Master of Public Health

Applied Practice Experience

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

by

Christine Ebert

MPH Candidate

submitted in partial fulfillment of the requirements for the degree

MASTER OF PUBLIC HEALTH

Graduate Committee:
Dr. Priscilla Brenes, PhD, MPH
Dr. Ellyn Mulcahy, PhD, MPH
Dr. Vicki Collie-Akers, PhD, MPH

Applied Practical Experience Site:
Lawrence-Douglas County Public Health
January 2024-October 2025

Applied Practical Experience Preceptor:
Jonathan Smith, MPH

KANSAS STATE UNIVERSITY
Manhattan, Kansas

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Chapter 1 - Portfolio Products

I completed my Applied Practice Experience (APE) at Lawrence-Douglas County Public Health (LDCPH), located in Lawrence, Kansas. Lawrence-Douglas County Public Health was established in 1942 through a joint resolution between the City of Lawrence and Douglas County. It is one of only two city-county health departments in the state of Kansas. The LDCPH mission is, “Creating abundant and equitable opportunities for good health” and its vision is, “Leading change to advance health for all.” Both guide LDCPH’s commitment to advancing policies, practices, and programs that protect health, prevent disease, and promote equity.

An emphasis area for LDCPH has been expanding preventive services through improved access to care. In January 2024, LDCPH joined a national learning collaborative through the National Council for Mental Wellbeing, implementing the Comprehensive Health Integration (CHI) Framework in partnership with Bert Nash Community Mental Health Center. Bert Nash is 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 care and coordinated treatment. To support this mandate, LDCPH and Bert Nash entered into the first-ever Designated Collaborating Organization (DCO) Agreement between a CCBHC and a local public health department in Kansas. Through this agreement, LDCPH provides physical health exams, chronic disease management, medication management, and preventive services on behalf of Bert Nash clients.

During my APE, I contributed to operationalizing this integrated care model by developing key procedural documents, creating communication tools, and aligning program structures to evidence-based best practices. These deliverables demonstrated leadership, systems thinking, and applied public health management in action.

Table 1.1 Summary of Portfolio Products

Portfolio Product		Description
	Standard Operating Procedures (SOPs)	Developed SOPs for initial physicals and chronic care management visits provided by LDCPH for Bert Nash clients. The SOPs standardized workflows, defined staff roles,

		and embedded evidence-based screening recommendations for chronic conditions.
	Integrated Care Workflow and Process Map	Created a visual process map of the client journey between LDCPH and Bert Nash to identify gaps, delays, and duplication in service delivery. This tool informed workflow redesign and cross-agency coordination.
	Dietitian Referral Checklist for Providers	Designed a checklist to guide medical providers in identifying when a patient should be referred to a registered dietitian. The checklist was informed by current research and practice guidelines on nutrition and chronic disease management, helping bridge the gap between primary care and nutrition services.

The products identified above, need to address at least one or more of the competencies chosen for Chapter 2 – Competencies.

Table 1.2 Portfolio Products and Competency Addressed

Portfolio Product		**Number and Competency Addressed**	
	Standard Operating Procedures (SOPs)	5, 9, 13, 16	Compare the organization, structure and function of health care, public health and regulatory systems across national and international settings Design a population-based policy, program, project or intervention Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making
	Integrated Care Workflow and Process Map	5, 13, 16, 22	Compare the organization, structure and function of health care, public health and regulatory systems across national and international settings

			Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making Apply systems thinking tools to a public health issue
	Dietitian Referral Checklist for Providers	9, 16	Design a population-based policy, program, project or intervention Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making

Chapter 2 - Competencies

Table 2.1 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 gained a deep understanding of how public health and behavioral health systems intersect by operationalizing the first Designated Collaborating Organization (DCO) agreement between a public health department and a CCBHC in Kansas. This work required comparing how clinical, regulatory, and public health systems function and align under federal CCBHC standards and state public health mandates, ensuring compliance while maintaining population-focused care.
9	Design a population-based policy, program, project or intervention	I designed components of an integrated care program that expanded access to physical health services for individuals receiving behavioral health care at Bert Nash. This included creating standard operating procedures for physical exams, chronic care management, and nutrition referrals, ensuring that preventive and chronic disease services reached a population that previously lacked consistent access to care.
13	Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes	I identified and helped convene key stakeholders from LDCPH, Bert Nash, and the National Council for Mental Wellbeing to align goals and define shared priorities for integrated care. By facilitating regular communication and shared planning, I helped build a cross-sector coalition committed to expanding whole-person care and improving health outcomes for high-need populations.
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 by developing a process map that visualized the client journey between LDCPH and Bert Nash. This tool identified bottlenecks in referrals, communication, and follow-up care, allowing us to redesign workflows for greater efficiency and coordination. The systems approach ensured improvements addressed the root causes of fragmentation rather than surface-level symptoms.

Competency 5: The integration of care between LDCPH and Bert Nash required a deep understanding of how two distinct systems – public health and behavioral health – operate within their respective organizational and regulatory frameworks. This work came to life through the implementation of the DCO and OHCA agreements, which were the first of their kind in Kansas between a CCBHC and a local public health department. The process required analyzing and reconciling differences in structure, funding, and oversight: CCBHCs function under federal and Medicaid requirements emphasizing access, integration, and care coordination, while local public health agencies operate under mandates centered on prevention, population health, and equity. Developing the SOPs and process map directly reflected this competency, as they translated complex organizational and regulatory differences into streamlined, unified workflows. This required familiarity with Medicaid billing processes, CCBHC certification standards, public health reporting, and privacy protections under the Health Insurance Portability and Accountability Act (HIPAA) and 42 Code of Federal Regulations (CFR) Part 2. By aligning these systems through shared goals and clearly defined procedures, I strengthened my ability to navigate and operationalize how diverse health systems can work together to deliver integrated, client-centered care that meets both clinical and public health goals.

Competency 9: Developing the SOPs, process map, and referral checklist collectively represented the design and implementation of a population-based intervention aimed at improving chronic disease management and access to integrated services. These tools formalized the programmatic backbone of the LDCPH-Bert Nash partnership by transforming broad framework guidance into repeatable, sustainable procedures. The SOPs established consistent standards for physical exams, chronic care management, and referral coordination, while the process map visually connected each stage of care across two organizations. The dietitian referral checklist filled a crucial programmatic gap by ensuring nutrition services were systematically considered in treatment planning. Together, these deliverables operationalized

integration as a population-level health intervention rather than an ad hoc collaboration, aligning directly with public health goals of prevention, early detection, and chronic disease control. Together, these tools collectively function as population-based interventions, improving continuity, consistency, and coordination of services across systems to reduce chronic disease risk in an underserved population.

Competency 13: The success of the integration depended on coalition building between agencies that had historically worked in parallel. This competency was demonstrated through the creation of cross-organizational governance and communication structures, leadership meetings, provider meetings, and specialized subgroups (EHR/billing and referrals workgroups). The SOPs and process map were developed collaboratively, ensuring that each stakeholder group (clinical staff, administrators, finance, etc.) had input. These deliverables not only codified shared responsibilities but also strengthened trust and transparency. The dietitian referral checklist further expanded the coalition by engaging LDCPH's nutrition and WIC staff, connecting clinical and community resources. The project's collaborative structure became a model for how local public health and behavioral health systems can align to improve outcomes through partnership rather than duplication.

Competency 16: Leadership was central to the creation and implementation of each deliverable. Developing SOPs required guiding teams through complex discussions about scope, accountability, and standards of care. Facilitating process-mapping sessions demanded coordination across multiple disciplines and balancing the perspectives of executives, clinicians, and operational staff. Governance principles were applied through structured meeting cadence, documentation of decisions, and transparent communication with the LDCPH Health Board. Effective management was reflected in aligning staffing, training, and resources with the integration's needs, ensuring that each component, from the dietitian referral process to billing workflows, was both feasible and sustainable. This competency was achieved through steady facilitation, conflict resolution, and the ability to move diverse teams toward shared goals under clear governance.

Competency 22: Perhaps the most defining competency of the entire integration initiative was the application of systems thinking. The deliverables were designed to illuminate and strengthen the connections between individual services, departments, and organizations. The process map served as a visualization of how inputs, workflows, and outcomes are interrelated within the integrated care model. The SOPs operationalized these relationships by clarifying how each step in the process influences others, from screening to documentation to follow-up. The dietitian referral checklist addressed a system-level feedback loop between behavioral and

nutritional health, emphasizing how improved coordination in one domain (nutrition) can influence outcomes in another (mental health and chronic disease). Each product acknowledged complexity, reduced fragmentation, and made interdependencies visible, core hallmarks of systems thinking in practice.

Table 2.2 MPH Foundational Competencies Course Mapping

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	DMP 815, FNDH 880 or KIN 796				
19. Communicate audience-appropriate (i.e., non-academic, non-peer audience) public health content, both in writing and through oral presentation	DMP 815, FNDH 880 or KIN 796				
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	

Appendix A – SOP for Initial Physical Exams

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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)		
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RESPONSIBLE PARTIES:

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

Appendix B – SOP for Chronic Care Management

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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	
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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)

Appendix C – SOP for Registered Dietitian Referral

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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 ≥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): ≥5% unintentional weight loss in 6 months or ≥10% in 12 months; BMI <20 (<70y) or <22 (≥70y). [GLIM, 2019]
- Unintentional Weight Loss / Low BMI: ≥5% weight loss in 6 months or ≥10% in 12 months; BMI <18.5 kg/m² (underweight) or <20 if <70y, <22 if ≥70y; <75% of estimated intake for ≥7 days. [GLIM, 2019; WHO, 2023; NICE NG7, 2017]
- Behavioral Health / Antipsychotics: ≥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 ≥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)		
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APA (2023). Schizophrenia & Weight Management Recommendations.

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Appendix D - Dietitian Referral Checklist

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REGISTERED DIETITIAN REFERRAL CHECKLIST

Metabolic/Cardio

☐ BMI ≥30 or ≥25 with comorbidity (HTN, dyslipidemia, T2D, ASCVD) [USPSTF, 2021]

☐ A1c ≥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 ≥5% in 6 months or ≥10% in 12 months [GLIM, 2019]

Unintentional Weight Loss/Low BMI

☐ BMI <18.5 (underweight) or <20 if <70y, <22 if ≥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

☐ ≥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 E – Process Map