# CCBHC Rural Services

# Session 7: Care Coordination and Population Health Management

April 15, 2025

NATIONAL COUNCIL for Mental Wellbeing

HEALTHY MINDS STRONG COMMUNITIES

# Acknowledgements and Disclaimer

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- *For example:*
  - Emma Hayes, National Council
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  - Click on the **Participants** icon at the bottom of the screen
  - Find your name and hover your mouse over it
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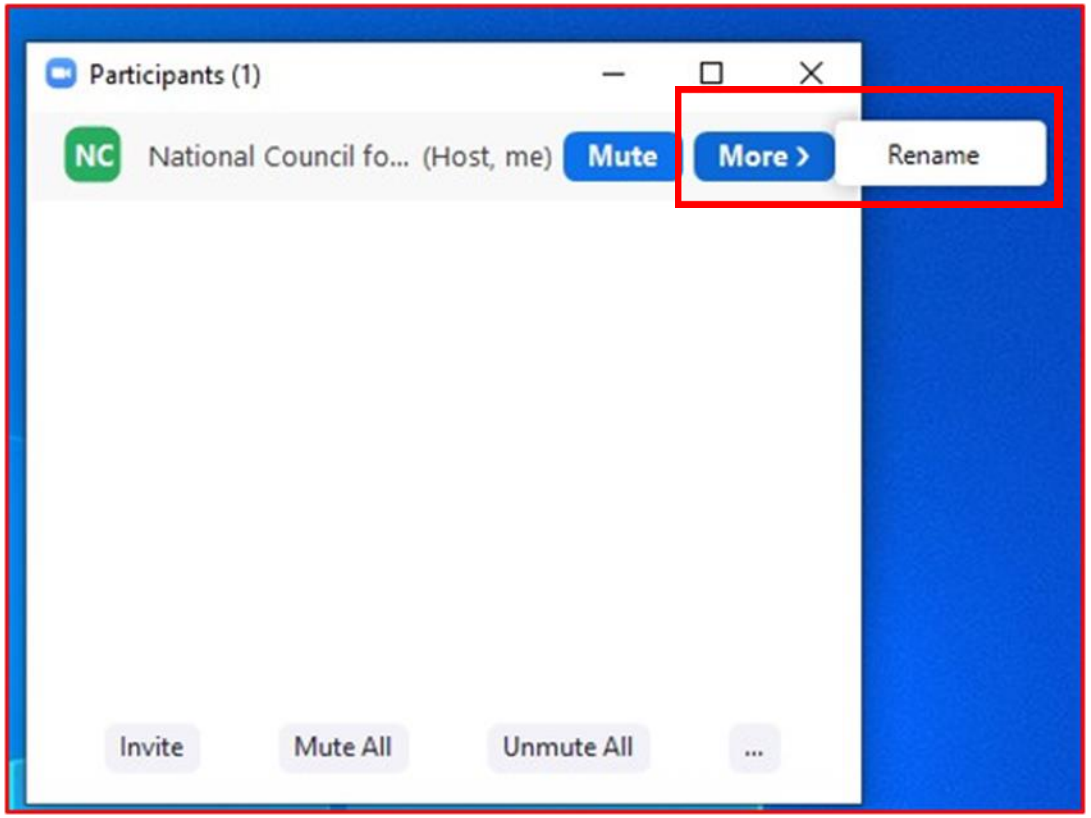
- If you are having any issues, please send a Zoom chat message to **Emma Hayes, National Council**



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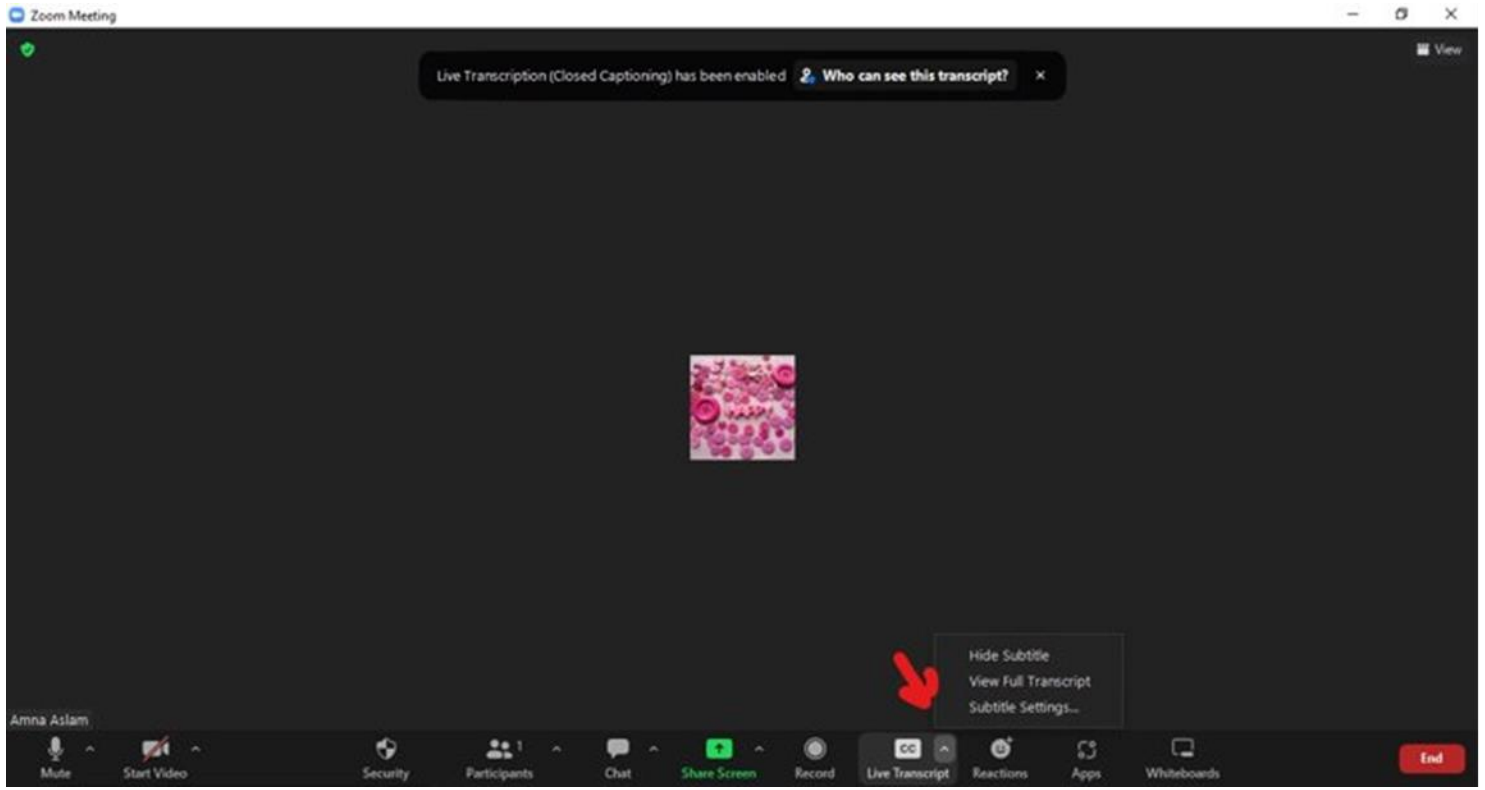


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# Learning Objectives

- Identify challenges in care coordination and population health management for rural CCBHCs
- Increase strategies that support care coordination and population health management in rural CCBHCs
- Engage opportunity to learn from peers who have demonstrated innovations in care coordination and population health management

# Your Learning Community Team

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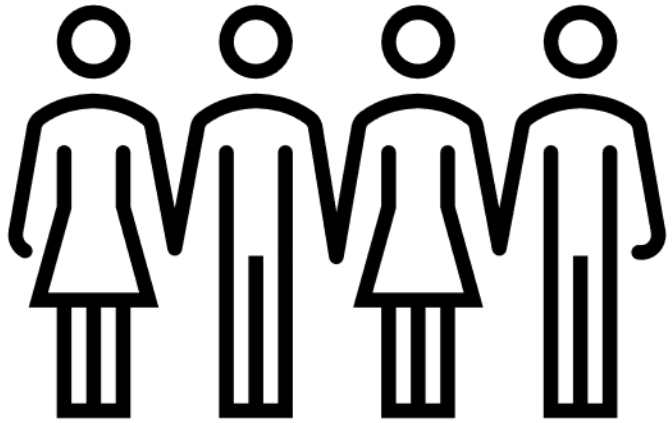
# Session Presenters

**Jesse Sieger-Walls, PhD, MSW, LCSW**
Owner & Managing Principal
Wellbeing In Action

**Andrew Schwend, MBA**
Chief Strategy Officer
Brightli

# Polling Questions



Does your CCBHC have designated Care Coordinators or is the function of care coordination built into other positions?

- Designated Care Coordinators
- Care Coordination built into other positions
- Other (please enter details into chat)

Considering the local FQHCs/RHCs/PCPs, do you know which primary care clinic has the largest shared population with your FQHC?

- Yes- we are able to run reports to see individual assignment to primary care
- No, we have not been collecting this data
- No, we collect this information but it is not easily accessible/reportable

Does your CCBHC collect lab values (HgbA1c, lipid panel)?

Yes

No

Does your CCBHC collect medical diagnosis?

Yes

No

# Rural Health

# Reality of Rural Healthcare

Rural Communities face a unique set of challenges and health inequities that are not seen in urban communities (transportation, internet and infrastructure, distance to provider, workforce shortages, etc.).

Approximately 63% of Primary Care Health Professional Shortage Areas are in rural areas and related to mental health and substance use treatment services, 65% of rural areas do not have a psychiatrist, and 47% do not have a psychologist.

# Care Coordination in Rural Settings

*Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs.*

Considerations

- Access to the continuum of care
- Leverage existing partnerships
- Data sharing is an iterative process and should have mutual benefit
- Documentation of the activity
- Care coordination can lead to shared population health management

# Population Health Management in Rural Settings

*The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as population health management, quality improvement, quality measurement and reporting, reducing disparities, outreach, and for research.*

Considerations:

- Farmworkers/Agricultural community
- Elderly/retired community
- School aged children and adolescents
- Socioeconomic status
- Partnerships that support care delivery and data sharing

# Population Health Management and Care Coordination for Rural Community-Based Behavioral Health Centers (CCBHCs): Concepts, Challenges, and Innovations

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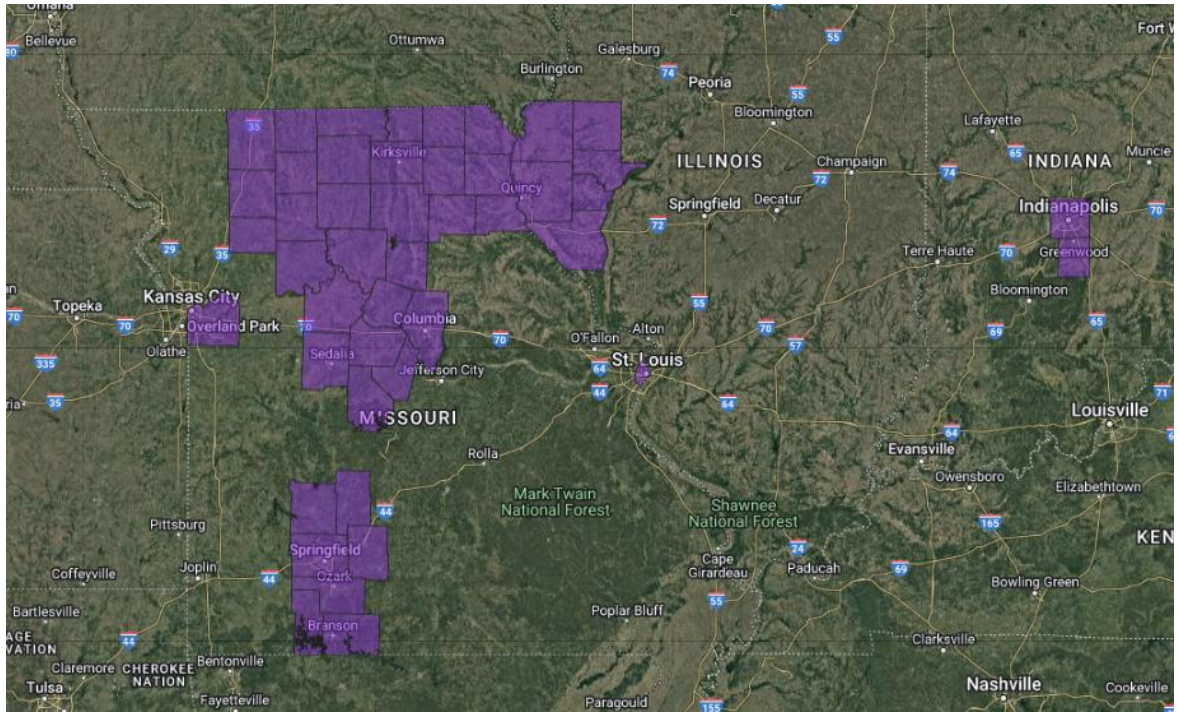
*Jesse Sieger-Walls, PhD, MSW, LCSW, Owner and Managing Principal, Wellbeing in Action*

*Andrew Schwend, MBA, Chief Strategy Officer, Brightli*

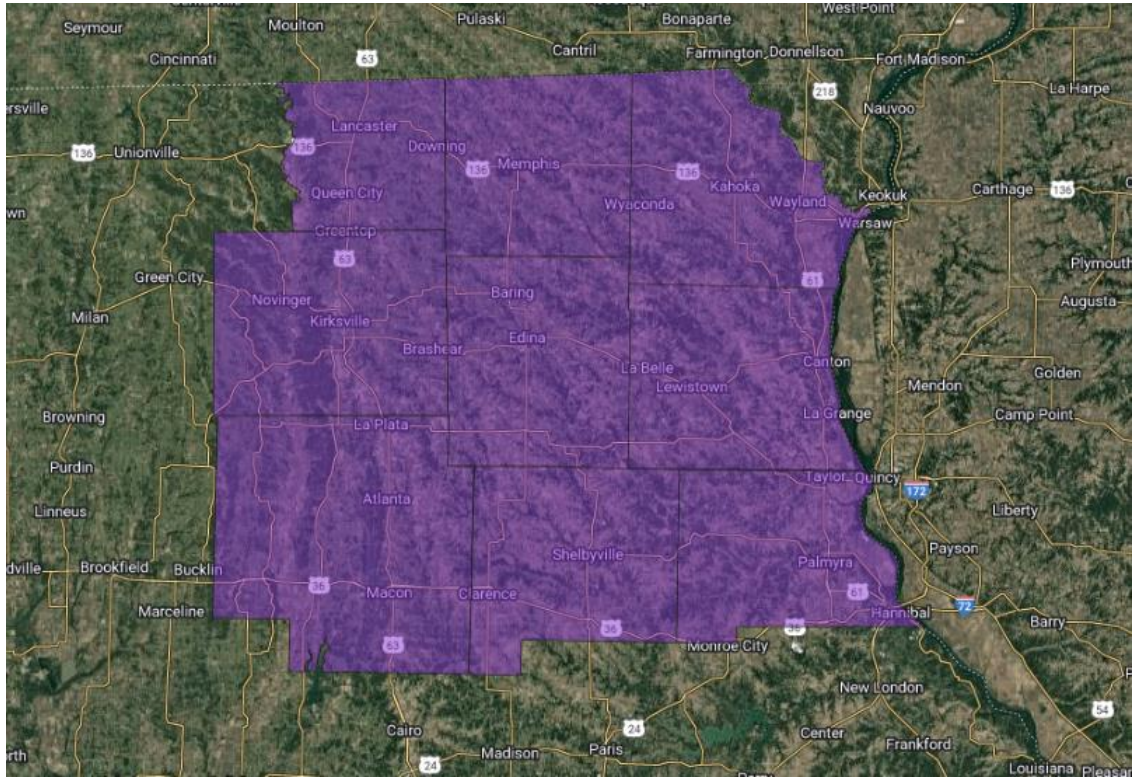
# Brightli CCBHC Overview

- Chief Strategy Officer – Brightli
  - 5,725 Employees, 5 States
  - 8 CCBHC Designated Service Areas
  - Mix of Rural & Urban



# Brightli CCBHC Overview

- Missouri **Service Area 14**
- Total Population: **104,309**
- Population Density: **22.66** sq/mi
  - Largest City = **17,483**
  - Nearest City > 50K = **90+** Miles



# Objectives

- Review Population Health Management core concepts
- Identify challenges in care coordination and population health management for rural CCBHCs
- Increase strategies that support care coordination and population health management in rural CCBHCs
- Engage opportunity to learn from peers who have demonstrated innovations in care coordination and population health management

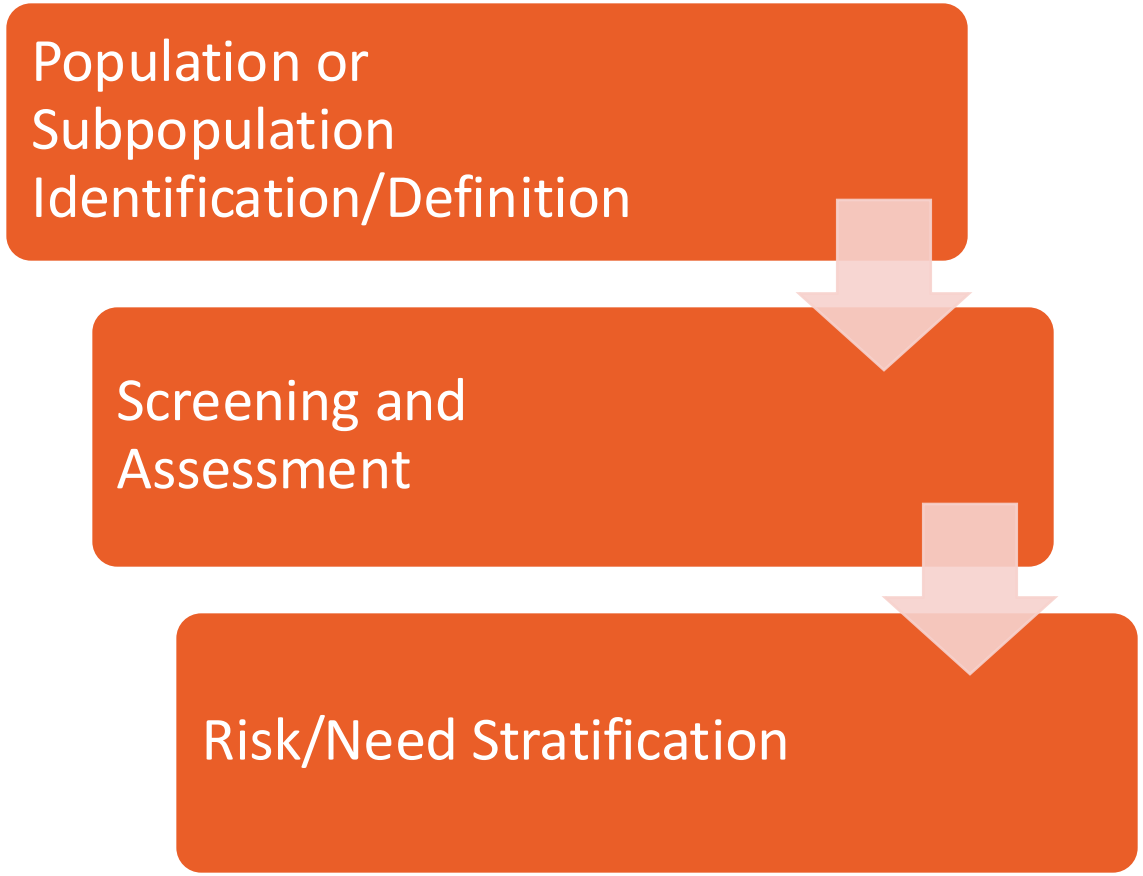
# Population Health Management

*"PHM programs are a **set of interventions** designed to **maintain and improve people's health across the full continuum of care**—from low-risk, healthy individuals to high-risk individuals with one or more chronic conditions" (Felt-Lisk & Higgins, 2011).*

PHM uses information systematically to determine appropriate client-centered strategies and interventions, including approaches that address hesitancy toward care or treatment.

# Basic PHM Steps

- **Population/Subpopulations**: defined by client characteristics (e.g., demographics, clinical presentations, use or engagement services or systems) tied to community needs.
- **Screening and Assessment:** a 2-step process for determining someone's level of need or health risk.
- **Risk/Need Stratification:** Grouping the population/subpopulation into subgroups that will get different levels of support/services.



# Spotlight:

- Should involve:
  - Healthcare
  - Social services
  - Criminal justice
  - Education
  - Special population servicing organizations/system e.g., veterans, disability services
  - Other behavioral health care settings

# Care Coordination Example

1. Population/Subpopulation Identification: Medicaid/CHIP members
2. Screening and Assessment: SDOH needs and ACEs
3. Stratification and Applied Techniques
   - Level 1 (lower needs) - Basic care coordination
     - Resource identification and referral, periodic follow-up, prevention care prompts
   - Leve 2 (Higher needs) – 'boots on the ground'
     - Assigned Community Health Worker for high intensity care coordination/management and wellness coaching, frequent check-ins and monitoring for closed-loop resource acquisition.
     - Personalized care plans and care asset mapping
     - Direct coordination with healthcare providers and community resources
   - Level 3 (Highest/Complex needs) – State-sponsored High-Fidelity Wraparound

# Common Rural Care Coordination Challenges

- Community provider/resource shortages
- Low volume to support more costly/intensive models of care
- Geographic dispersion
- Costly Health Information Technology Infrastructure
- Establishing a strong, reliable care coordination workforce e.g., smaller workforce pool to draw from, and poor retention can lead to prolong service gaps.

# Overcoming Rural Care Coordination Challenges

## Community provider/resource shortages

- Prioritize partnerships with your best resourced community assets, e.g., hospitals, FQHCs, county and city entities.
- Promote team-based models of care in the community that alleviate physician and optimize the license and skills of other team-members/health professionals
- Low volume to support more costly/intensive models of care

## Geographic dispersion

- Telehealth/Video Conferencing for key touchpoints
- Lend or procure minimally necessary devises for care engagement for clients
- Mobile units
- Co-location with community staples e.g., schools, FQHCs, hospitals, shopping hubs

# Overcoming Rural Care Coordination Challenges

## Costly Health Information Technology Infrastructure

- Establish shared technology platforms e.g., shared EHR systems with sister organizations or other healthcare providers.

## Establishing a strong, reliable care coordination workforce e.g., smaller workforce pool to draw from, and poor retention can lead to prolong service gaps.

- Invest in transdiagnostic models of care and training
- Emphasis on cross-training
- Leverage emerging health information tools/AI-technologies to help staff work at the top of the skills and streamline document.

# What have been your experiences with these challenges? What have you found most or least effective?

# APPENDIX: Clinical and Programmatic Sustainability Assessment Tools

*Tools that can be used for strategic planning of care coordination implementation and sustainability efforts*

# Clinical/Programmatic Sustainability Assessments Tools

| Clinical Sustainability | Programmatic Sustainability |
| --- | --- |
| • Engaged Staff & Leadership<br>• Engaged Stakeholders<br>• Organizational Readiness<br>• Workflow Integration<br>• Implementation & Training<br>• Monitoring & Evaluation<br>• Outcomes & Effectiveness | • Environmental Support<br>• Funding Stability<br>• Partnerships<br>• Organizational Capacity<br>• Program Evaluation<br>• Program Adaptation<br>• Communications<br>• Strategic Planning |

# How the Tools Work

- Rating scale: 1 (no extent) to 7 (great extent)
- Takes approximately 10-15 minutes to complete
- **Program Sustainability Assessment Tool** v2

  **Rating Instructions**

  Once you have completed the Program Sustainability Assessment Tool, transfer your responses to this rating sheet to calculate your average scores. Please record the score for each item (1-7), or write "NA" if you were not able to answer.

| | | DOMAIN | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Envirmntl. Support | Funding Stability | Partnerships | Organizational Capacity | Program Evaluation | Program Adaptation | Communications | Strategic Planning |
| ITEM | 1. | | | | | | | | |
| | 2. | | | | | | | | |
| | 3. | | | | | | | | |
| | 4. | | | | | | | | |
| | 5. | | | | | | | | |
| Add up your scores in each column. Exclude 'NA' | **Domain Total:** | | | | | | | | |
| Divide the domain total by the total number of items with a score. Exclude 'NA' | **Average Score for Domain:** | | | | | | | | |
| Average together all the domain scores | **Overall Score:** | | | | | | | | |

Use these results to guide sustainability action planning for your program. The domains with lower average scores indicate areas where your program's capacity for sustainability could be improved.

## Environmental Support

| | Rating |
|---|---|
| 1. Champions exist who strongly support the program. | 4.5 |
| 2. The program has strong champions with the ability to garner resources. | 5.0 |
| 3. The program has leadership support from within the larger organization. | 3.0 |
| 4. The program has leadership support from outside of the organization. | 3.0 |
| 5. The program has strong public support. | 4.0 |

## Partnerships

| | Rating |
|---|---|
| 1. Diverse community organizations are invested in the success of the program. | 3.0 |
| 2. Community leaders are involved with the program. | 2.0 |
| 3. Community members are passionately committed to the program. | 3.0 |
| 4. The program communicates with community leaders. | 2.0 |
| 5. The community is engaged in the development of program goals. | 3.0 |

## Program Evaluation

| | Rating |
|---|---|
| 1. The program has the capacity for quality program evaluation. | 2.5 |
| 2. The program reports short term and intermediate outcomes. | 3.0 |
| 3. Evaluation results inform program planning and implementation. | 2.5 |
| 4. Program evaluation results are used to demonstrate successes to funders and other key stakeholders. | 4.5 |
| 5. The program provides strong evidence to the public that the program works. | 4.0 |

## Communications

| | Rating |
|---|---|
| 1. The program has communication strategies to secure and maintain public support. | 4.0 |
| 2. Program staff communicate the need for the program to the public. | 4.0 |
| 3. The program is marketed in a way that generates interest. | 4.5 |
| 4. The program increases community awareness of the issue. | 4.0 |
| 5. The program demonstrates its value to the public. | 3.5 |

## Funding Stability

| | Rating |
|---|---|
| 1. The program exists in a supportive state economic climate. | 4.0 |
| 2. The program implements policies to help ensure sustained funding. | 4.5 |
| 3. The program is funded through a variety of sources. | 3.5 |
| 4. The program has a combination of stable and flexible funding. | 3.0 |
| 5. The program has sustained funding. | 2.0 |

## Organizational Capacity

| | Rating |
|---|---|
| 1. The program is well integrated into the operations of the organization. | 5.0 |
| 2. Organizational systems are in place to support the various program needs. | 5.5 |
| 3. Leadership effectively articulates the vision of the program to external partners. | 4.5 |
| 4. Leadership efficiently manages staff and other resources. | 5.5 |
| 5. The program has adequate staff to complete the program's goals. | 5.0 |

## Program Adaptation

| | Rating |
|---|---|
| 1. The program periodically reviews the evidence base. | 5.5 |
| 2. The program adapts strategies as needed. | 5.0 |
| 3. The program adapts to new science. | 4.5 |
| 4. The program proactively adapts to changes in the environment. | 4.0 |
| 5. The program makes decisions about which components are ineffective and should not continue. | 5.0 |

## Strategic Planning

| | Rating |
|---|---|
| 1. The program plans for future resource needs. | 3.5 |
| 2. The program has a long-term financial plan. | 4.0 |
| 3. The program has a sustainability plan. | 5.0 |
| 4. The program's goals are understood by all stakeholders. | 3.5 |
| 5. The program clearly outlines roles and responsibilities for all stakeholders. | 3.5 |

# How the Tools Work

- Rating scale: 1 (no extent) to 7 (great extent)
- Takes approximately 10-15 minutes to complete
- Individual or group assessment options

## Clinical Sustainability Assessment Tool

### Rating Instructions

Once you have completed the Clinical Sustainability Assessment Tool, transfer your responses to this rating sheet to calculate your average scores. Please record the score for each item (1-7), or write "NA" if you were not able to answer.

| | | DOMAIN | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Engaged Staff & Leadership | Engaged Stakeholders | Organizational Readiness | Workflow Integration | Implementation & Training | Monitoring & Evaluation | Outcomes & Effectiveness |
| ITEM | 1. | | | | | | | |
| | 2. | | | | | | | |
| | 3. | | | | | | | |
| | 4. | | | | | | | |
| | 5. | | | | | | | |
| Add up your scores in each column. Exclude 'NA' | Domain Total: | | | | | | | |
| Divide the domain total by the total number of items with a score. Exclude 'NA' | Average Score for Domain: | | | | | | | |
| Average together all the domain scores | Overall Score: | | | | | | | |



### Engaged Staff & Leadership

| | Rating |
|---|---|
| 1. The practice engages leadership and staff throughout the process. | 4.3 |
| 2. Clinical champions of the practice are recognized and respected. | 4.3 |
| 3. The practice has engaged, ongoing champions. | 4.7 |
| 4. The practice has a leadership team made of multiprofessional partnerships. | 4.3 |
| 5. The practice has team-based collaboration and infrastructure. | 4.0 |

### Engaged Stakeholders

| | Rating |
|---|---|
| 1. The practice engages the patient and family members as stakeholders. | 7.0 |
| 2. There is respect for all stakeholders involved in the practice. | 7.0 |
| 3. The practice is valued by a diverse set of stakeholders. | 6.7 |
| 4. The practice engages other medical teams and community partnerships as appropriate. | 5.7 |
| 5. The practice team has the ability to respond to stakeholder feedback about the practice. | 5.7 |

### Monitoring & Evaluation

| | Rating |
|---|---|
| 1. The practice has measurable process components, outcomes, and metrics. | 6.0 |
| 2. Evaluation and monitoring of the practice are reviewed on a consistent basis. | 6.0 |
| 3. The practice has clear documentation to guide process and outcome evaluation. | 6.0 |
| 4. Practice monitoring, evaluation, and outcomes data are routinely reported to the clinical care team. | 6.5 |
| 5. The practice process components, outcomes, and metrics are easily assessed and audited. | 6.5 |

### Implementation & Training

| | Rating |
|---|---|
| 1. The practice clearly outlines roles and responsibilities for all staff. | 4.0 |
| 2. The reason for the practice is clearly communicated to and understood by all staff. | 4.0 |
| 3. Staff receive ongoing coaching, feedback, and training. | 4.3 |
| 4. Practice implementation is guided by feedback from stakeholders. | 4.3 |
| 5. The practice has ongoing education across professions. | 4.3 |

### Outcomes & Effectiveness

| | Rating |
|---|---|
| 1. The practice has evidence of beneficial outcomes. | 4.0 |
| 2. The practice is associated with improvement in patient outcomes that are clinically meaningful. | 4.0 |
| 3. The practice is clearly linked to positive health or clinical outcomes. | 4.0 |
| 4. The practice is cost-effective. | 4.0 |
| 5. The practice has clear advantages over alternatives. | 5.3 |

### Workflow Integration

| | Rating |
|---|---|
| 1. The practice is built into the clinical workflow. | 4.3 |
| 2. The practice is easy for clinicians to use. | 4.3 |
| 3. The practice integrates well with established clinical practices. | 4.3 |
| 4. The practice aligns well with other clinical systems (e.g., EMR). | 4.7 |
| 5. The practice is designed to be used consistently. | 4.3 |

### Organizational Readiness

| | Rating |
|---|---|
| 1. Organizational systems are in place to support the various practice needs. | 5.7 |
| 2. The practice fits in well with the culture of the team. | 5.3 |
| 3. The practice has feasible and sufficient resources (e.g., time, space, funding) to achieve its goals. | 5.0 |
| 4. The practice has adequate staff to achieve its goals. | 4.7 |
| 5. The practice is well integrated into the operations of the organization. | 4.3 |

# Discussion

# Resources

- CCBHC-E National Training and Technical Assistance Center
- Rural Health Information Hub

# CCBHC-Expansion Grantee National Training and Technical Assistance Center

***We offer CCBHC grantees…***

## Virtual Learning Communities, Webinars and Office Hours

Regular monthly offerings that are determined based on grantees expressed needs.

## Opportunities for Collaboration with Other Grantees

Monthly Peer Cohort Calls for CCBHC Program Directors, Executives, Evaluators and Medical Directors.

## Direct Consultation

Request individual support through our website requesting system and receive 1:1 consultation.

## On-demand Resource Library

Includes toolkits, guidance documents, and on-demand learning modules.

Access our website to register for upcoming events, submit a consultation request or scan our on-demand resource library:
*https://www.thenationalcouncil.org/program/ccbhc-e-national-training-and-technical-assistance-center/*

# Questions?

NATIONAL COUNCIL *for* Mental Wellbeing

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CCBHC-E
National Training and Technical Assistance Center
Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing