 (PHQ-9)/General Anxiety Disorder-7 (GAD-7) alongside hemoglobin A1c (A1c), blood pressure (BP), body mass index (BMI), and lipid panels to tailor stepped interventions that include behavioral activation, problem-solving therapy, and diet/activity counseling (Katon et al., 2010; Green et al., 2015).

Peer-reviewed empirical literature on direct integration inside local health department clinics is comparatively limited, yet public health-primary care integration is conceptually well-described: joint surveillance, aligned prevention programs, shared data, and collaborative chronic disease management (Goodwin, 2016; Valentijn et al., 2015). In practice, health departments frequently co-locate immunization, sexually transmitted infection (STI) testing/treatment, tuberculosis (TB) screening, the Special Supplemental Program for Women, Infants, and Children (WIC), and family planning with primary care partners, creating one-stop access points (Allen et al., 2024). Leveraging CHI, health departments can formalize clinical pathways (e.g., bidirectional referral protocols with CHCs and CCBHCs), embed nutrition and tobacco-cessation services in behavioral health visits, and use shared performance dashboards (e.g., depression remission rates; A1c control among patients with co-occurring depression) (National Council for Mental Wellbeing, 2021; Katon et al., 2010). Public health nurses and community health workers (CHWs) are uniquely positioned to bridge medical and social needs, screening for food insecurity and coordinating with community resources, thus operationalizing CHI's patient/family engagement and social care elements in outpatient settings (Buchanan et al., 2024; Allen et al., 2024).

Reverse integration in behavioral health settings addresses stark cardiometabolic disparities for individuals with SMI (Fortuna et al., 2020). Randomized and quasi-experimental studies show that adding medical care management and/or embedded primary care within CMHCs increases receipt of preventive and chronic disease services and can reduce acute medical utilization (Druss et al., 2010; Breslau et al., 2018). Certified Community Behavioral Health Clinics advance this model by mandating comprehensive primary care screening, coordinated service delivery, and standardized quality reporting (Wishon et al., 2023). Peer-reviewed studies have linked CCBHC implementation to broader service capacity and reductions in behavioral health-related emergency department visits (Brown et al., 2023; Wishon et al., 2023). Implementation elements include nursing-led metabolic monitoring for antipsychotic-treated patients, tobacco treatment integration, and onsite or closely linked MNT and exercise programs (McGinty & Daumit, 2020). Trials of lifestyle interventions in SMI populations, such as ACHIEVE and STRIDE, demonstrate clinically meaningful weight loss and cardiometabolic risk reduction when behavioral strategies are paired with structured nutrition and activity supports in outpatient behavioral health contexts (Daumit et al., 2013; Green et al., 2015).

Integration Strategies

Physical proximity enables same-day introductions between behavioral and medical colleagues, reducing referral leakage, fragmentation, and stigma associated with seeking behavioral health services in separate locations (Possemato et al., 2018). Co-location increases opportunities for informal consultation and team communication, but evidence suggests it is necessary but not sufficient for meaningful integration (Archer et al., 2012; Woltmann et al., 2012; Possemato et al., 2018). Outcomes improve when co-location is paired with structured workflows, defined referral protocols, and joint case review processes that ensure care transitions are timely and coordinated (Archer et al., 2012; Woltmann et al., 2012). Regular team huddles and interdisciplinary case discussions are associated with stronger treatment adherence, improved chronic disease management, and higher patient satisfaction (Archer et al., 2012; Woltmann et al., 2012).

Core elements of effective integration include clearly defined staff roles, such as care managers, navigators, and embedded behavioral health specialists, supported by standardized workflows and shared registries that enhance coordination (Archer et al., 2012; Woltmann et al., 2012). These structures promote accountability and enable proactive management of both behavioral and physical health needs by ensuring that every client has a clear point of contact for follow-up (Katon et al., 2010; McGinty & Daumit, 2020). Population registries that track

metrics such as A1c, blood pressure (BP), low-density lipoprotein (LDL), and BMI allow for real-time identification of clients needing outreach or treatment adjustment (Katon et al., 2010; Woltmann et al., 2012; McGinty & Daumit, 2020). When integrated systems flag abnormal results through alerts or dashboards, care teams can respond with stepped treatment intensification, medication titration, or referrals to registered dietitians for targeted nutrition therapy (Katon et al., 2010). This proactive approach prevents clinical deterioration, reduces duplication of services, and aligns with population health management principles that emphasize prevention and early intervention (Woltmann et al., 2012; McGinty & Daumit, 2020).

Functional integration, through shared documentation, care plans, and quality dashboards, creates continuity across disciplines and organizations by ensuring that information follows the patient rather than remaining siloed within departments (Valentijn et al., 2015). These tools allow both behavioral and medical teams to view progress, adjust interventions collaboratively, and ensure that care remains patient-centered and coordinated (Valentijn et al., 2015). Privacy and regulatory safeguards are essential in these models, particularly when substance use disorder records are involved, given the sensitive nature of information governed by the Health Insurance Portability and Accountability Act (HIPAA) and 42 Code of Federal Regulations (CFR) Part 2 (O'Donnell et al., 2011). Consent workflows, shared problem lists, medication reconciliation, and lab result integration remain foundational for safe outpatient integration, promoting both patient safety and legal compliance (O'Donnell et al., 2011). In addition, standardized templates and communication protocols facilitate consistent data capture across sites, improving quality reporting and compliance with payer and federal requirements (Valentijn et al., 2015; National Council for Mental Wellbeing, 2021). These functional tools translate policy and compliance frameworks into tangible, daily practices that sustain integration across systems (Valentijn et al., 2015).

Workforce development is another central strategy for integration, as staff capacity and training determine the success of coordinated models (Fortuna et al., 2020). Primary care teams benefit from training in brief behavioral interventions, motivational interviewing, and patient-centered counseling to address nutrition and physical activity within medical visits (Fortuna et al., 2020). Conversely, behavioral health providers gain from training in cardiometabolic risk identification, tobacco cessation, and the physiological impacts of psychotropic medications, allowing them to detect and respond to emerging medical concerns during behavioral visits (Fortuna et al., 2020). Cross training expands the skill set of both professions and ensures that clients receive consistent, whole-person guidance regardless of their entry point into care (Fortuna et al., 2020). Interprofessional education, joint supervision, and team shadowing

further foster shared values, trust, and mutual understanding of each discipline's contributions, which are linked to stronger implementation fidelity and more cohesive care (Valentijn, 2016). Over time, this kind of interprofessional collaboration helps shift organizational culture toward collective accountability for outcomes rather than discipline-specific performance (Valentijn, 2016).

Financial structures remain critical determinants of whether integration efforts are sustained, as the ability to fund coordination and data systems determines long-term viability (Kathol et al., 2010). Fee-for-service reimbursement models often fail to cover the non-billable activities that underpin team-based care, such as case management, registry maintenance, and case conferencing (Kathol et al., 2010). As a result, many programs rely on hybrid financing mechanisms to sustain integrated operations, leveraging multiple revenue streams to offset funding gaps (Bao et al., 2015; Brown et al., 2023). These include capitated payments that reward efficiency, shared-savings contracts through ACOs, CoCM billing codes, prospective payment for CCBHCs, and grant support (Bao et al., 2015; Brown et al., 2023). The CHI framework explicitly emphasizes aligning financing structures with population health outcomes, encouraging local agencies to design payment models that incentivize prevention, quality improvement, and care coordination rather than service volume (National Council for Mental Wellbeing, 2021). Sustainable funding allows integrated programs to invest in data systems, cross-training, and continuous quality improvement (CQI) infrastructure necessary for long-term success (Kathol et al., 2010; National Council for Mental Wellbeing, 2021).

Collectively, the above strategies create the conditions under which integration can thrive (Valentijn et al., 2015; Fortuna et al., 2020; Kathol et al., 2010; Bao et al., 2015; National Council for Mental Wellbeing, 2021). When implemented together, they transform separate services into cohesive systems capable of delivering coordinated, equitable, and patient-centered care across physical and behavioral health domains (Valentijn et al., 2015; National Council for Mental Wellbeing, 2021).

IV. Outcomes of Integrated Care

Clinical Outcomes

Collaborative care consistently improves depression and anxiety outcomes versus usual care across short- and longer-term horizons, with moderate effect sizes and improved remission rates (Archer et al., 2012; Woltmann et al., 2012). Primary care behavioral health (PCBH) studies show improvements in functioning and access with more heterogeneous symptom effects (Possemato et al., 2018). In primary care, Katon et al. (2010) demonstrated that

integrated depression care combined with proactive management of diabetes and cardiovascular risk achieved better glycemic control and BP compared with usual care. In behavioral health-anchored settings, embedding medical care increased monitoring and treatment intensity for diabetes and hypertension (Breslau et al., 2018; Druss et al., 2010).

Randomized trials in SMI populations indicate that structured behavioral weight-loss programs embedded in outpatient behavioral health achieve clinically meaningful weight loss (e.g., ACHIEVE) and improvements in cardiometabolic risk (Daumit et al., 2013; Green et al., 2015). These programs integrate nutrition counseling, skills training, and activity support – components readily aligned with CHI's clinical delivery and workforce domains (McGinty & Daumit, 2020).

Integration is theorized to improve population health when implemented at scale with registries, community partnerships, and social determinants of health (SDOH) workflows (Goodwin, 2016; Valentijn et al., 2015). In safety-net contexts, integrated models help reduce disparities in chronic disease processes (e.g., increased metabolic monitoring among antipsychotic-treated patients; higher rates of tobacco treatment), with downstream potential to narrow gaps in outcomes over time (Breslau et al., 2018; Fortuna et al., 2020).

A meta-analysis of integrated care programs found lower total costs and better outcomes on average, with stronger effects in studies ≥ 12 months (Rocks et al., 2020). In behavioral health-anchored settings, integration has been associated with reductions in emergency and inpatient utilization for physical conditions (Druss et al., 2010) and with lower behavioral health ED visits in CCBHC demonstration states (Brown et al., 2023). Economic gains likely accrue through avoided crises and improved chronic disease control; however, savings may take time to manifest and depend on payment models that reward prevention (Rocks et al., 2020; Bao et al., 2015; Kathol et al., 2010). Patients report higher satisfaction and perceived coordination in integrated clinics, citing convenience, reduced stigma, and consistent messaging from a unified team (Possemato et al., 2018; Goodwin, 2016). Patient-reported outcomes improve when programs incorporate self-management support and shared decision-making, core elements of CoCM/chronic care management, and when nutrition and lifestyle services are embedded rather than referred out (Woltmann et al., 2012; Katon et al., 2010; Daumit et al., 2013; Green et al., 2015).

V. Special Populations and Equity Considerations

Integrated care mitigates access gaps in rural settings by co-locating services in primary care and leveraging telehealth (Bolin et al., 2015). Reviews of tele-mental health show

diagnostic and treatment outcomes comparable to in-person care, supporting its role in rural integration (Hilty et al., 2013). Embedding nutrition counseling via telehealth group visits or asynchronous education can extend reach where dietitians are scarce, aligning with CHI's workforce and HIT domains (Batsis et al., 2020).

For individuals with SMI, integrated outpatient models address cardiometabolic disparities through systematic screening, tobacco treatment, and access to MNT and exercise programs (Fortuna et al., 2020). Weight-loss and lifestyle trials demonstrate that when nutrition interventions are delivered in tandem with behavioral strategies inside routine care, outcomes improve more than with referral alone (Daumit et al., 2013; Green et al., 2015). Medical care management in CMHCs also increases uptake of preventive services and chronic disease follow-up (Druss et al., 2010; Breslau et al., 2018).

Peer-reviewed frameworks emphasize functional and normative integration with community resources, food assistance, housing, transportation, as essential to equity (Valentijn et al., 2015; Goodwin, 2016). The CHI framework operationalizes this by recommending standardized SDOH screening, closed-loop referrals, and partnerships with community-based organizations (National Council for Mental Wellbeing, 2021). Addressing food insecurity is particularly germane to nutrition-sensitive conditions; integrating referrals to produce prescription programs, food pantries, or medically tailored meals into care plans can enhance adherence and metabolic control in outpatient populations (Berkowitz et al., 2019). Equity-oriented integration requires culturally responsive care, language access, and CHWs/peer specialists who can bridge trust gaps (Chin et al., 2012; Kangovi et al., 2018). Shared decision-making and culturally adapted nutrition counseling are crucial for sustained behavior change across diverse populations; these align with CHI's patient/family engagement and workforce domains and with Rainbow Model of Integrated Care's (RMIC's) normative integration (Resnicow et al., 2019; Peek et al., 2016; National Council for Mental Wellbeing, 2021; Valentijn, 2016).

VI. Gaps in the Literature

Despite strong evidence that nutrition and exercise interventions benefit patients, especially those with SMI, the literature remains thin on systematic, sustained integration of dietitians and structured lifestyle programs inside outpatient behavioral health and primary care, and on payment models that support them (Daumit et al., 2013; Green et al., 2015). Research should examine scalable, reimbursable models (e.g., group visits, tele-MNT) within integrated teams.

While depression outcomes and some chronic disease/process improvements are well-supported, fewer studies track outcomes beyond 24 months, limiting understanding of durability and total cost impact (Rocks et al., 2020). Longitudinal evaluations are needed to assess effects on complications (e.g., myocardial infarction, stroke) and mortality.

VII. Conclusion

Integrated care in outpatient settings has emerged as a critical response to the persistent fragmentation of health and social services in the United States. Across primary care clinics, CHCs, public health departments, CMHCs, and CCBHCs, evidence demonstrates that integration improves mental and physical health outcomes, enhances patient experience, and holds promise for reducing disparities and long-term costs (Archer et al., 2012; Druss et al., 2010; Brown et al., 2023). The CHI framework provides a practical roadmap that complements peer-reviewed models by synchronizing clinical delivery, workforce training, HIT, financing, and patient engagement, making it actionable for real-world implementation (National Council for Mental Wellbeing, 2021; Valentijn et al., 2015).

The review highlights that integrated outpatient models consistently improve depression and anxiety outcomes, strengthen monitoring and treatment of chronic conditions such as diabetes and hypertension, and enhance patient-reported outcomes when nutrition and lifestyle services are embedded within care pathways (Katon et al., 2010; Daumit et al., 2013; Green et al., 2015). These findings underscore that integration is not limited to behavioral health or medical management alone, but is most effective when whole-person strategies, including nutrition counseling, physical activity supports, and self-management tools, are fully integrated into care teams.

Equity considerations remain central. Integrated models in rural and underserved settings leverage telehealth and co-location to reduce access gaps, while CHWs, peer specialists, and culturally tailored interventions strengthen trust, engagement, and sustainability in diverse populations (Kangovi et al., 2018; Chin et al., 2012). Integration that explicitly addresses SDOH, including food insecurity, housing, and transportation, has the potential to reduce disparities in nutrition-sensitive conditions such as diabetes and obesity through embedded referrals and partnerships with community-based organizations (Berkowitz et al., 2019).

Despite progress, gaps remain. Longitudinal studies of integrated care are still limited, particularly regarding durability of outcomes, cost savings beyond two years, and integration of nutrition services within behavioral health (Rocks et al., 2020). Research on scalable and

reimbursable models such as group medical visits and tele-MNT is urgently needed to inform sustainable financing structures (McGinty & Daumit, 2020).

Overall, this review supports that integrated care in outpatient settings improves outcomes and aligns with public health goals of prevention, equity, and chronic disease management. The CHI framework provides a unifying structure that bridges evidence and practice by addressing domains often overlooked in clinical trials, such as financing and HIT. For public health and clinical leaders, adopting CHI-guided strategies offers a path to create equitable, whole-person, sustainable systems of care that reduce fragmentation, improve access, and advance population health.

Chapter 2 - Learning Objectives and Project Description

Learning Objectives

1. Engage with the Comprehensive Health Integration (CHI) framework: Build knowledge of the CHI framework, developed by the National Council for Mental Wellbeing, including its core domains, assessment process, and role in guiding sustainable integrated care models.
2. Apply the CHI Framework in Practice: Translate the CHI assessment into operational strategies by aligning findings with LDCPH's partnership with Bert Nash, creating a shared roadmap for integration.
3. Explore Structural Pathways to Implementation: Examine organizational and contractual mechanisms that enable integration, including the Designated Collaborating Organization (DCO) Agreement and the Organized Health Care Arrangement (OHCA) Agreement between LDCPH and Bert Nash.
4. Advance Integrated Physical and Mental Health Care: Contribute to the development of workflows that operationalize integrated care, including the incorporation of medical nutrition therapy, chronic disease management, and behavioral health treatment into a unified outpatient care model.

Activities Performed

1. Participation in Governance and Oversight: Provided regular updates to agency leadership and the Board of Health on CHI-related progress, challenges, and recommendations.
2. Development of Standardized Procedures: Drafted/refined standard operating procedures (SOPs) to support integrated workflows between LDCPH and Bert Nash (e.g., initial physicals, chronic care management).

Products

1. Standard Operating Procedures (SOPs): Clear written SOPs that formalize integrated care workflows between LDCPH and Bert Nash.
2. Process Map: A detailed visual process map documenting current referral/coordination processes, showing how CHI strategies and contractual clauses (from DCO/OHCA) can be operationalized locally.
3. Provider Referral Checklist: An evidence-based checklist with criteria for when providers should refer patients to registered dietitians, ensuring consistency and equitable access.

Chapter 3 - Results

The integration project between Lawrence-Douglas County Public Health (LDCPH) and Bert Nash Community Mental Health Center reflects nearly two years of deliberate work to move integrated care from concept into practice. Guided by the Comprehensive Health Integration (CHI) Framework developed by the National Council for Mental Wellbeing, the project focused on planning, communication, and the translation of frameworks and agreements into operational steps. Much of 2024 was dedicated to preparation and groundwork, including leadership meetings, workflow design, and agreement development. The start of 2025 marked a shift into implementation, with direct client services being delivered under the integrated care model. In addition to client care, efforts in 2025 have focused on EHR sharing, the establishment of billing workflows, and ongoing use of CQI practices to refine processes and sustain progress.

Throughout 2024, LDCPH and Bert Nash leadership met every other week to maintain steady momentum and solve foundational issues. These meetings focused on defining the scope and limits of integration, mapping initial referral pathways, and anticipating the compliance, privacy, and reimbursement conditions that would govern day-to-day work. Late in 2024, the teams began hands-on work with EHR workflows to ensure that information could move compliantly and predictably once services went live. The cadence and continuity of these leadership meetings prevented drift, kept the work visible across both organizations, and created a shared understanding of how the CHI principles would be expressed locally.

A major milestone came at the end of 2024 with the execution of the Designated Collaborating Organization (DCO) Agreement and the Organized Health Care Arrangement (OHCA). The DCO Agreement (effective January 1, 2025) formalized LDCPH's role as a designated collaborator responsible for defined primary care screening and monitoring services on behalf of the CCBHC. The agreement's overview section established that LDCPH would provide services listed in Exhibit A (Figure 3-1) through LDCPH providers, aligning activities with Section 2402(a) of the Affordable Care Act (person- and family-centered care), relevant Medicaid standards, and each organization's internal quality policies. It clarified availability standards (e.g., no denial of services on the basis of homelessness or inability to pay) and set expectations for timely access: appointments within 10 business days of referral, with crisis-level needs addressed within one business day.

Exhibit A

Scope of Services

LDCPH will administer the DCO Services through LDCPH Providers on behalf of Bert Nash. The DCO Services include all services included in the below CPT codes.

- *Codes 99211 – 99215*: Evaluation and Management (Level 1 through 5)
- *Code 96161*: Maternal Depression Screening
- *Code 96160*: Health Risk Assessment
- *Code 96160*: Health and Behavioral Assessment
- *Code 99490*: Chronic Care Management

For those services or procedures administered during a visit that are not DCO Services, LDCHD shall retain independent responsibility and bill for such services. In addition, LDCPH, as a DCO to Bert Nash, agrees to administer DCO Services in compliance with the below.

1. Outpatient Primary Care Screening and Monitoring:
 - a. Access to Care: LDCPH will accept Patients referred by Bert Nash that are identified as needing a physical health assessment after a primary health screening is completed. LDCPH will schedule a follow up appointment with the Patient and will see the Patient within ten (10) business days of the referral from Bert Nash.
 - b. Physical Health Assessment: During the appointment, LDCPH Providers will complete a physical health assessment of the Patient. LDCPH will provide a report and recommendations for follow-up care for the Patient to Bert Nash.
2. Mental Health Screenings: LDCPH Providers will assess patients and their need for mental health services using a reliable depression screening tool. Specifically, LDCPH Providers will complete a PHQ-9 (Patient Depression Questionnaire) screening for LDCPH Patients and identify any Patient in need of mental health care. For Patients that screen positive, or if the Patient otherwise indicates a need for mental health services, LDCPH will gather the Patients demographic information, and health assessment if available, to facilitate referring the Patient to Bert Nash for services. LDCPH will also coordinate with the Bert Nash Care Navigation Team to begin the admissions process and to schedule an intake appointment for the identified patients.
3. Interpretation/Translation Services: This Service provides appropriate and timely language services to patients with limited English proficiency (“LEP”). Such Services may include but are not limited to contracting with bilingual providers, onsite interpreters, and a language telephone line. LDCPH shall ensure that auxiliary aids and services are readily available, Americans with Disabilities Act (“ADA”) compliant and are responsive to the needs of patients with disabilities.

Figure 1-1: DCO Agreement Exhibit A

Exhibit A (Figure 3-1) to the DCO Agreement defined the scope of services by CPT code and program elements. Covered services included Evaluation and Management codes 99211-099215; maternal depression screening (96161); health risk and health/behavioral assessment (96160); and chronic care management (99490). Operationally, LDCPH agreed to accept

referrals from Bert Nash for clients identified as needing physical health assessment, complete that assessment, and provide recommendations back to Bert Nash for follow-up. LDCPH would also perform PHQ-9 screening for LDCPH patients and coordinate positive screens with the Bert Nash Care Navigation Team, initiating the admissions pathway and scheduling intakes as indicated. Language access and auxiliary aids obligations were explicitly included, with expectations for interpreters, bilingual services, telephone language lines, ADA-compliant supports, and timely availability of translated materials at intake.

The OHCA, executed November 11, 2024, created the privacy and data-sharing structure necessary for integrated care within HIPAA and 42 CFR Part 2. As covered entities, both organizations agreed to operate as an organized health care arrangement for specified treatment, payment, and health care operations, relying on a single patient authorization to support appropriate sharing of protected health information (PHI) and, when applicable, patient-identifying information (PII) related to substance use disorder treatment. The OHCA established shared responsibilities for minimum necessary access, safeguards, workforce training and sanctioning, breach notification (within seven days of discovery for PHI/PII received through the OHCA), controls against redisclosure of Part 2-protected information, and standardized processes for joint quality improvement, population-level analytics, and clinical guideline development.

With the DCO and OHCA in place, January 1, 2025 became the operational start of integrated services. LDCPH began seeing Bert Nash clients for physical health services under the DCO scope, and co-location commenced (Figure 3-2), with Bert Nash staff based at LDCPH to support warm handoffs and reduce logistical barriers for clients. Concurrently, LDCPH obtained view-only access to the Bert Nash EHR, enabling pre-visit chart review, better preparation for physical exams, and more effective post-visit communication back to behavioral health teams. Although each organization retained its own system, this bridge closed critical information gaps at key moments in care.



Figure 3-2: Co-location of services (from left to right: Patrick Schmitz, Bert Nash CEO, Nicole Parker, LDCPH APRN, Brittney Schuetz, LDCPH APRN/Nurse Supervisor, Dr. Nana Dadson, Bert Nash CMO, Marsha Page-White Bert Nash Senior Director of Community Based Services, Christine Ebert, LDCPH Director of Clinic Services, Jonathan Smith, LDCPH Executive Director)

Beginning in January 2025, monthly updates to the LDCPH Health Board ensured leadership visibility, reinforced accountability, and safeguarded continued alignment with the department's public health mission (Figure 3-3). These briefings summarized volume trends, access timeliness, early outcomes, staffing capacity, and operational issues (EHR, billing, and referrals) that required board awareness.

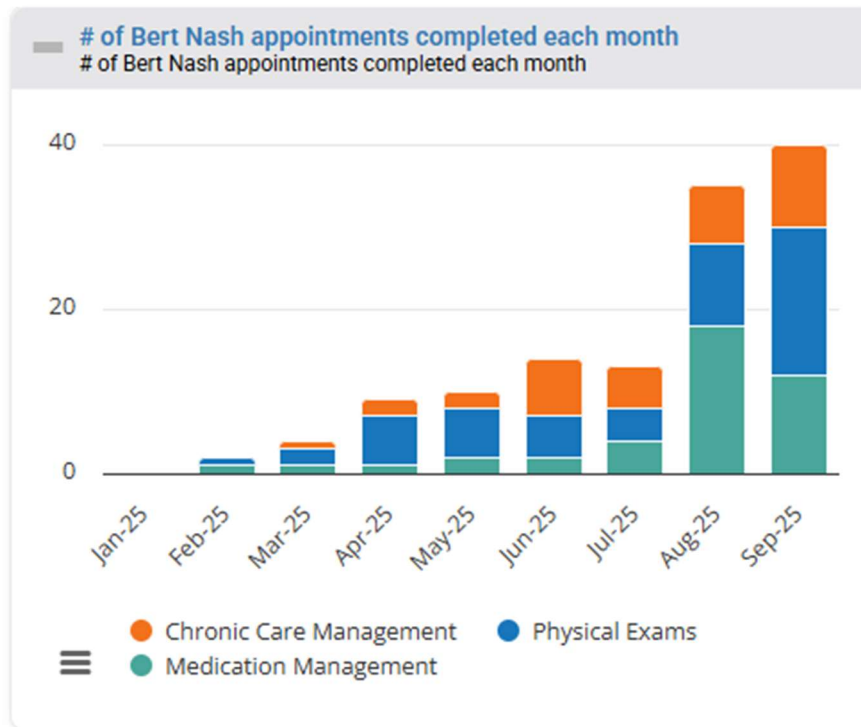


Figure 3-3: Example of the Health Board update - number of Bert Nash appointments completed by LDCPH each month

By summer 2025, the work matured from leadership-led design to daily clinical collaboration. Twice-monthly provider meetings brought together LDCPH clinicians and Bert Nash front-line staff to discuss specific clients, troubleshoot workflow friction, and agree on incremental improvements. These meetings became a predictable venue for closed-loop communication, case consultation, and “micro-changes” that accumulated into smoother processes. A notable theme emerging from provider discussions was the central role of nutrition, especially as it relates to chronic disease management, medication adherence, and mental health recovery. The group elevated integrated nutrition supports (including registered dietitian consults) as a practical, high-yield component of whole-person care.

Standard operating procedures (SOPs) were finalized after provider meetings were underway, which allowed the procedures to reflect actual clinical experience. SOPs now guide initial physical exams for referred clients, chronic care management enrollment and follow-up, cross-organizational communication expectations, and closed-loop confirmation back to behavioral health teams. To support consistent adoption, the teams developed text macros and smart phrases for documentation, templated return messages, and order sets aligned to

common chronic conditions and preventive care (e.g., standardized labs for A1C and lipids; vitals and BP recheck intervals; tobacco cessation prompts; metabolic monitoring for antipsychotic use). These tools reduced variation, lowered cognitive load for busy clinicians, and codified what “good” looks like at each step of the workflow.

Staffing capacity was strengthened with advanced practice coverage. The LDCPH clinician team includes three APRNs, one of whom is a Psychiatric Mental Health Nurse Practitioner (PMHNP). The PMHNP also provides street medicine, seeing clients in the field and at the shelter, meeting people where they are to reduce access barriers and build trust. Providers completed additional integrated-care-focused training, covering referral criteria, documentation, chronic disease protocols, communication standards under the OHCA, and person- and family-centered approaches consistent with the DCO. The combined effect of staffing, training, and SOPs has been a more reliable pathway from behavioral health identification to timely physical health assessment and ongoing chronic care.

On the administrative side, billing and revenue cycle design moved from concept to practice. Consistent with the DCO Agreement, clients receiving DCO services are considered Bert Nash patients for the DCO scope; Bert Nash bills for those services and remains clinically and financially responsible, while LDCPH supplies the data necessary to submit Medicaid claims and retains independent billing responsibility for any non-DCO services delivered during the same visit. Exhibit B (Figure 3-4) to the DCO Agreement specifies compensation: LDCPH is paid an estimated \$140,031.76 annually, disbursed on a capitated monthly basis of \$11,669.31, calculated on an estimated two Bert Nash patient visits per day over 250 clinic days. In addition to the fixed capitation, a per-visit payment of \$280.06 is paid for each visit exceeding the “Weekly Visit Threshold” (two visits multiplied by the clinic’s open days that week), invoiced by LDCPH and paid the following month. Rebasing is built into the methodology: by July 30, 2026, Bert Nash will provide summary information on Medicaid DCO visits through December 31, 2025 to evaluate and adjust the total capitation, with a new rate effective January 1, 2027 and subsequent rebasing aligned to state cycles (the next rebase on or around January 1, 2028). This model provides financial predictability while recognizing volume growth.

Exhibit B
Compensation Amount and Methodology

LDCPH will be paid an estimated \$140,031.76 annually to administer the DCO Services. This amount will be paid out on a monthly capitated basis as provided in this Exhibit B.

Bert Nash will allocate to LDCPH a percentage of the Prospective Payment System (“PPS”) payment for all eligible DCO Services which occur pursuant to this Agreement. LDCPH will be paid \$11,669.31 monthly based upon an estimated two (2) Bert Nash patient visits per day over 250 days per year that are administered by LDCPH in furtherance of the DCO Services.

In addition to the monthly fixed amount, for each week that DCO Services are provided, Bert Nash will reimburse LDCPH \$280.06 for each visit exceeding the Weekly Visit Threshold, and every visit thereafter in that same week, in which LDCPH administers the DCO Services. The “Weekly Visit Threshold” shall be the product of the number of days that LDCPH’s office is open during the week in question multiplied by two (2) visits. For example, if LDCPH’s office is open four (4) days in a given week, the Weekly Visit Threshold would be eight (8) visits. LDCPH may provide Bert Nash with an invoice for any week that it performs more visits than the Weekly Visit Threshold, which must include the number of visits that LDCPH performed DCO Services. Bert Nash will pay LDCPH the additional per visit reimbursements in the following month’s payment.

Below is an annualized example chart showing how the compensation to LDCPH will be calculated.

Example

		<u>Model 1</u>
Number of days per year providing patient care		250
Number of visits per day		2
Per visit reimbursement required	\$	280.06
Labs and pharmaceuticals		TBD
Resultant Annual Revenue	\$	140,031.76
Monthly revenue	\$	11,669.31

By July 30, 2026, Bert Nash will provide summary information to LDCPH documenting the total visits for Patients with Medicaid as of December 31, 2025 who received DCO Services from LDCPH as a percentage of the overall eligible CCBHC visits for Patients with Medicaid for the same period. This summary information will be used to evaluate and rebase the total capitation amount to LDCPH for the subsequent period. The new compensation amount will take effect on January 1, 2027.

Subsequent rebase periods will occur on a periodic basis in order to align the rebase of this Agreement with Bert Nash’s periodic compensation rebase with the State of Kansas. The first rebase (after the initial rebase as described in the above paragraph) will take place on or around January 1, 2028.

Figure 3-4: DCO Agreement Exhibit B

Quality and reporting processes followed the structure outlined in Exhibit C (Figure 3-5). LDCPH supplies monthly data sufficient for CCBHC reporting, including demographics, staffing, access timeliness, service utilization, screening and prevention, care coordination, and

outcomes. The timeliness measure (appointment offered within ten business days of referral) is tracked, as is routine depression screening with documented follow-up when indicated. Under Section 1.7 of the DCO Agreement and Exhibit C (Figure 3-5), encounter and quality data are shared at least monthly, with content sufficient for SAMHSA Uniform Reporting System elements where applicable. These reporting obligations dovetail with CQI cycles, which the teams have used to test and scale improvements (for example, refining referral confirmation macros or adjusting order sets to streamline lab workflows).

Exhibit C **Quality Measure Reporting**

As a CCBHC, Bert Nash is required to report out on specific quality indicators to the Kansas Department of Aging and Disability Services (“KDADS”) in order to maintain its State Certification. LDCPH must collect the information outlined in the quality measures set forth below and report that information to Bert Nash.

1. Timeliness: The number/percent of new Patients with appointment provided within three to five days of health screening.
2. Depression Screening: The percentage of patients aged 12 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

In addition to the State required CCBHC quality measures, it is critical for Bert Nash to receive the following additional information, on a monthly basis, but no later than 15th of following month. As such, LDCPH shall provide Bert Nash with the necessary information in the appropriate form for Bert Nash to collect, report, and track encounter, outcome, and quality data, including, but not limited to data capturing: (1) Patient demographics, diagnosis, and clinical presentation information; (2) LDCPH Provider staffing levels; (3) Access to healthcare services; (4) Patient utilization; (5) Screening, prevention, and treatment services provided; (6) Patient care coordination; (7) Patient discharge planning; and (8) Patient outcomes.

1. Demographic Information regarding clients served
2. Services provided to clients by CPT code, provider, etc.
3. Payor profile of individuals served and aggregated
4. Length of time from walk-in to service, and then from first service to next service
5. Disposition of Patients

Figure 3-5: DCO Agreement Exhibit C

The integration produced early clinical successes that illustrate the value of the model. Clients who had not previously engaged with primary care established care through LDCPH after behavioral health referrals; timely initial physicals identified untreated hypertension, leading to medication initiation or titration, self-monitoring plans, and structured follow-up. Several clients achieved meaningful blood pressure control over subsequent visits, supported by

consistent communication between LDCPH and Bert Nash clinicians and reinforced by case discussion in provider meetings. Others benefited from weight management supports; referrals to the registered dietitian led to tailored nutrition counseling, realistic goal setting, and improved diet quality. For a subset of clients, integrating RD consults with medication reconciliation and activity goals produced measurable weight loss and improved energy, which, in turn, supported behavioral health treatment engagement.

Street-based care by the PMHNP also yielded gains. Clients staying at the shelter or living unsheltered received field assessments, medication starts, and direct scheduling for clinic follow-up. This reduced missed opportunities for care, shortened the time from identification to treatment, and created a bridge for clients who otherwise faced significant logistical and trust barriers. Routine PHQ-9 screening at LDCPH visits helped identify depressive symptoms; positive screens triggered warm navigation back to Bert Nash, where admissions were initiated and follow-up appointments scheduled.

The EHR/billing workgroup meets regularly to refine data exchange and claims submission. Practical outputs included: (1) a referral checklist to minimize back-and-forth; (2) standardized paragraphs in LDCPH notes; (3) weekly reconciliation of visits against the Weekly Visit Threshold for timely invoicing; and (4) adjustments to data extracts that improved first-pass claim acceptance. Meanwhile, the referrals subgroup continued testing the smoothest route for outbound referrals from Bert Nash to LDCPH and for inbound results from LDCPH to Bert Nash, with an emphasis on timeliness and minimal duplication.

Equity and access features embedded in the agreements and SOPs translated into daily practice. Interpreters were readily available by phone and, when needed, scheduled for in-person support. Staff also used bilingual providers when possible, and accessible communication supports were provided to meet ADA requirements, such as ensuring clients with hearing or vision needs could fully participate in their visits. These operational choices aligned with Exhibit A's (Figure 3-1) access provisions and Section 3's requirements for linguistic and cultural competence.

Finally, the partners outlined future directions consistent with the CHI framework and local needs: strengthening integrated nutrition services; formal linkages with LDCPH Family Support Programs and WIC; evaluating the feasibility of an embedded primary care panel at LDCPH for a defined cohort; and, long-term, exploring Federally Qualified Health Center (FQHC) Look-Alike status to expand the breadth and sustainability of services while maintaining the DCO construct for CCBHC-covered functions.

Chapter 4 - Discussion

The integration between LDCPH and Bert Nash followed a carefully sequenced trajectory. The early focus in 2024 on planning and governance laid the groundwork, while the execution of the DCO and OHCA at the end of that year created the legal and compliance structures that allowed for safe and effective sharing of responsibilities beginning in January 2025. This structured approach highlights an important lesson: legal agreements are not just administrative requirements but preconditions for reliable practice. The DCO set clear standards for timeliness and scope, while the OHCA provided the framework for HIPAA- and Part 2-compliant information exchange. These agreements gave staff confidence to proceed, ensuring that when clinical services began in 2025, they were both operationally feasible and compliant.

Once agreements were in place, the real challenge became translating broad principles into daily tools and workflows. The introduction of SOPs, order sets, text macros, and standardized referral templates turned high-level commitments into repeatable clinical processes. These tools simplified communication, reduced variability, and gave providers a consistent framework for documentation and care coordination. As a result, processes such as blood pressure follow-up, PHQ-9 documentation, and referrals back to Bert Nash became more consistent and reliable. Without these practical supports, the agreements alone would not have produced the same level of operational clarity.

The addition of co-location (Figure 3-2) in October 2024, and its expansion in January 2025, along with field-based services provided by the PMHNP, were pivotal in reducing barriers to care. These access points allowed clients to engage with services in spaces that were convenient, familiar, and responsive to their needs. For individuals experiencing homelessness, the ability to receive assessments and treatment at the shelter or in the field meant that physical health services became accessible in ways that traditional clinic-based care could not provide. Similarly, co-location (Figure 3-2) at LDCPH enabled warm handoffs and immediate coordination that otherwise might have been delayed by transportation or scheduling barriers. These practices directly align with the DCO's access provisions and embody the spirit of whole-person care that the CHI framework calls for.

Provider meetings emerged as one of the most impactful components of the project. Meeting twice monthly created a dependable forum for staff to raise issues, consult on client cases, and test practical improvements. These meetings gave front-line providers ownership of integration and moved the work from a leadership-driven initiative to a collaborative, team-based effort. It was in these discussions that nutrition rose to the surface as a major theme,

reinforcing the need for integrated nutrition services provided by a registered dietitian. The meetings also allowed the team to focus on incremental change by making one small improvement at a time, without overwhelming staff. This rhythm proved to be a highly effective model for CQI.

Financial sustainability has also been an important consideration. The compensation structure outlined in Exhibit B (Figure 3-4) of the DCO Agreement balances stability with flexibility. The monthly capitation provided a predictable funding base, while the per-visit payments above the Weekly Visit Threshold ensured that resources scaled with demand. This model not only supported operational consistency but also allowed the organizations to manage unexpected increases in volume without straining staff or finances. The scheduled rebasing process, beginning with Medicaid visit data due in mid-2026, will further align the model with actual service delivery. This arrangement demonstrates that integrated care can be both clinically meaningful and financially sustainable when compensation is designed thoughtfully.

The early outcomes observed reinforce the value of this work. Clients who had been disconnected from primary care were re-engaged through LDCPH, leading to the detection and treatment of unmanaged hypertension, with many achieving blood pressure control through structured follow-up. Clients also reported improvements in weight management when registered dietitian consults were integrated with their behavioral health plans. Nutrition counseling, medication management, and lifestyle goal setting worked synergistically to improve both physical and mental health outcomes. These early successes validate the investment in integration and show the promise of a model that bridges public health and behavioral health.

Despite the progress, challenges remain. Workforce capacity continues to be a constraint, and staff frequently juggle competing demands. Separate EHRs create inefficiencies that require continued workarounds, including standardized documentation packets and macros. Cultural differences between public health's focus on population-level outcomes and behavioral health's emphasis on therapeutic relationships still require careful navigation. Yet these challenges are not insurmountable. The governance structure in place (monthly leadership meetings, twice-monthly provider sessions, ongoing EHR and billing workgroups, and regular board updates) ensures that issues are identified and addressed in a timely manner. The cadence is light enough to avoid overwhelm but reliable enough to maintain alignment.

Looking forward, several priorities have emerged. Strengthening nutrition integration is a clear next step, with opportunities to formalize dietitian referral criteria, establish follow-up cadences, and embed nutrition goals into chronic care order sets. Referral timeliness and visibility also need continued attention, with dashboards to track whether clients are seen within

the DCO's ten-day standard for outbound LDCPH referrals to Bert Nash. On the administrative side, refining billing workflows, improving first-pass claim acceptance, and preparing for the 2027 rebase will be crucial for sustainability. Training refreshers will remain important as new staff join and protocols evolve. Finally, long-term strategies such as integrating with Family Support Programs and WIC, piloting an embedded primary care panel at LDCPH, and exploring FQHC Look-Alike designation represent opportunities to expand scope while maintaining alignment with the DCO model.

In conclusion, the LDCPH-Bert Nash integration demonstrates that with deliberate planning, strong legal agreements, and practical operational tools, integrated care can move from aspiration to reality. The work has already improved access, strengthened chronic disease management, and advanced whole-person care in Douglas County. The foundation now in place positions both organizations to build further, addressing challenges while scaling successes in a way that remains true to the CHI framework and responsive to community needs.

Chapter 5 - Competencies

Student Integration of MPH Foundational Competencies

Table 5.1 Summary of MPH Foundational Competencies

Number and Competency		Description
5	Compare the organization, structure and function of health care, public health and regulatory systems across national and international settings	I integrated public health, behavioral health, and regulatory systems to operationalize Kansas's first Designated Collaborating Organization (DCO) agreement between a CCBHC and a public health department. This work required aligning federal CCBHC standards, Medicaid billing, HIPAA/42 CFR Part 2, and local public health mandates into one coordinated framework, demonstrating my ability to bridge complex systems into a unified model of population-based care.
9	Design a population-based policy, program, project or intervention	I designed and guided the development of an integrated care model that expanded preventive and chronic disease management for an underserved behavioral health population. Through strategic decisions and system design, I aligned public health and behavioral health practices into one coordinated framework focused on prevention, equity, and sustainable, population-level impact.
13	Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes	I led the creation of a cross-organizational coalition that aligned LDCPH and Bert Nash under a unified framework for integrated care. Through the intentional design of governance structures, communication systems, and collaborative processes, I established a sustainable partnership that transformed two independent agencies into a coordinated, equity-focused model for population health improvement.
16	Apply leadership and/or management principles to address a relevant issue	I led LDCPH through the process of building an integrated care system from the ground up, coordinating across departments and agencies to establish new workflows and clinical procedures. Through adaptive leadership, I empowered staff, fostered collaboration, and maintained alignment with LDCPH's mission of creating

		abundant and equitable opportunities for good health.
22	Apply a systems thinking tool to visually represent a public health issue in a format other than a standard narrative	I applied systems thinking to examine how clients, staff, and processes interacted across LDCPH and Bert Nash. By identifying bottlenecks in communication, referrals, and follow-up care, I was able to redesign workflows for greater efficiency and coordination. This systems-based approach ensured that improvements addressed the root causes of fragmentation rather than surface-level symptoms.

Competency 5: Throughout the integrated care initiative between LDCPH and Bert Nash, I created and operationalized a new framework that unified two distinct systems, public health and behavioral health, under a single, coordinated model of care. This work culminated in developing Kansas's first Designated Collaborating Organization (DCO) and Organized Health Care Arrangement (OHCA) agreements between a CCBHC and a local public health department. I formulated the processes that aligned federal CCBHC standards for access, integration, and care coordination with LDCPH's state and local mandates focused on prevention, population health, and equity.

I constructed this integration by selecting and sequencing the operational steps needed to reconcile differences in structure, funding, and oversight. This required bridging Medicaid billing requirements, CCBHC certification standards, and regulatory frameworks such as HIPAA and 42 CFR Part 2. Beyond creating agreements, I developed governance mechanisms, workflow designs, and documentation processes that ensured compliance while supporting efficient, population-based service delivery. Through this synthesis, I transformed two parallel systems into an integrated, sustainable model of care that maintained regulatory integrity while expanding access and advancing health equity. This process reflected not only an understanding of how systems function but also my ability to build and evaluate a new operational structure that now serves as a template for future collaborations statewide.

Competency 9: I led the design and development of an integrated care model that redefined how preventive and chronic disease services reach individuals receiving behavioral health care in Douglas County. This work required both strategic vision and applied systems thinking to align two distinct organizational structures, public health and behavioral health, under a shared framework for population-based care. Rather than adapting existing systems, I constructed a new operational model that embedded public health principles within the

behavioral health environment, ensuring that prevention, equity, and chronic disease management became central components of care delivery.

The process required a series of deliberate judgments and decisions to translate broad integration goals into functional practice. I defined service priorities, established eligibility criteria, and developed coordinated pathways that balanced feasibility with long-term sustainability. At each stage, I evaluated how structural and regulatory differences could be reconciled to create efficient, client-centered workflows. I built governance processes and communication systems that strengthened accountability, reduced duplication, and supported cross-agency collaboration.

The resulting model expanded access to preventive screenings and chronic disease management for individuals who previously lacked consistent care. It operationalized the principles of whole-person health by bridging clinical and population health approaches, transforming conceptual integration into an evidence-informed, sustainable system of practice. This initiative not only demonstrated the feasibility of coordinated public health and behavioral health service delivery but also established a scalable framework for future implementation across other settings.

Competency 13: The success of the integrated care initiative between LDCPH and Bert Nash was grounded in the establishment of a cross-sector coalition that I structured and led. Prior to this work, the two organizations functioned independently, each with its own systems, priorities, and regulatory requirements. Recognizing that sustainable integration required more than operational agreements, I created the coalition that would unify both entities under a shared vision for coordinated, whole-person care.

I developed the coalition's structure intentionally, building multiple layers of governance and communication to ensure inclusivity and accountability. This included establishing recurring leadership meetings between executive teams, cross-disciplinary provider meetings, and specialized subgroups focused on key operational domains such as electronic health records, billing alignment, and referral coordination. Each component of the coalition was designed to balance authority and collaboration, allowing for joint problem-solving while maintaining clarity in roles and decision-making. I guided these groups with a systems-oriented approach, sequencing their development to ensure that foundational communication and governance mechanisms were in place before advancing to technical or procedural alignment.

My leadership in this effort extended beyond coordination to cultivating trust, mutual understanding, and shared purpose across organizations. I emphasized transparency, active listening, and a commitment to equity as core values guiding all collaboration. This relational

work was as essential as the structural design; it allowed staff and leadership to move beyond organizational boundaries and view integration as a collective responsibility. The coalition became a vehicle not only for implementing systems change, but for redefining how agencies communicate, share accountability, and make decisions in service of community health.

By constructing both the structural and cultural foundations for collaboration, I transformed two parallel systems into a cohesive and enduring partnership. The coalition continues to serve as a model of sustainable governance, demonstrating how local public health and behavioral health systems can integrate effectively to achieve improved health outcomes through coordinated, evidence-informed practice.

Competency 16: The integrated care initiative between LDCPH and Bert Nash was characterized by leadership that was both visionary and pragmatic. I developed the conceptual framework for integration between the organizations, designed the process through which it could be operationalized, and led its implementation from inception through full execution. This undertaking required more than organizational coordination, it needed the deliberate construction of a governance and management system capable of bridging two distinct institutional structures while maintaining alignment in purpose, accountability, and direction.

From the project's outset, I established its scope, structure, and sequence. I delineated milestones, defined roles and responsibilities, and developed mechanisms for communication and decision-making that would guide progress across both organizations. My leadership approach was intentionally adaptive, balancing strategic oversight with facilitative management. This ensured that multidisciplinary teams could collaborate effectively while remaining grounded in LDCPH's mission of creating abundant and equitable opportunities for good health.

Effective leadership in this context required managing both the technical and relational dimensions of systemic change. I aligned staffing and training needs with project objectives, created processes that fostered transparency and accountability, and facilitated constructive dialogue to navigate complex decisions regarding priorities and resource allocation. Throughout the process, I applied systems thinking to anticipate the downstream effects of policy, procedural, and cultural adjustments, recognizing that sustainable integration depended equally on operational coherence and organizational trust.

Ultimately, I transformed an abstract vision into a functioning, sustainable model of integrated care. The resulting system reflects the intentional design, disciplined management, and collaborative leadership that guided its development, which is anchored in clarity, equity, and shared purpose. By leading LDCPH and Bert Nash through this transformation, I demonstrated the capacity to apply leadership and management principles to design and

implement organizational change that advances public health systems, strengthens interagency collaboration, and improves population-level health outcomes.

Competency 22: Systems thinking served as a foundational framework for the integrated care initiative between LDCPH and Bert Nash. I applied systems thinking to analyze how clients, staff, and processes interacted across organizational boundaries, identifying the interdependencies and feedback loops that influenced service delivery, communication, and outcomes. Viewing integration as a complex adaptive system allowed me to assess not only where inefficiencies existed, but also how structural and relational factors contributed to fragmentation within and between agencies.

Through this lens, I evaluated how decisions in one area, such as referral coordination, data sharing, or client follow-up, impacted operations across the entire continuum of care. This comprehensive understanding guided the redesign of workflows to improve coordination, eliminate duplication, and strengthen accountability. I applied systems thinking to anticipate both the intended and unintended consequences of organizational changes, ensuring that interventions addressed root causes rather than surface-level symptoms.

By embedding systems thinking throughout the project, I facilitated a more cohesive and adaptive model of care that strengthened communication and improved population-level outcomes. This approach not only enhanced efficiency and continuity across agencies but also established a foundation for sustainable, evidence-informed integration, demonstrating how the intentional application of systems thinking can transform fragmented services into a unified, learning-oriented public health system.

Table 5.2 MPH Foundational Competencies and Course Taught In

22 Public Health Foundational Competencies Course Mapping	MPH 701	MPH 720	MPH 754	MPH 802	MPH 818
Evidence-based Approaches to Public Health					
1. Apply epidemiological methods to settings and situations in public health practice	x		x		
2. Select quantitative and qualitative data collection methods appropriate for a given public health context	x	x	x		
3. Analyze quantitative and qualitative data using biostatistics, informatics, computer-based programming and software, as appropriate	x	x	x		
4. Interpret results of data analysis for public health research, policy or practice	x		x		
Public Health and Health Care Systems					
5. Compare the organization, structure and function of health care, public health and regulatory systems across national and international settings		x			

6. Discuss the means by which structural bias, social inequities and racism undermine health and create challenges to achieving health equity at organizational, community and systemic levels					x
Planning and Management to Promote Health					
7. Assess population needs, assets and capacities that affect communities' health		x		x	
8. Apply awareness of cultural values and practices to the design, implementation, or critique of public health policies or programs					x
9. Design a population-based policy, program, project or intervention			x		
10. Explain basic principles and tools of budget and resource management		x	x		
11. Select methods to evaluate public health programs	x	x	x		
Policy in Public Health					
12. Discuss multiple dimensions of the policy-making process, including the roles of ethics and evidence		x	x	x	
13. Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes		x		x	x
14. Advocate for political, social or economic policies and programs that will improve health in diverse populations		x			x
15. Evaluate policies for their impact on public health and health equity		x		x	
Leadership					
16. Apply leadership and/or management principles to address a relevant issue		x			x
17. Apply negotiation and mediation skills to address organizational or community challenges		x			
Communication					
18. Select communication strategies for different audiences and sectors	FNDH 880				
19. Communicate audience-appropriate (i.e., non-academic, non-peer audience) public health content, both in writing and through oral presentation	FNDH 880				
20. Describe the importance of cultural competence in communicating public health content		x			x
Interprofessional Practice					
21. Integrate perspectives from other sectors and/or professions to promote and advance population health		x			x
Systems Thinking					
22. Apply a systems thinking tool to visually represent a public health issue in a format other than a standard narrative			x	x	

Student Attainment of MPH Emphasis Area Competencies

Table 5.3 Summary of MPH Emphasis Area Competencies

MPH Emphasis Area: Public Health Nutrition		
Number and Competency		Description
1	Information literacy of public health nutrition	Inform public health practice through analysis of evidence-based policy, systems, and environmental change.

2	Compare and relate research into practice	Examine chronic disease surveillance, policy, program planning and evaluation, and program management, in the context of public health nutrition.
3	Population-based health administration	Critically examine population-based nutrition programs.
4	Analysis of human nutrition principles	Examine epidemiological concepts of human nutrition in order to improve population health and reduce disease risk.
5	Analysis of nutrition epidemiology	Describe criteria for validity in nutritional epidemiological methodology.

Competency 1 – I applied information literacy by using evidence-based guidelines and recommendations to shape the foundation of integrated care between LDCPH and Bert Nash. National standards for diabetes, hypertension, and obesity screening informed the structure of preventive and chronic care services, ensuring consistency and adherence to public health best practices. My coursework in FNDH 600: Public Health Nutrition strengthened my ability to evaluate and apply this evidence, while my literature review reinforced the importance of early screening and nutrition interventions in populations with behavioral health conditions. By embedding these recommendations into integrated workflows, I ensured that the model was practical, sustainable, and aligned with the best available evidence in public health nutrition.

Competency 2 – I connected nutrition and chronic disease research directly to the integrated care model by translating findings from the literature, epidemiologic data, and client records into actionable program strategies. Bert Nash client data revealed high rates of obesity, diabetes, and diet-related conditions among individuals with behavioral health diagnoses, a pattern that mirrored national findings explored in FNDH 844: Nutritional Epidemiology. Recognizing these connections, I worked to embed medical nutrition therapy and nutrition-focused care plans into chronic disease management protocols, ensuring nutrition remained a core component of preventive health. My literature review reinforced the strong evidence base supporting nutrition interventions for improving metabolic outcomes and quality of life in this population. By combining research, surveillance, and local context, I demonstrated how academic inquiry can directly inform and improve the design of public health programs.

Competency 3 – Through the integrated care initiative, I applied principles of population-based health administration to expand preventive and nutrition-focused care for individuals who lacked consistent access to primary care. Many Bert Nash clients had unmet needs related to chronic disease screening, laboratory testing, and nutrition education. Drawing from FNDH/MPH 720: Administration of Health Care Organizations, I helped develop administrative processes

that extended LDCPH's preventive health services into behavioral health environments, aligning staff capacity, data systems, and reporting structures to support population-level outcomes. This approach reduced systemic barriers to care and positioned integrated services as an accessible entry point for high-need clients. By merging administrative systems from public and behavioral health sectors, I demonstrated how coordinated governance and population-based planning can improve equity, efficiency, and overall community health impact.

Competency 4 – I ensured that human nutrition principles were fully embedded in the integrated care framework by incorporating nutrition-related risk factors into every stage of assessment, intervention, and follow-up. Standardized screenings for BMI, A1C, blood pressure, and dietary indicators created opportunities for early identification and management of chronic disease. My coursework in FNDH 600: Public Health Nutrition provided the foundation for understanding the relationships between diet, metabolism, and disease prevention, which I applied directly in shaping these protocols. By linking nutritional risk to behavioral health outcomes, I reinforced the role of diet in both physical and mental well-being. This approach emphasized prevention, improved coordination among providers, and helped close long-standing gaps in care for populations experiencing health inequities.

Competency 5 – I applied nutrition epidemiology by analyzing client-level outcomes from integrated care and situating them within broader public health data to guide program priorities. Data from Bert Nash revealed a high co-occurrence of serious mental illness, diabetes, and cardiovascular disease, patterns consistent with findings reviewed in FNDH 844: Nutritional Epidemiology and national surveillance reports. This synthesis of local and population-level evidence informed the design of chronic disease prevention and nutrition education strategies that addressed both immediate clinical needs and systemic risk factors. By grounding the integration model in valid, evidence-based epidemiologic methods, I ensured our interventions were both scientifically sound and community-responsive. This process demonstrated how applied nutrition epidemiology can guide strategic decision-making and improve health outcomes in complex, underserved populations.

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Appendices

Appendix 1: Standard Operating Procedures (SOPs)

SOP for Initial Physical Exams:



BERT NASH INITIAL PHYSICAL EXAM PROTOCOL

PURPOSE: To provide comprehensive, integrated physical examinations for clients referred by Bert Nash or presenting to LDCPH through walk-in from Bert Nash, ensuring both physical and behavioral health needs are identified and addressed.

SCOPE: Applies to all clinic staff conducting or supporting initial physicals for new or existing clients engaged in integrated care services.

PROCEDURE:

Scheduling and Intake:

1. Bert Nash staff (including nurses, case managers, care coordinators, etc.) will make a referral or walk client over.
2. LDCPH staff will schedule initial physicals in Athena using appointment type: Bert Nash Initial Physical (duration: 60 minutes). If known, enter the Bert Nash patient identification number (PID)
3. LDCPH staff will confirm insurance coverage, complete presumptive eligibility checklist, or provide sliding fee scale discount information

Pre-visit Preparation:

1. LDCPH provider will review patient's electronic health record (EHR) in SmartCare. Identify care gaps (immunizations, screenings, labs, chronic condition follow-up).

Client Check-in:

1. Verify demographics, scan ID and insurance (if applicable), review consent forms

Clinical Examination:

1. Perform a full physical exam per clinic protocol (vitals, height/weight, systems review).
2. Address preventive health (immunizations, cancer screenings, reproductive health, nutrition counseling).
3. Review and reconcile medications, including behavioral health prescriptions.
4. Identify any physical conditions that may impact behavioral health (e.g., diabetes, thyroid issues, cardiovascular risk).
5. Warm hand-off to behavioral health staff (if on site) or schedule follow-up at Bert Nash.
6. Initiate referrals for labs, specialty care, or community resources as needed.

Documentation and Follow-up:

1. Document findings in EHR.
2. Provide After Visit Summary to Bert Nash.
3. Schedule follow-up for chronic care management (see Chronic Care Management SOP)

BN Initial Physical	Review Cycle – 12 months	Reviewed By : Director of Clinic Services, APRN	
Origin Date	2025		
Revision Date(s)			
Review Date(s)			Page 1

RESPONSIBLE PARTIES:

- Bert Nash frontline staff (referrals, follow up, care coordination)
- LDCPH front desk staff (scheduling and intake)
- LDCPH providers (exam, labs, immunizations, referrals)

BN Initial Physical	Review Cycle – 12 months	Reviewed By : Director of Clinic Services, APRN	
Origin Date	2025		
Revision Date(s)			
Review Date(s)			Page 2

SOP for Chronic Care Management:



BERT NASH CHRONIC CARE MANAGEMENT PROTOCOL

PURPOSE: To deliver coordinated, person-centered management of chronic physical health conditions (e.g., diabetes, hypertension, asthma, etc.) for clients engaged with the Bert Nash Integrated Care Clinic.

SCOPE: Applies to all staff managing chronic conditions in integrated care clients, with emphasis on care continuity between physical and behavioral health providers.

PROCEDURE:

Enrollment and Consent:

1. Identify eligible clients during initial physical or through Bert Nash referral.
2. Obtain informed consent for chronic care management (CCM) services and information sharing.
3. Assign a LDCPH primary care provider, if appropriate.

Comprehensive Assessment:

1. Collect medical history, behavioral health diagnoses, social determinants of health, and lifestyle factors.
2. Review current treatment plans from both Bert Nash and LDCPH.
3. Establish or review baseline measures (A1C, BP, BMI, lipids, etc.) within last 3-6mo.

Individualized Care Plan Development:

1. Develop care plan with input from client, LDCPH provider(s), and Bert Nash provider(s).
2. Include medication adherence, nutrition counseling, physical activity, and behavioral health supports.
3. Align with evidence-based guidelines and patient goals.

Ongoing Monitoring & Follow-Up:

1. Schedule regular follow-up visits (monthly to quarterly, based on condition severity, clinical judgement, and best practice).
2. Conduct vitals, labs, and screenings as appropriate.
3. Use motivational interviewing to address barriers to adherence.
4. Document any behavioral health changes that impact physical health (e.g., medication side effects, depression symptoms, etc.).

Care Coordination:

1. Hold joint case conferences (monthly or as needed) between Bert Nash and LDCPH providers.
2. Ensure medication reconciliation across behavioral and physical health providers.
3. Provide warm hand-offs for urgent needs.

Patient Engagement and Education:

1. Provide culturally and linguistically appropriate education materials.

BN Initial Physical	Review Cycle – 12 months	Reviewed By: Director of Clinic Services, APRN	
Origin Date	2025		
Revision Date(s)			
Review Date(s)			Page 1



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BERT NASH CHRONIC CARE MANAGEMENT PROTOCOL

2. Encourage use of peer support, group education classes, or chronic disease self-management programs.
3. Address health literacy and digital literacy when using patient portals.

Quality & Reporting

1. Track key outcomes (A1C, BP control, ED visits, hospitalizations, depression scores).
2. Report metrics quarterly to Bert Nash and public health leadership.
3. Incorporate patient satisfaction and experience surveys.

RESPONSIBLE PARTIES:

- Bert Nash med services staff (referrals, follow up, care coordination)
- LDCPH front desk staff (scheduling and intake)
- LDCPH providers (exam, labs, immunizations, referrals)
- Data/quality team (outcomes reporting)

BN Initial Physical	Review Cycle – 12 months	Reviewed By: Director of Clinic Services, APRN	
Origin Date	2025		
Revision Date(s)			
Review Date(s)			Page 2

SOP for Dietitian Referral:



REGISTERED DIETITIAN REFERRAL PROTOCOL

PURPOSE: Ensure timely, evidence-based referral to a Registered Dietitian Nutritionist (RDN) for Medical Nutrition Therapy (MNT) when nutrition care can improve outcomes, reduce risk, or is the standard of care (USPSTF, 2021; ADA, 2025).

SCOPE: Applies to all primary care, chronic care, and behavioral health providers within LDCPH.

PROCEDURE:

Referral Triggers and Quantitative Thresholds:

- Obesity/Overweight + Risk: BMI ≥ 30 kg/m² or BMI ≥ 25 kg/m² with comorbidity (HTN, dyslipidemia, T2D, ASCVD). [USPSTF, 2021]
- Diabetes/Prediabetes: A1c $\geq 7.0\%$ or new diagnosis of diabetes/prediabetes; RDN MNT reduces HbA1c by 1–2%. [ADA, 2025]
- Cardiometabolic Risk: LDL-C ≥ 130 mg/dL or TG ≥ 150 mg/dL despite initial therapy. [AHA/ACC, 2019]
- Chronic Kidney Disease: eGFR < 60 mL/min/1.73m² or albuminuria ≥ 30 mg/g; electrolyte abnormalities. [KDOQI, 2020]
- NAFLD/MASLD: Steatosis with BMI ≥ 25 ; RDN-guided 7–10% weight loss improves liver histology. [AASLD, 2023]
- IBS / GI Disorders: RDN-guided low-FODMAP diet (restriction 4–6 weeks, followed by reintroduction). [ACG, 2021]
- Malnutrition Risk (GLIM): $\geq 5\%$ unintentional weight loss in 6 months or $\geq 10\%$ in 12 months; BMI < 20 ($< 70y$) or < 22 ($\geq 70y$). [GLIM, 2019]
- Unintentional Weight Loss / Low BMI: $\geq 5\%$ weight loss in 6 months or $\geq 10\%$ in 12 months; BMI < 18.5 kg/m² (underweight) or < 20 if $< 70y$, < 22 if $\geq 70y$; $< 75\%$ of estimated intake for ≥ 7 days. [GLIM, 2019; WHO, 2023; NICE NG7, 2017]
- Behavioral Health / Antipsychotics: $\geq 7\%$ weight gain on SGA or metabolic abnormalities; SCOFF ≥ 2 . [APA, 2023]
- Pregnancy / GDM: Gestational diabetes or preexisting diabetes in pregnancy; MNT is first-line therapy. [ADA, 2025]
- Food Insecurity: Positive Hunger Vital Sign ("often/sometimes true" to either item). [Hager et al., 2010]

Timeline:

- High priority (A1c $\geq 8\%$, GDM, CKD, GLIM+, IBS, BMI < 18.5): RD visit within 2 weeks.
- Standard (BMI ≥ 30 , NAFLD, dyslipidemia, food insecurity): RD visit within 4 weeks.

Follow-up:

- Initial + 2–3 visits in 3–6 months, consistent with intensive multicomponent intervention models. [USPSTF, 2021]

RD Referral	Review Cycle – 12 months	Reviewed By: Director of Clinic Services, APRN, RD	
Origin Date	2025		
Revision Date(s)			
Review Date(s)			Page 1

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RD Referral	Review Cycle – 12 months	Reviewed By: Director of Clinic Services, APRN, RD	
Origin Date	2025		
Revision Date(s)			
Review Date(s)			Page 2

Dietitian Referral Checklist:



REGISTERED DIETITIAN REFERRAL CHECKLIST

Metabolic/Cardio

- ☐ BMI ≥ 30 or ≥ 25 with comorbidity (HTN, dyslipidemia, T2D, ASCVD) [USPSTF, 2021]
- ☐ A1c $\geq 7.0\%$ or new diabetes/prediabetes diagnosis [ADA, 2025]
- ☐ LDL-C ≥ 130 mg/dL or TG ≥ 150 mg/dL despite therapy [AHA, 2019]

Renal/Liver

- ☐ eGFR < 60 or albuminuria ≥ 30 mg/g, electrolyte abnormalities [KDOQI, 2020]
- ☐ NAFLD/MASLD with BMI ≥ 25 , weight-loss target 7–10% [AASLD, 2023]

GI/Nutrition Risk

- ☐ IBS – RDN-guided low-FODMAP (4–6 weeks) [ACG, 2021]
- ☐ Celiac disease (suspected or confirmed) [AND, 2023]
- ☐ Weight loss $\geq 5\%$ in 6 months or $\geq 10\%$ in 12 months [GLIM, 2019]

Unintentional Weight Loss/Low BMI

- ☐ BMI < 18.5 (underweight) or < 20 if $< 70y$, < 22 if $\geq 70y$ [GLIM, 2019; WHO, 2023]
- ☐ $< 75\%$ of estimated intake for ≥ 7 days [NICE NG7, 2017]
- ☐ Recent appetite decline or poor intake post-illness [NICE NG7, 2017]

Behavioral & Pregnancy

- ☐ $\geq 7\%$ weight gain on antipsychotics; SCOFF ≥ 2 [APA, 2023]
- ☐ GDM or pre-existing diabetes in pregnancy [ADA, 2025]

Social Risk

- ☐ Positive Hunger Vital Sign (food insecurity screen) [Hager et al., 2010]

Follow-up: Initial + 2–3 RDN visits in 3–6 months [USPSTF, 2021].

Appendix 2: Process Map

