

NATIONAL
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CENTER OF EXCELLENCE for Integrated Health Solutions

*Funded by Substance Abuse and Mental Health Services Administration
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Care Coordination and Referral Partnerships in the Integrated Care Field

Tuesday March 31, 2026

3 – 4 PM ET

Disclaimer

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About the Center of Excellence for Integrated Health Solutions (CoE-IHS)

- The National Council for Mental Wellbeing, through the National Center of Excellence for Integrated Health Solutions grant award from the Substance Abuse and Mental Health Administration (SAMHSA), is home to the newest **evidence-based resources, tools and support for organizations working to integrate primary and behavioral health care.**
- The CoE-IHS advances **bidirectional primary and behavioral health care integration by providing high quality, evidence-informed training and technical assistance (TTA) to a national audience, including a specific focus on the collaborative care model.** The CoE-IHS supports the improvement of integrated care models and provides training and technical assistance to health systems, health care providers and members of the public.



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Polls



1) Which best describes your agency/organization?

- ❖ Mental health provider organization
- ❖ Substance use provider organization
- ❖ Primary care provider organization
- ❖ Government (federal, state, island area, local)
- ❖ Education or research institute
- ❖ Association, coalition, or network-for-advocacy, professionals, or individuals
- ❖ Business (health management, insurer, or other industry)
- ❖ Other

2) Are you a Promoting the Integration of Primary and Behavioral Health Care (PIPBHC) recipient or provider organization?

- ❖ Yes, I am a current PIPBHC: Collaborative Care Model (CoCM) recipient
- ❖ Yes, I am a current PIPBHC: Collaborative Care Model (CoCM) provider organization
- ❖ Yes, I am a current PIPBHC: States recipient
- ❖ Yes, I am a current PIPBHC: States provider organization
- ❖ Yes, I am a former PIPBHC recipient or provider organization
- ❖ No
- ❖ I don't know



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Presenter

Renee Boak, MPH
Lead Consultant
National Council for Mental Wellbeing

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Learning Objectives

- **Define care coordination** and its role in integrated healthcare
- **Recognize opportunities** for leveraging health information technology to support care coordination
- **Identify strategies** to develop and support care coordination partnerships

Poll Questions



Does your organization utilize Memoranda of Understanding (MOUs), Business Associate Agreements (BAAs), or another form of documented agreement with (external) care coordination partners?

- Yes
- No
- Unsure



Does your organization have dedicated Care Coordinator positions?

- Yes
- No
- Somewhere in between



Is your organization aware of metrics and/or population specific needs that are important to referral partners (timely access to care, bilingual staff, provide services in the community)?

- Yes
- No



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Care Coordination



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What is Care Coordination?

According to the Agency for Healthcare Research and Quality, [care coordination](#) involves deliberately organizing care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the individual's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care.

Source: Agency for Healthcare Research and Quality (2024)



(Microsoft, 2025).



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Care Coordination in Integrated Care Settings

Broad Care Coordination Approaches

- Teamwork
- Care management
- Medication management
- Health information technology
- Patient-centered medical home

Care Coordination Activities

- Communicating/sharing knowledge
- Helping with transitions of care
- Creating a proactive care plan
- Supporting self-management goals
- Linking to community resources
- Working to align resources with patient and population needs



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Who To Coordinate Care With

- Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and other Primary Care Providers (PCPs)
- Specialty care providers
- Hospitals, emergency departments, urgent care (crisis continuum)
- Criminal justice/justice involved partnerships
- Child and youth focused organizations, including schools, child welfare system, foster care, juvenile justice, and treatment centers
- Social service organizations



(Microsoft, 2025).



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Care Coordination Staffing Models



Embedded multidisciplinary approach

A wide range of client-facing staff coordinate care within their roles, and no single person is designated as the care coordinator (except when serving children and youth, who have a dedicated lead coordinator).



Population-specific team approach

Care coordination is team-based approach, with roles such as nurses, primary care managers, community health workers and peer specialists assigned on patient needs. For example, a team including both primary care and behavioral health clinicians, coordinates care for people with comorbid conditions.



Case manager/care coordinator partnership approach

Case managers and care coordinators work collaboratively to provide consistent support to the person served and address internal and external referrals.



Dedicated care coordinator approach:

One care coordinator is the lead point of contact for the person served through internal and (to varying extents) external coordination.

Source: National Council for Mental Wellbeing (2024)



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Outcomes Associated with Care Coordination Model

Care coordination creates positive impacts for providers though consistently improved outcomes to help increase job satisfaction, reduce turnover and create a culture of results-driven care.

- Overarching understanding of beneficial strategies and services
- Improved staff satisfaction
- Efficient service delivery through streamlined and targeted approaches
- Multidisciplinary, team-based approach to care
- Efficient staffing models
- Improved return on investment



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Care Coordination Enhances Integrated Care

Care coordination is critical in integrated behavioral health to bridge gaps between mental and physical healthcare, resulting in improved patient outcomes, reduced costs, and enhanced care quality. By fostering collaboration among providers, it prevents fragmented care, reduces medical errors, and lowers unnecessary emergency room visits, ensuring a holistic "whole-person" approach. [Center For Medicaid and Medicare Services, 2014](#)

Opportunity for Engagement

- What does care coordination look like at your agency?
- What skills or abilities have been instrumental in care coordination?
- What trainings or support structures do you recommend for care coordination/care coordinators who are working in an integrated care setting?



(Microsoft, 2025).



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Leveraging Health Information Technology to Support Care Coordination



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Leveraging Health Information Technology (HIT)



Electronic Health Record (EHR) System



A high-level or dashboard view of all assigned clients, with the ability to view client-level information



Access to client-level information, including information collected in client registration fields (e.g., family relationships, preferences for language and communication, pronouns) and behavioral health and physical health activities



A display of the client's care team members (e.g., behavioral health providers, physical health providers, care coordinators, social workers, peer support team members)

Source: National Council for Mental Wellbeing (2024).



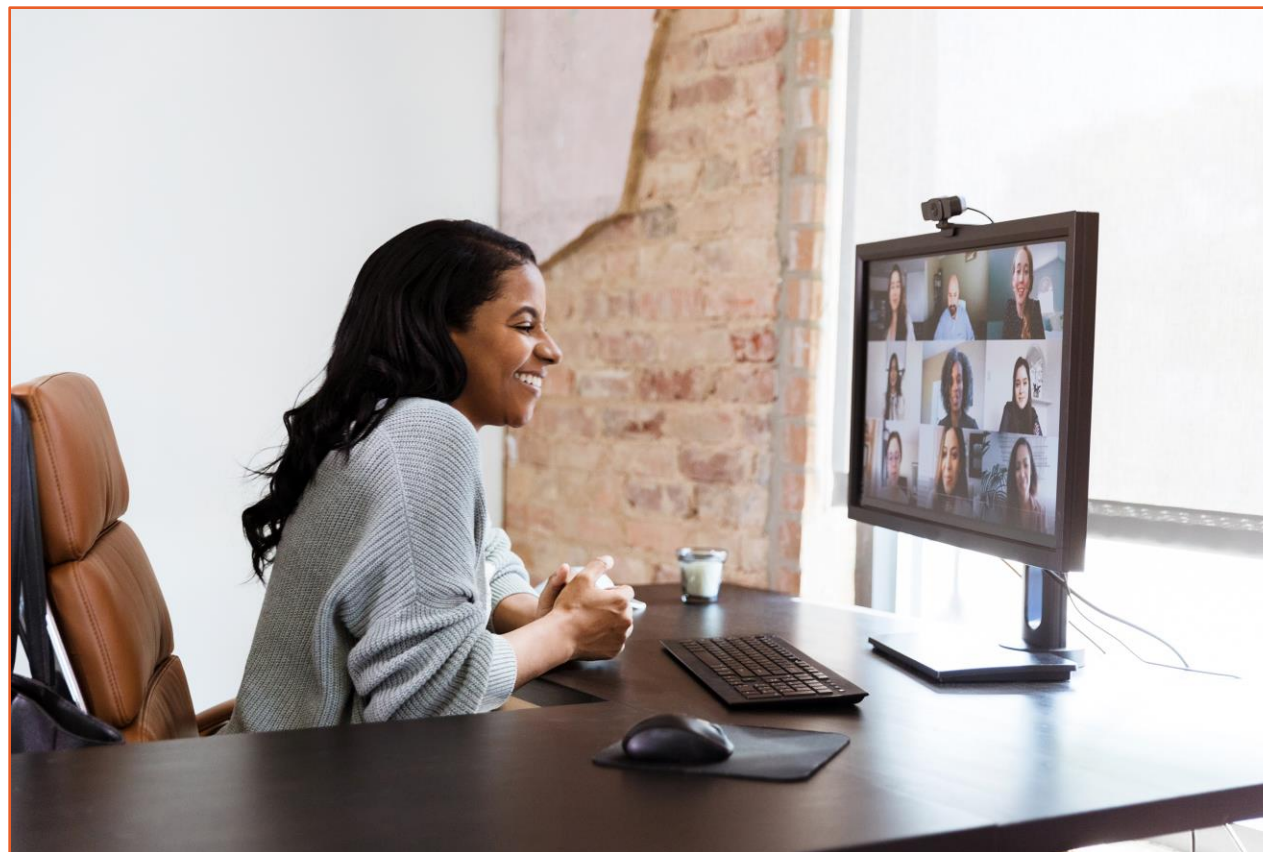
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Opportunity for Engagement (1/2)

- How does your agency leverage health information technology to support care coordination activities?
 - *Closing the loop* on referrals
 - Daily huddles
 - ED/Inpatient utilization



(Microsoft, 2025).



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Strategies and Considerations to Support Care Coordination Partnerships



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Strategies and Considerations

Partnerships	Leverage existing partnerships and affiliations
Align Services	Prioritize and align services with community needs
Analyze	Analyze existing information on care coordination and partnerships
Data Sharing and Referral Processes	Come to an agreement on data sharing and referral processes
Training	Support in training and consultation
CQI and Population Health	Engage in CQI and population health management activities
Outreach and Engagement	Enhance outreach and engagement strategies



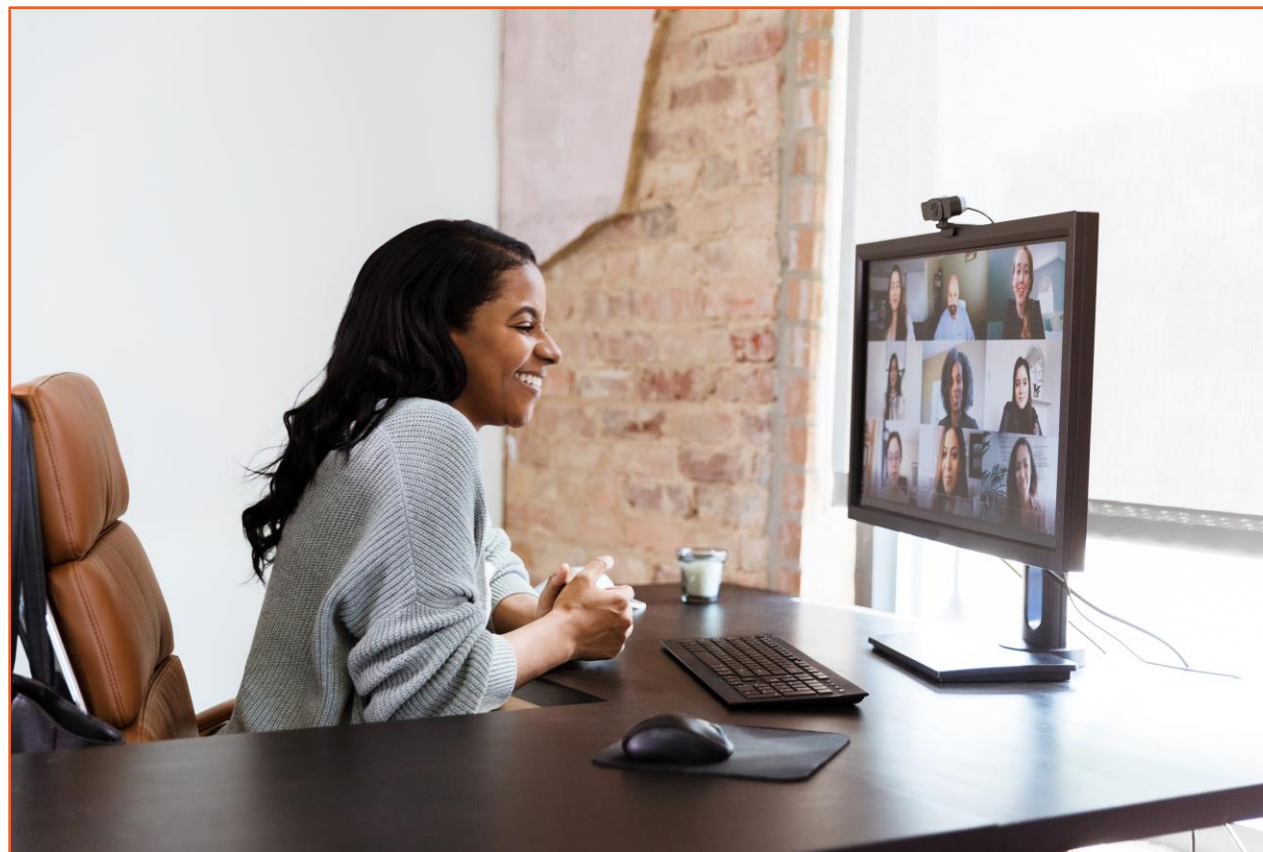
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Opportunity for Engagement (2/2)

- How has your organization leveraged partnerships to advance care coordination?
 - Do you have written or verbal agreements?
 - Did you collaboratively develop workflows?
 - Do you have a position or FTE dedicated to managing relationships?



(Microsoft, 2025).



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- Agency for Healthcare Research and Quality. (2024, November). *Care coordination*. U.S. Department of Health and Human Services. <https://www.ahrq.gov/ncepcr/care/coordination.html>
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Questions and Discussion



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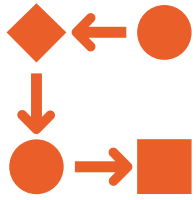
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The logo features a central orange square with white text. The text is arranged in four lines: 'NATIONAL', 'COUNCIL', 'for Mental', and 'Wellbeing'. The words 'for Mental' and 'Wellbeing' are in a lowercase, italicized serif font, while 'NATIONAL' and 'COUNCIL' are in a clean, uppercase sans-serif font. The square is set against a background of several overlapping, semi-transparent light beige rounded rectangles of various sizes and orientations.

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