AdvaNCe Health TOGETHER

STRENGTHENING HEALTH THROUGH COLLABORATION

Learning Community Framework

Integrated Case Management & Care Coordination Excellence

March 27, 2026

AdvaNCe Health TOGETHER
STRENGTHENING HEALTH THROUGH COLLABORATION

Michael Allen

Executive Vice President
OPEN MINDS

AdvaNCe Health TOGETHER
STRENGTHENING HEALTH THROUGH COLLABORATION

Christy Dye, MPH

Senior Associate

Formerly Chief Executive Officer
Partners In Recovery

Deanne Cornette, MHA

Senior Associate

Formerly VP of Strategic Development
Tampa Family Health Centers

Welcome

AdvaNCe Health TOGETHER
STRENGTHENING HEALTH THROUGH COLLABORATION

Welcome & Introductions

Track 3 Focus: Integrated Case Management & Care Coordination Excellence

Wi-Fi | Restrooms | Agenda-at-a -Glance

Participation Expectations

- Use microphones when speaking
- Ask questions anytime
- Virtual participants: chat + Q&A
- Respectful, practical dialogue

Purpose & Objectives Of Track 3

AdvaNCe Health TOGETHER
STRENGTHENING HEALTH THROUGH COLLABORATION

Purpose: Strengthen executive leadership capacity to design and implement effective integrated case management and care coordination models that improve access, outcomes, and performance within the CCBHC framework.

- Align leadership around a clear definition of care coordination
- Map workflows that improve key clinical performance measures
- Use cohort-based planning and risk stratification to guide services
- Redesign access and intake (“front door”) processes
- Implement closed-loop referrals and transition management
- Identify operational gaps and prioritize organizational improvements

What Leaders Are Facing Now

Behavioral health organizations are being asked to do more than ever before.

Rising complexity of patient needs.

Higher expectations for coordination.

Performance measurement and reporting pressures.

How Today Will Be Different

AdvaNCe Health TOGETHER
STRENGTHENING HEALTH THROUGH COLLABORATION

- Scenario-Based System Analysis
- Peer Strategy Exchange
- Action-Oriented Planning
- Workflow Design & Performance Improvement

Outcomes + Ground Rules

Today's Outcomes: By the end of this session, participants will leave with:

- A shared definition of integrated case management & care coordination
- A front door access blueprint aligned with CCBHC expectations
- One redesigned workflow tied to a key performance measure

Ground Rules for the Session:

- Focus on system patterns, not individual organizations
- Work in table groups with a spokesperson for report-outs
- Share practical insights and real-world challenges

Morning Session:

Right Care, Right Time, Every Time: Building Coordination That Works

10:10 AM – 12:00 PM

No Wrong Door, No Loose Ends: Care Coordination Excellence For CCBHC Leaders

Why Now?

- Up to 50% of referrals are not completed
- CCBHC requirement: no refusal based on ability to pay or residence
- Deliver coordinated care across multiple programs and providers rather than operating in service silos.
- Ensure timely access and seamless transitions of care, including hospital follow-up, crisis response, and referrals across the continuum.
- Manage complex, high-cost populations with multiple health, behavioral, and social needs.

Poll

Which gap is most costly?

1. Transitions
2. Referrals
3. Access
4. Role Clarity
5. Measurement/reporting

On a scale of 1-5, how confident are you that your organization can document care coordination consistently?

Working Definitions

Care coordination intentionally organizes patient care activities across providers, programs, and settings to ensure that individuals receive the right care at the right time. Key elements include:

- Communication across care teams
- Information sharing across settings
- Clear accountability for transitions and referrals

Focus of Today's Work
Today, we will focus on identifying "coordination moments" in the care journey:

- Access and the front door
- Referrals and closed-loop communication
- Transitions of care (e.g., hospital follow-up)
- Team-based care and workflow accountability

CCBHC Care Coordination Scope (SAMHSA)

Care Coordination in the CCBHC Model

"Care coordination must **integrate services across behavioral health, physical health, and social supports** to ensure whole-person care."

Key Expectations

Whole-Person Coordination

- Behavioral health services
- Primary care and medical needs
- Social supports and community services

Transitions of Care

- Hospital discharge follow-up
- Crisis stabilization transitions
- Referral coordination across providers

Information Sharing

- Coordination across treatment teams
- Appropriate use of health information systems
- Communication across care settings

Privacy & Consent Protections

- Compliance with HIPAA and 42 CFR Part 2
- Appropriate patient consent for information sharing

Activity: What Is It / What Isn't It?

Step 1: Sort the Activities

At your table, review the example activities and place each one into the appropriate category.

Five Buckets

1. Care Coordination
2. Case Management
3. Care Navigation
4. Clinical Care
5. Administrative Support

Step 2: Discuss the Boundaries

After sorting, discuss:

- Where definitions overlap
- Where responsibilities should be clarified
- Which activities require workflow accountability

Debrief Question (Bottom)

What activities does your organization currently call "care coordination" that actually belong in another category?

Team-based Care Structures

Team-based care only works when accountability, communication, and data are built into the structure.

- Embedded multidisciplinary teams
- Population-specific or dedicated coordinators
- Shared care plans across disciplines
- Structured case review meetings / care team huddles
- Closed-loop referral tracking and follow-up
- Risk-stratified coordination for high-need populations

The Front Door Re-Design Lab: Building Access Without Barriers

The Front Door Requirement

The front door is no longer intake — it is the coordination hub of the entire system.

- No rejection based on payer or residence
- Availability and accessibility requirements
- Same-day or rapid access to screening and assessment
- Multiple entry points (walk-in, crisis, referral, hospital discharge)
- Clinical triage to determine level of care
- Immediate connection to care coordination

Activity: The Front Door Redesign Lab

Scenario

Your organization must accept all individuals regardless of payer, residence, or level of need while meeting CCBHC access expectations.

A person could arrive through any of the following pathways:

- Walk-in seeking services
- Crisis call or mobile crisis referral
- Hospital discharge
- Referral from primary care
- Justice system referral
- Family member seeking help

Your challenge is to design a front door model that ensures every individual is quickly assessed and connected to the right care.

Activity: The Front Door Redesign Lab, Continued

At your table, discuss and sketch out how your organization's **front door should function**.

Consider the following questions:

1. **Access**
How can individuals access your organization today?
How many entry points exist?

2. **Screening and Triage**
Who performs the initial screening?
How do you determine level of need and urgency?

3. **Immediate Services**
What services must be available immediately (crisis, assessment, medication, care coordination)?

4. **Care Coordination**
When does care coordination begin?
Who owns the handoff to services?

5. **Follow-Up**
How do you ensure individuals do not fall through the cracks before their first appointment?

Lunch Break

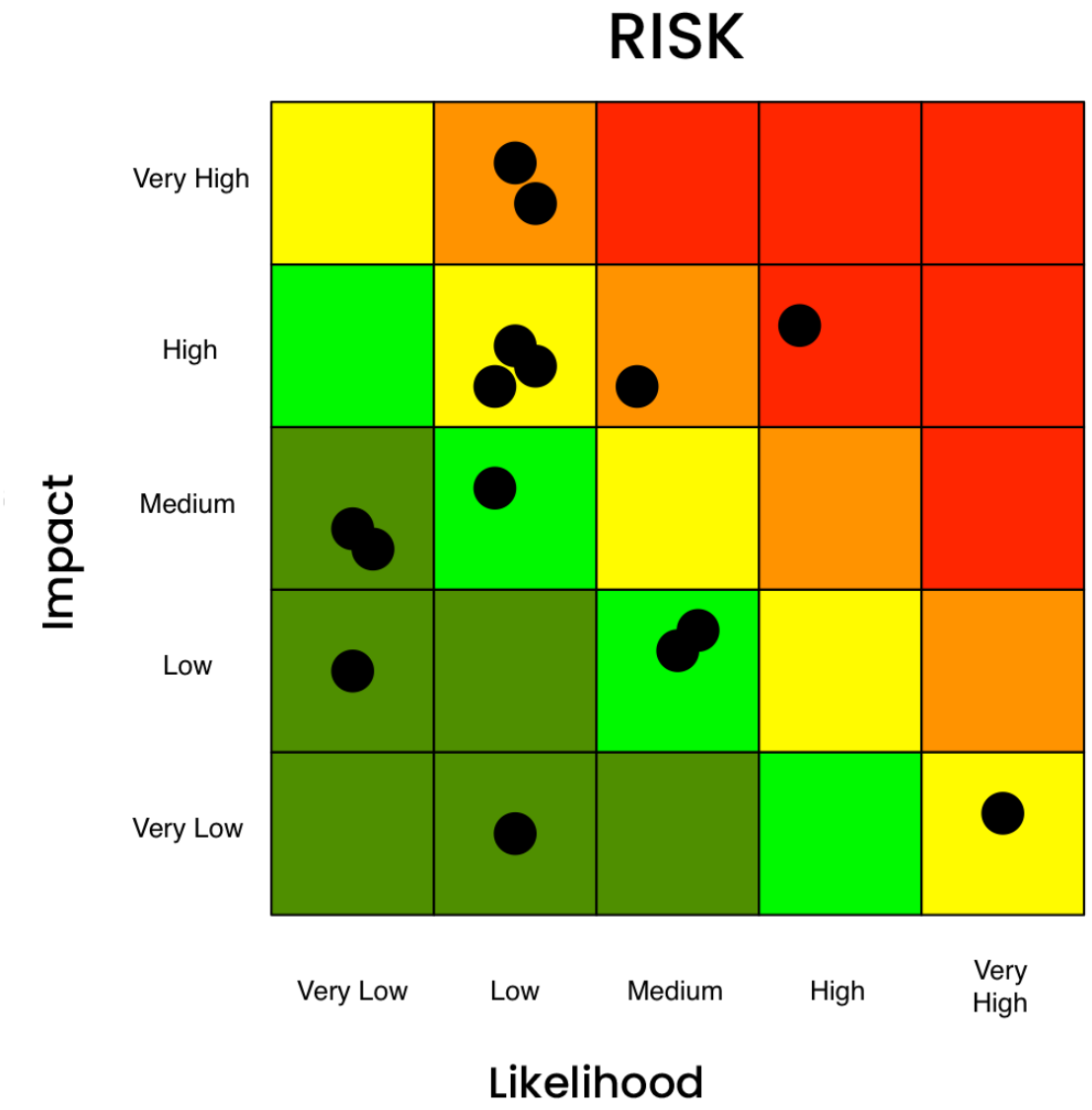
12:00 PM – 1:00 PM

Afternoon Session:

From Handoffs To Hold: Integrated Case Management That Moves Measures

1:00 PM – 4:00 PM

Readiness Assessment Heat Map



Why Readiness Assessment?

You cannot build integrated care until you understand how the system actually operates today.

- Convert scenarios into practical assessment tools
- Identify operational gaps and investment priorities
- Align leadership around current operational reality
- Standardize expectations across programs and teams
- Prioritize system design improvements
- Establish a baseline to track progress over time

Activity: Risk Scenario Lab

Patient enters system → Assessment → Referral → Service → Crisis/Hospital → Follow-up → Ongoing care

Task 1: Identify Coordination Moments

Where must coordination happen?

Who is responsible?

What information must be shared?

Activity: Risk Scenario Lab *(Continued)*

AdvaNCe Health TOGETHER
STRENGTHENING HEALTH THROUGH COLLABORATION

Task 2: Create Your Readiness Heatmap

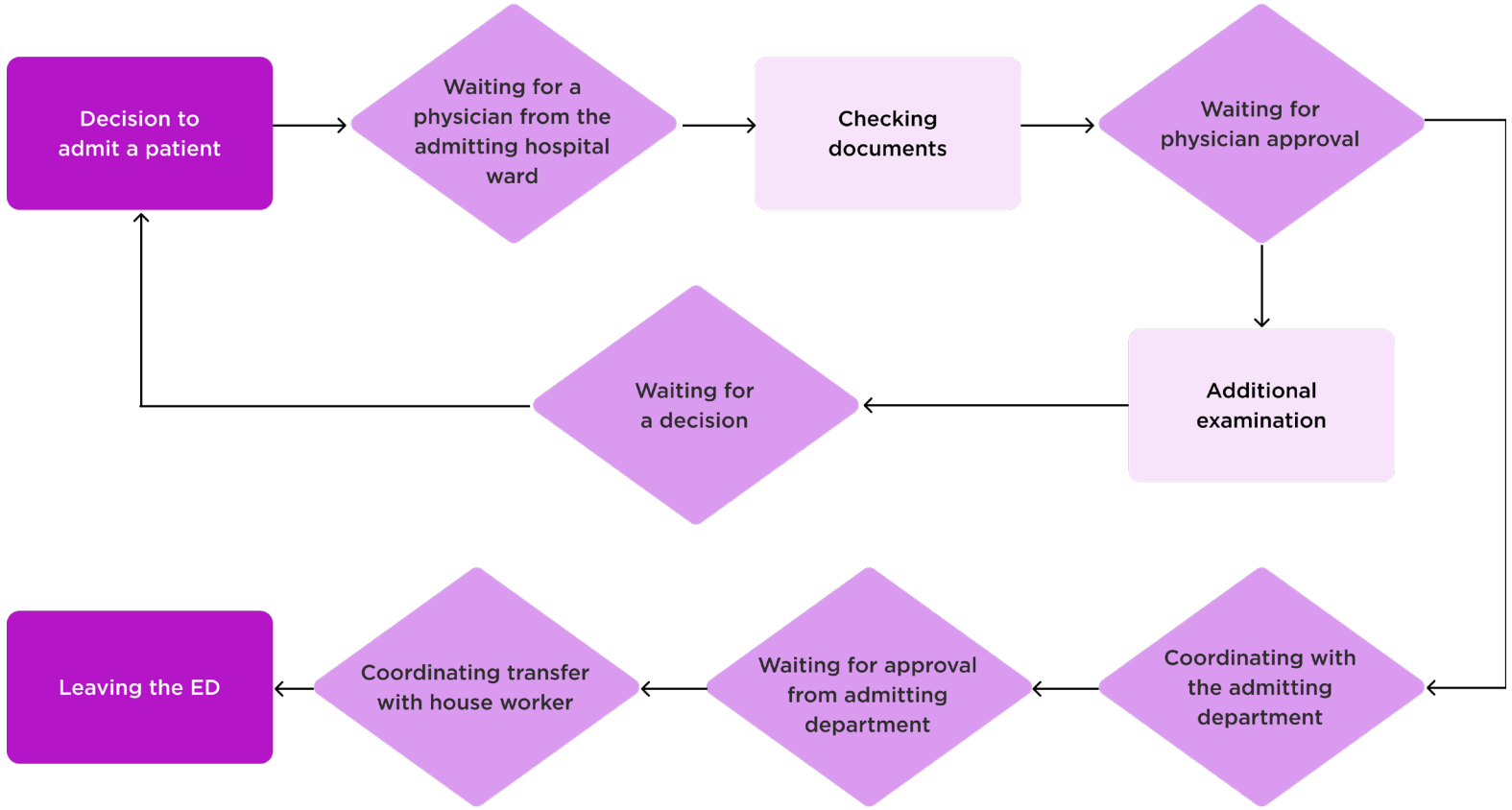
Domain	Strong	Developing	Gap
Front Door			
Care Coordination			
Team-Based Care			
Referrals & Transitions			
Data & Tracking			

- Where does coordination break down today?
- What capabilities must be strengthened?

Workflow Mapping For Performance Improvement

Patient Workflow

Enter your sub headline here



Choose The Measure

Follow-Up After Hospitalization for Mental Illness (FUH)
Focus:

- Rapid post-discharge contact
- Care coordination with hospital
- Appointment scheduling within 7 days

Depression Screening & Follow-Up (GSD-AD)
Focus:

- Routine screening
- Documentation
- Follow-up treatment planning

Initiation and Engagement in SUD Treatment (I-SERV)
Focus:

- Rapid engagement
- Care navigation
- Early treatment retention

Depression Remission at 6 Months (DEP-REM-6)
Focus:

- Ongoing symptom tracking
- Treatment adjustments
- Outcome monitoring

Table Discussion

1. Choose one measure your team will improve
2. Identify one workflow that must change

Improving performance measures is not a documentation problem — it is a workflow design problem.

How To Map A Workflow

Using the 6-Step Swimlane Method

AdvaNCe Health TOGETHER
STRENGTHENING HEALTH THROUGH COLLABORATION

1. Define the Starting Point

Identify the trigger event
Example: Hospital discharge notification

2. Identify Roles / Lanes

Who is involved? Care coordinator, clinician, intake, peer support, etc

3. Map Key Actions

Document each step taken by each role

4. Identify Handoffs

Where information or responsibility moves between teams

5. Identify Breakdowns

Where delays, missed follow-ups, or lost referrals occur

6. Design Improvements

Redesign steps to improve coordination and outcomes

Validate Through Walkthrough

- Walk through the workflow step-by-step
- Confirm with frontline staff
- Test whether the workflow produces the desired outcome

Intake	Care Coordinator	Clinician	Peer Support
Step	Step	Step	Step
Step	Step	Step	Step

Performance measures improve when workflows are designed intentionally—not when staff work harder.

Build The Workflow

Design a workflow that improves your selected performance measure

Trigger	Intake	Care Coordinator	Clinician	Follow-Up
Hospital Discharge	Notification Received	Contact Patient	Appointment	Check Follow-up

Your workflow should include:

Trigger
What starts the process?

Owner
Who is responsible for the step?

Timeframe
How quickly must the step happen?

Documentation
Where is the step recorded?

Metric
How will success be measured?

Escalation
What happens if the step fails?

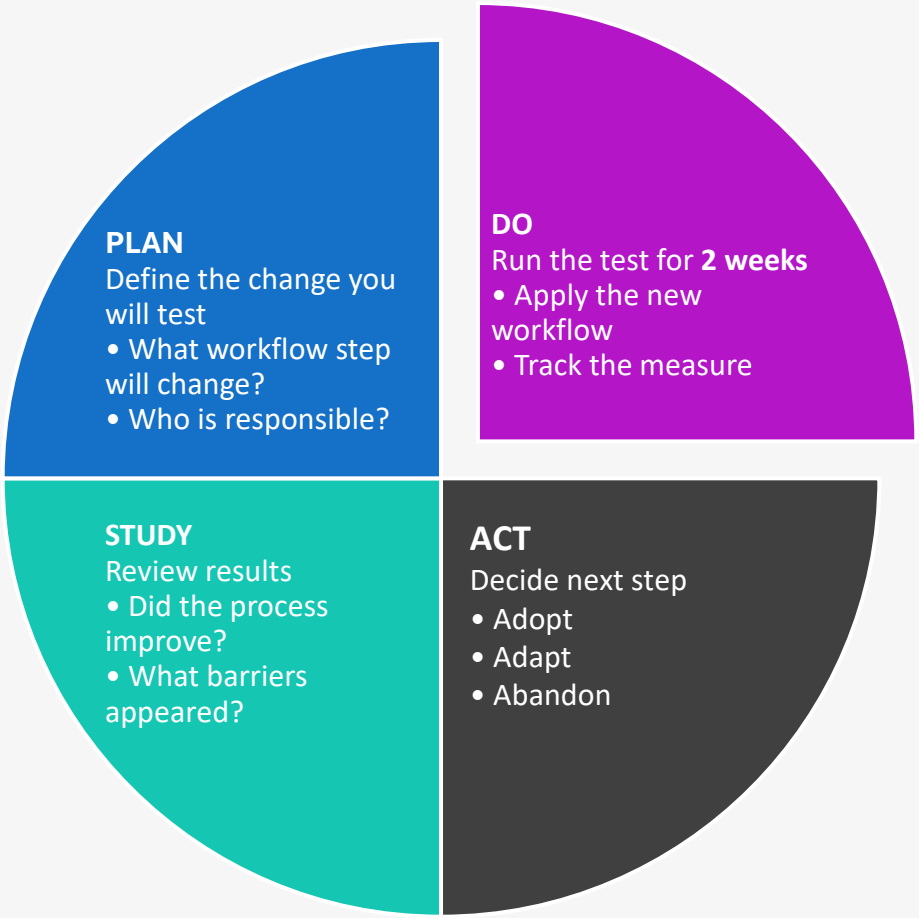
Table Task

1. Build a swimlane workflow for your selected measure
2. Identify one step where coordination often breaks down
3. Propose one improvement to strengthen the process

If a workflow step has no owner, no timeframe, and no metric — it rarely happens consistently.

PDSA Planning

Test your workflow improvement using the Model for Improvement



Teams should define:

Measure

Which performance metric are you improving?

Workflow Change

What step will be tested?

Owner

Who leads the test?

Data to Track

What will show improvement?

Table Activity

Define a **2-week PDSA test** for the workflow your team designed.

Be ready to share:

- The change you will test
- The measure you will monitor
- The leader responsible

Improvement happens through small tests of change — not large system overhauls.

Closing The Loop On Incomplete Referrals

Closing The Loop: Why It Matters

Ensuring referrals lead to completed care

Open Loop (The Problem)

- Referral sent → ❓ → No confirmation → Patient lost → Outcome unknown

Challenges

- Referrals may not be completed
- No visibility into outcomes
- Patients fall through gaps

Closed Loop (The Goal)

- Referral sent → Provider receives → Appointment scheduled → Care delivered → Status reported back

Key Elements

- Referral tracking system
- Bi-directional communication
- Confirmation of service completion
- Outcome visibility

Closed-loop referral systems ensure that every referral results in:

✓ Confirmed receipt
✓ Completed service
✓ Feedback to the referring provider

Activity: Closed-Loop Referral Design

Build a system that ensures every referral results in completed care

Referral Tracking Structure	Communication & Reporting
☐ Referral source documented	☐ Bi-directional communication established
☐ Receiving provider confirmed	☐ Follow-up responsibility assigned
☐ Appointment scheduled	☐ Escalation process defined
☐ Status updates tracked	☐ Monthly performance metrics tracked
☐ Service completion confirmed	☐ Referral completion rate reported

Table Activity

At your table:

1. Identify the key elements your referral tracking system must include
2. Define two metrics you will review monthly

Examples:

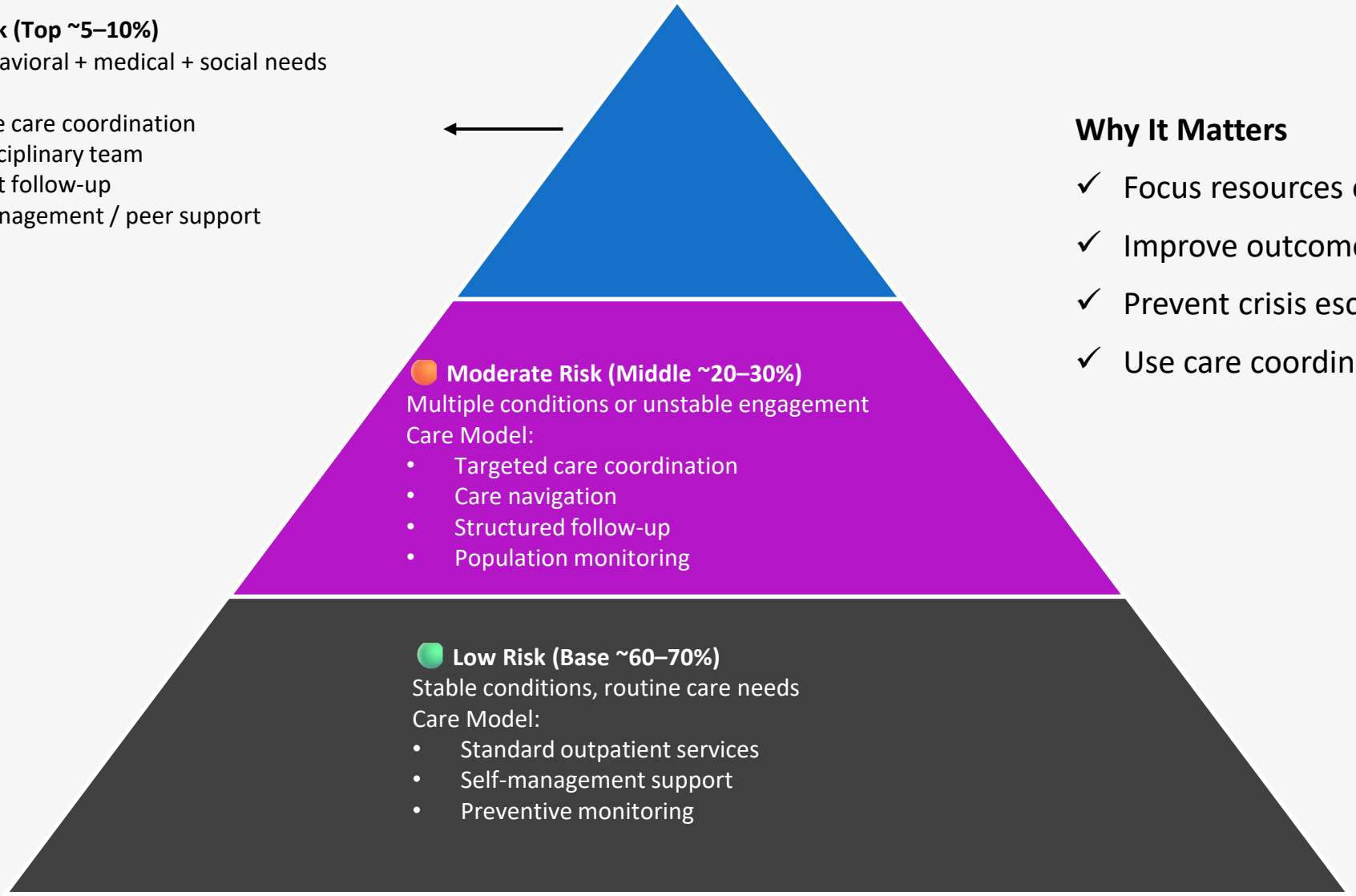
- Referral completion rate
- Time from referral to appointment
- Missed referral follow-up rate

Risk Stratification: Aligning Services To Need

Risk Stratification As Resource Allocation

Matching care coordination intensity to patient need

High Risk (Top ~5–10%)
Complex behavioral + medical + social needs
Care Model:
- Intensive care coordination
- Multidisciplinary team
- Frequent follow-up
- Case management / peer support



Why It Matters

- ✓ Focus resources on highest-need individuals
- ✓ Improve outcomes for complex populations
- ✓ Prevent crisis escalation and hospitalizations
- ✓ Use care coordination capacity strategically

Activity: Cohort Gap Analysis

Step 1: Identify Priority Cohorts

Examples may include:

Serious Mental Illness (SMI)
Substance Use Disorder (SUD)
Children with Serious Emotional Disturbance
Traumatic Brain Injury or Complex Needs

Step 2: Assess Service & Partner Gaps

For each cohort, discuss:

What services do we currently provide?
What services are missing or limited?
Which community partners are required?

Step 3: Define Near-Term Priorities

At your table, identify:

- ✓ 1–2 service gaps to address
- ✓ 1 partnership to strengthen or establish
- ✓ 30–60 day action priorities

If this cohort presented tomorrow at scale, would your organization have the services, coordination, and partnerships needed to meet their needs?

Leadership Commitments To Close Our Day

30–60–90 Day Leadership Commitments

Turning today's insights into action

Leadership Question

What is one workflow, one data improvement, and one partnership action your organization will commit to in the next 90 days?

Commitments & Next Actions

1. **Pilot a Coordination Workflow**
   - Launch a 2-week PDSA test
   - Focus on one measure (e.g., FUH, engagement, referrals)
2. **Strengthen Tracking & Reporting**
   - Implement referral tracking or workflow reporting
   - Review key coordination metrics monthly
3. **Activate Key Partnerships**
   - Identify one partner relationship to strengthen
   - Establish closed-loop communication

What is one coordination improvement your organization will begin in the next 30 days?

Closing Reflections

Leadership judgment matters

- Decisions under pressure
- CCBHC opportunity and responsibility

Integrated Q&A

3:00 PM – 3:45 PM

Open, moderated discussion

- In-person and virtual participation
- Scenario-based questions encouraged

Cindy Ehlers

Chief Strategy and Innovation Officer

Thank You

Appreciation for participation

- Follow-up supports available
- Session adjourned