

Addressing fragmentation through regional case conferencing: Lessons from 3 states

January 29, 2026



Agenda

- Welcome and goals
- Housekeeping
- Field practice:
 - New Jersey
 - Vermont
 - Oregon
- Q&A

Goals

- **Define complex case conferencing** and the role it has in strengthening ecosystems
- Highlight **examples of how complex case conferencing** has been implemented in three states by sharing experiences from New Jersey, Vermont and Oregon.
- **Discuss recommendations** for next steps in this work

Addressing fragmentation through regional case conferencing: Lessons from 3 states



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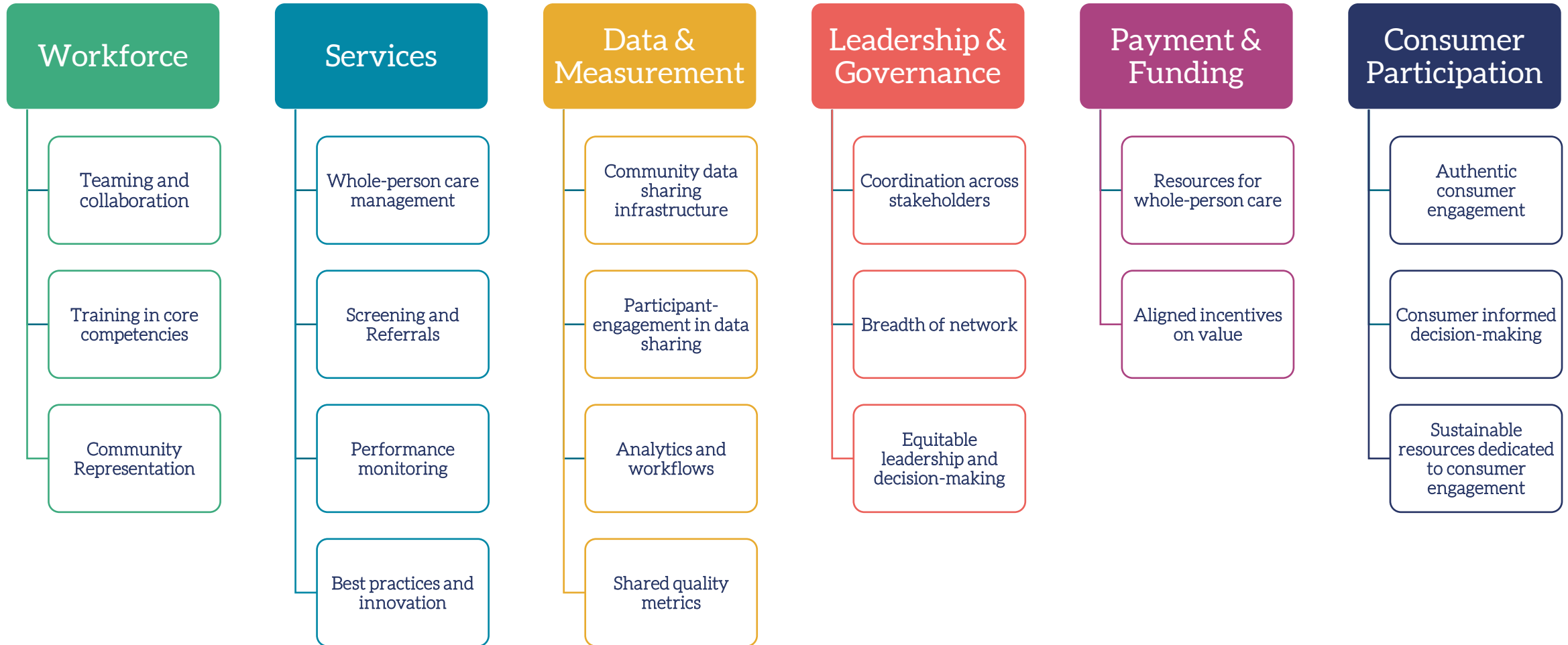


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The problem: Fragmented care for complex needs

- Individuals with complex health and social needs **navigate fragmented health and social care systems**
- Despite major investments in health IT, providers cannot easily see care across different systems/sectors or create shared care plans
- Fragmentation leads to poor outcomes, inefficiencies, high costs, and growing provider burnout
- Strong interventions are limited by weak care ecosystems

Six domains of a strong ecosystem



Regional, complex case conferencing

- A structured collaborative process in which **teams from multiple sectors**, such as healthcare, behavioral health, housing, and social services, **develop and maintain a coordinated plan of care** for individuals with complex needs
- Case conferencing serves as a practice to strengthen the ecosystem by:
 - Creating structured opportunities for cross-sector collaboration
 - Revealing real-time system barriers and opportunities for improvement
 - Supporting providers and care teams through shared problem-solving/learning





Field practice: New Jersey

Context for case conferencing

Pledge to Connect is a regional care coordination initiative designed to improve engagement and continuity of care for individuals with high behavioral health and social complexity who frequently use emergency room.

Camden
Coalition

Cooper

Oaks

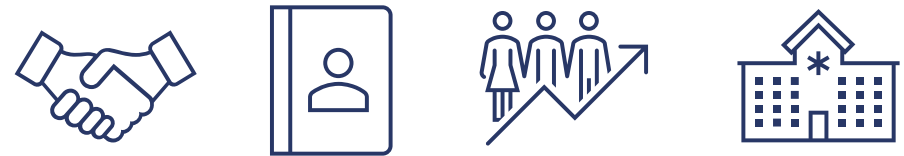
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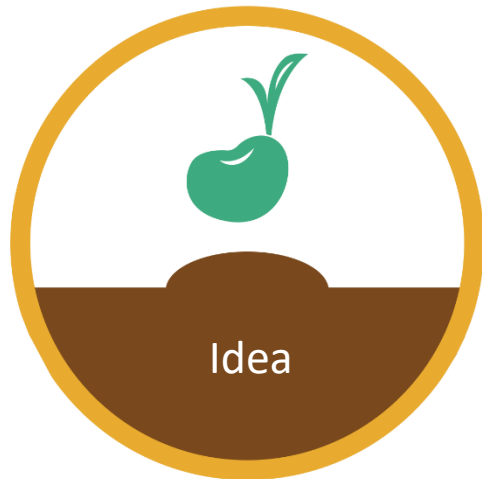
Case conferencing emerged as a core strategy to:



- Align partners around a shared understanding of patient needs
- Coordinate roles and develop unified care plans
- Use shared Health Information Exchange and behavioral health data to guide decisions
- Improve engagement for patients with frequent emergency room utilization

Pledge to Connect: Project history

Embedding CCBHC case managers in the ER to connect pts with mental health needs to outpatient BH care



Created protocols, PDSA cycles. Connected outcome metrics to NJ Medicaid pay for performance program



2022 - Present: Scaled the pilot to 4 health systems & focus on reaching high acuity patients.



The Why

Need was **identified by four regional health systems and two behavioral health partners** – the same patients were getting referred into our navigation program from different emergency rooms across the region.

We **needed a new way to coordinate their care** by:

- Identifying a lead care coordinator to be the main contact
- Identifying action steps that every partner could bring back to their teams.

The How

Cadence: Meet monthly virtually, with quarterly in-person meetings

Attendees:

- Four health systems (emergency providers, one substance use navigator team)
- Two behavioral health organizations (navigators)
- Future: Inviting additional partners to join

The Camden Coalition backbones the effort:

- Identifies patients via the Health Information Exchange (HIE) with partner input.
- Creates patient summaries based on HIE data.
- Convenes and facilitates case conference.
- Documents shared care plan & sends out action steps

Consent and data sharing

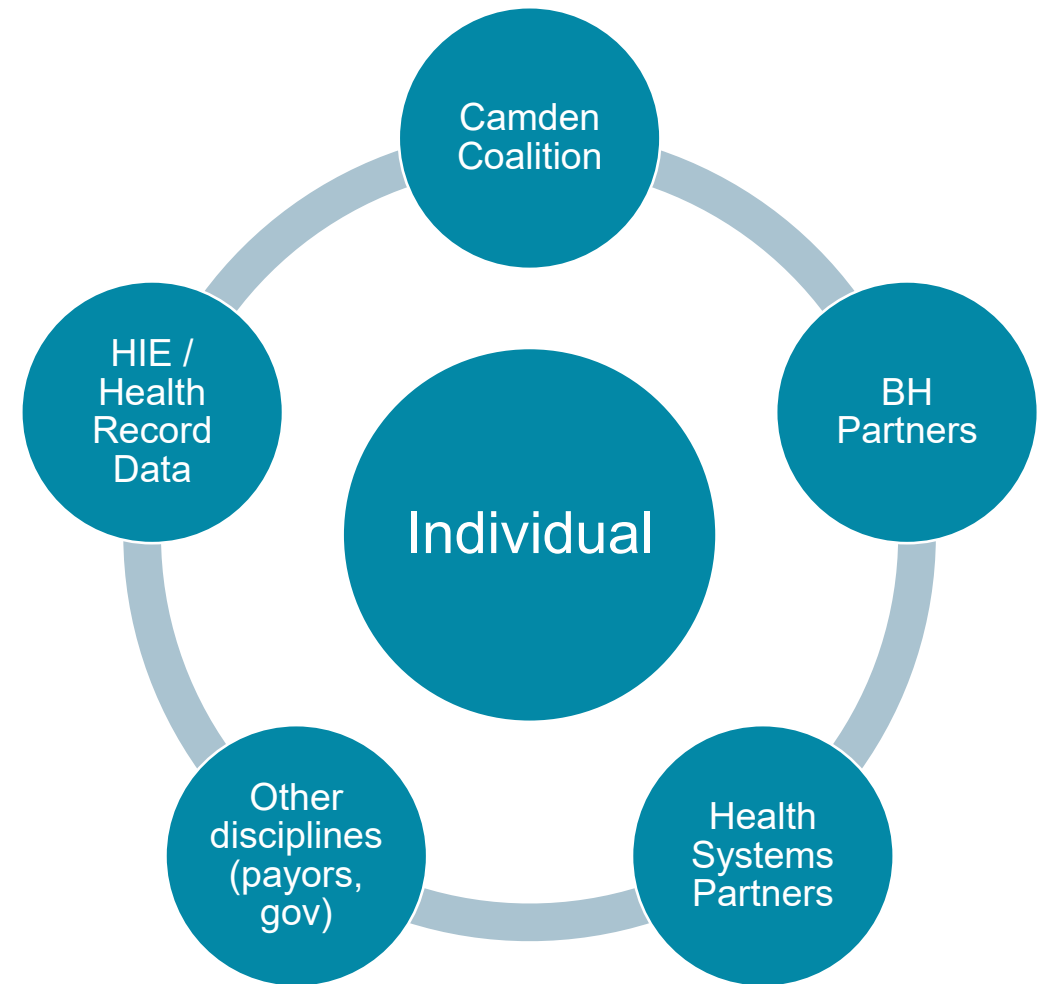
42 CFR Part 2 Reminder:

- The umbrella of HIPAA Care Coordination allows us to discuss these patients' emergency department and health care utilization/data.
- We will not discuss patients' connections or interactions, if any, with 42 CFR Part 2 drug treatment facilities, without their explicit consent.
- Under HIPAA, we can discuss the patients' diagnoses and treatment within the context of the emergency department to the extent needed for care coordination.

To ensure compliance with these parameters, we focus our discussion on care coordination within the ER setting and under Pledge to Connect/Regional Triage only.

Improving and refining our approach

- Improve how we use data to drive conversations and next steps
- Bring all the right people into the conversation within the confines of data sharing requirements
- Integrate underlying barriers like stigma into case conferencing structure so they become more visible



Patient case

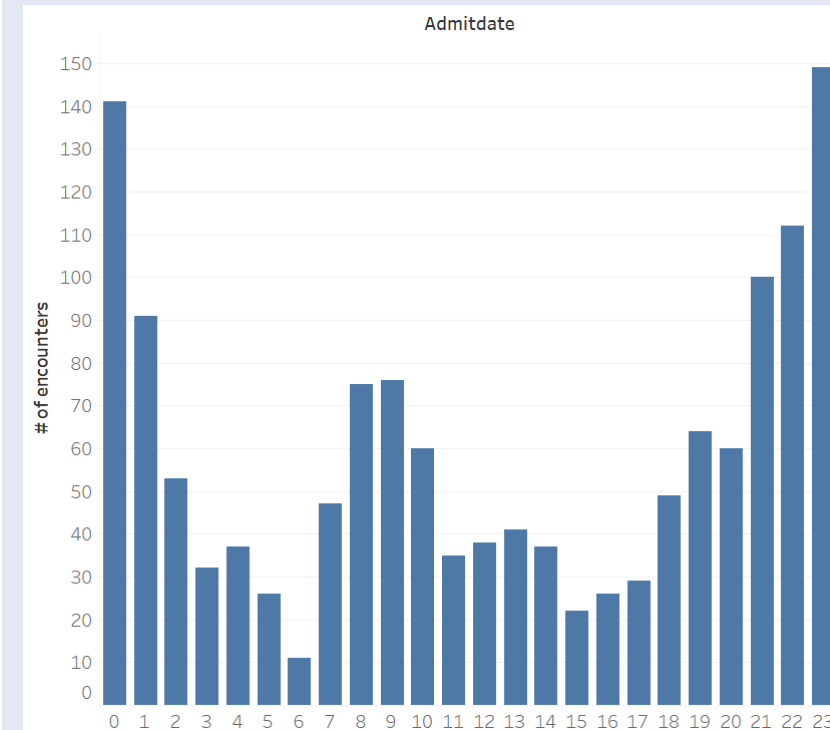
Patient summary:

- History of suicidal ideation
- Primary diagnoses: bipolar affective, polysubstance abuse, asthma
- Signs of intellectual or developmental disability but no diagnosis
- Homelessness/financial insecurity; impacts medication use
- In 2024, had **481 ER visits**, averaging **44/month**, many **off hours**

Pledge to Connect intervention:

- ED team relationship with patient was critical in establishing trust
- Initial goal was quick ED diversion, but team prioritized trust-building over time before progressing to community engagement.
- **Major barriers:** No ID and no documented notes of developmental disability
- **Major wins:** Successfully accompanied patient to DMV to get ID; Obtained paperwork for DD diagnosis; Warm hand off to long term care services with an assigned case manager

Patient ED admit times 2022 - 2025



Lessons and early outcomes

Provider survey feedback:

- Addressed critical gaps in regional care coordination
- **Despite the small sample size, respondents reported substantial improvements in identifying patients who frequent multiple ERs and enhanced communication capabilities across health systems**
- Established clear care coordination pathways, with participants reporting improved ability to identify appropriate contacts at other health systems and understanding of their roles within the regional workflow
- **Fostered meaningful collaborative problem-solving; all respondents planning to continue engagement in future activities.**

Key challenges when scaling:

- Privacy concerns especially relating to Part II data
- Formalize communication practice – shared care plan exist but not protocolized in each system's EHR
- Balance between diversion and respecting individual's autonomy

Early takeaways:

- Led to sharp decreases in utilization for some individuals.
- **Need to match the patients' long-term needs with a long-term intervention.**
- Focused still on diversion, but recognizing the need for relationship-building over time.



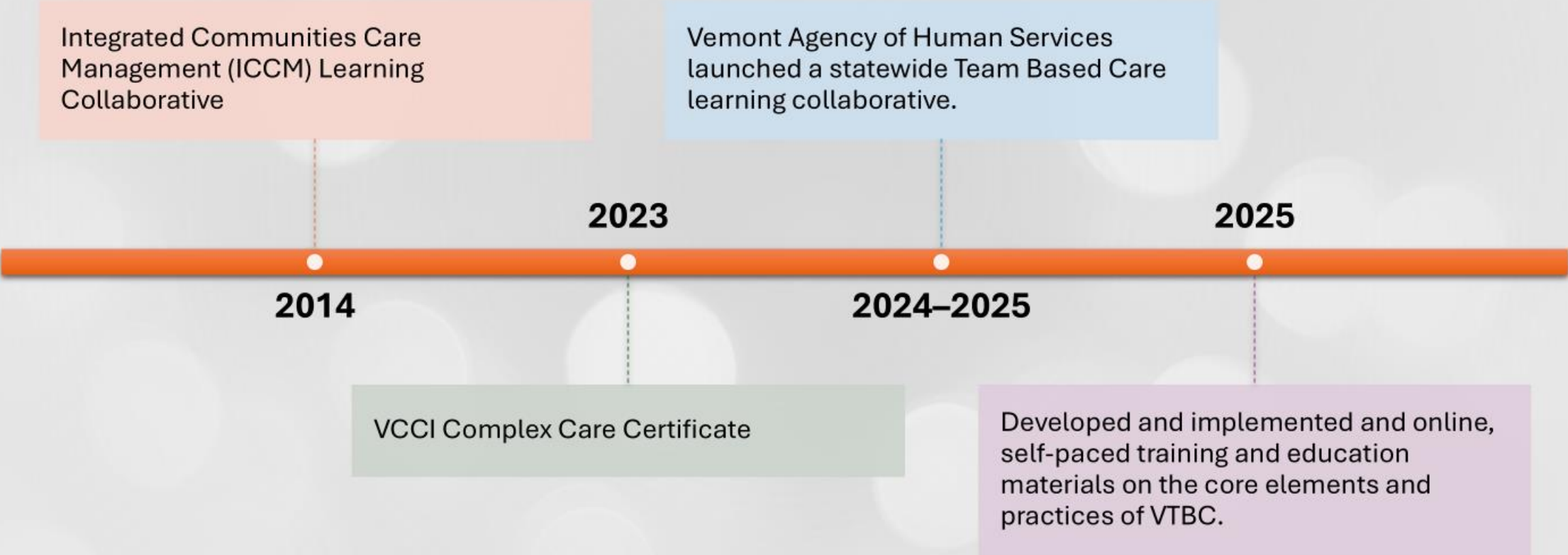
Field practice: Vermont



- Vermont Chronic Care Initiative (VCCI) provides holistic, intensive short-term case management services to Vermont residents enrolled in Medicaid.
- 18 Nurse Case Managers, 2 Outreach and Support Coordinators, 1 Admin Support and 1 Nurse Supervisor
- VCCI serves VT Medicaid members experiencing complex health and social needs, our priority population are individuals who do not have any connections with health care or service providers in the community.
- Our service model is whole person centered, using a team-based care approach.



Vermont Team-Based Care (VTBC)



Vermont TBC in Action

Case Conferencing

- Reoccurring or one off
- Connection with the Care Coordinator in the PCH, discharge planner, provider
- Does not include individual
- Treatment plan, concerns, barriers, next steps

Care Team Meetings

- Usually reoccurring
- Connection with cross sector of supports
- Ideally will include Individuals
- Focus on big picture
- Shared Care Planning

Who Participates

- Individual, Family, Friend or other supports
- VCCI and other state entities
- Primary Care Home, Specialists, Discharge Planners
- Housing Agency
- Designated Agency for Mental health
- Youth Services
- Field Services
- DOC

Structure

- Case Selection- complex health and social needs, duplication of services, accountability, TBC tools used to determine who should participate, focus of meeting
- Frequency- need based, working on or from Shared care Plan, is typical to schedule every 4-6 weeks to start/further out as goals met/independence gained
- Facilitation- lead care Coordinator facilitates by sending invites and agenda,
- Documentation and follow up- organization requirements, Shared Care Plan sent to individual and care team, next meeting scheduled at end of each meeting

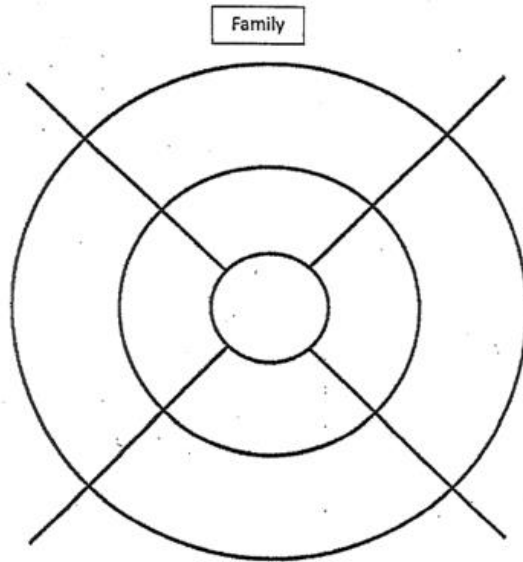
Complex Care Tools

Ecco Mapping

Care Planning Cards

People Map for:

People who support me at work or school



People whose job is to support me at home and other places

From The Learning Community for Person Centered Practices

| | | | | |
|--|--|---|---|-----------------------------|
| <p>Get a job and/or go back to school/work</p> | <p>Medication or Medical Equipment</p> | <p>Legal Issues</p> | <p>Talk to someone about my Mental Health</p> | <p>Have Transportation</p> |
| <p>Have a better Living Situation</p> | <p>Have a better relationship with my doctor or nurses</p> | <p>See if I qualify for Insurance and other Programs</p> | <p>Help people in my Community</p> | |
| <p>Identification</p> | <p>Feel Supported</p> | <p>Learn more about my Medical health (diabetes, COPD, etc)</p> | <p>Talk to someone about my drug or alcohol use</p> | <p>Food & Nutrition</p> |

Shared Care Plan

| Patient Information | | | |
|--|--|----------------------------------|-------------------------|
| This Care Plan is centered around: Member | | | |
| Address: 123 main St Vermont | | Birthdate: Jan 1, 1991 | Today's Date: 1/18/2026 |
| Phone: 555-555-5555 | | Identified Gender: Male | Contact Person: Self |
| PCP: Dr. Doctor at Health Center 222-222-2222 | | | |
| My Care Team | | | |
| Lead: PCP CC Nurse Nurse | | | |
| Role and Name | | Contact Information | |
| PCP CC | | 222-222-2222 | |
| VCCI RN CM | | 333-333-3333 | |
| Mental Health CM | | 444-444-4444 | |
| Youth Services Support | | 777-777-7777 | |
| My Goals - Summary | | | |
| Goal | Tasks | Responsible Person | Due Date |
| Goal 1: Schedule PCP appt and Medical Ride | MH CM will support phone call to PCH and transportation | Member with support from MH CM | 1/31/26 |
| Goal 2: Obtain live-in support for I-ADLs | Complete and submit HS VT and ASP applications, answer phone calls from HS VT and ASP | Member with support from VCCI CM | 3/31/26 |
| Goal 3: Increased independence with grocery shopping | Submit small order to Walmart delivery, obtain backpack and schedule Micro Moo ride to local grocery store | Member | 1/31/26 |
| Goal 4: Start Occupational and physical therapy for home assessment/safety/strengthening | Attend primary care appointment to discuss referral to home health, answer phone calls from home health agency | Member with support from VCCI CM | 2/15/26 |
| Goal 5: | | | |
| Transition Plan | | | |
| My Care Team moving forward: No changes | | | |
| Role and Name: | | Contact Information: | |
| | | | |

Consent and Information Sharing

- Respect individual's wishes r/t information sharing
- Organizations obtain their own consent. VCCI recently developed new combined consent, included many cross sectors of health care continuum on one document
- Team-Based Care Consent
- Inviting individual to be an active participant in TBC activities and meeting allows for verbal consent at start of meeting

Lessons

Key Challenges encountered when scaling or formalizing the practice.

- HIPAA
- Busy schedules
- Staff turn over
- Beliefs

What has helped sustain participation and buy-in over time?

- Education
- Getting people to the table
- Shared Care Planning
- Flexibility
- Less Work
- Continued Modeling



Field practice: Oregon

Healthcare x Homelessness Pilot as a Foundation

- Three year national pilot funded by Providence, Kaiser Permanente and CommonSpirit Health
- Institute of Healthcare Improvement + Community Solutions engaged with 5 pilot communities: **Washington County, Oregon**; *Sacramento, CA; Bakersfield, CA; Chattanooga, TN and Anchorage, AK*
- Creation of commitment and a dedicated space to design and implement projects for collaboration across health and homelessness systems
- Projects included data sharing, increasing respite care, liaison roles, aligning and dedicating resources, and **coordination through cross sector case conferencing**
- Spread and scale occurring post pilot within Tri County region in Oregon

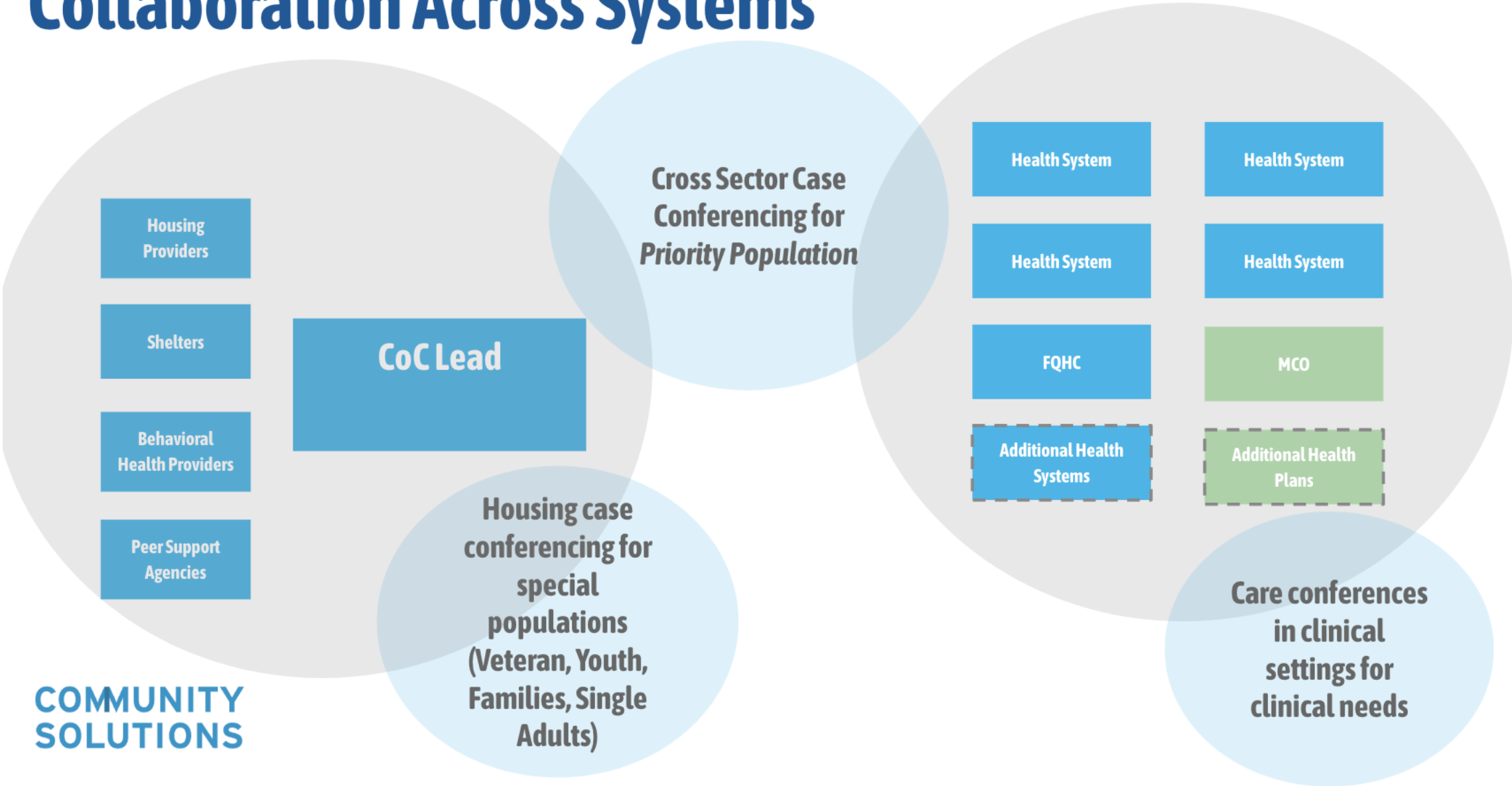
Why Pursue Cross Sector Case Conferencing

- People experiencing homelessness have significantly higher rates of mortality and reduced life expectancies
- Rates of several chronic conditions are significantly higher among people with a history of homelessness
- People experiencing homelessness visit emergency departments at higher rates than the overall population & have longer average hospital stays

Cross Sector Case Conferencing

- Formalized process
- Our clients, our resources
- Focus is not just clinical, not just housing, but both
- Systems working collaboratively to meet the needs of individuals
- Person-centered, power sharing

Collaboration Across Systems



Cross Sector Case Conferencing Table



**COMMUNITY
SOLUTIONS**

Establish a Regional System for Cross-Sector Collaboration

Each County Launched at Different Times

Washington County

- Began case conferencing in Spring 2023

Clackamas County

- Began conferencing in March 2024

Multnomah County

- Began conferencing November 2024

Establish Regional System for Cross-Sector Collaboration

Each County Space Is Unique but Share Universal Elements

- Held twice monthly
- Attended by county health system experts
- Local community partners in attendance
- Housing providers refer clients to the space

New!

- Health Share convenes a Community of Practice to support continuous quality improvement
- Health Share launched the Regional Integration Continuum, the hub for health and homeless services coordination

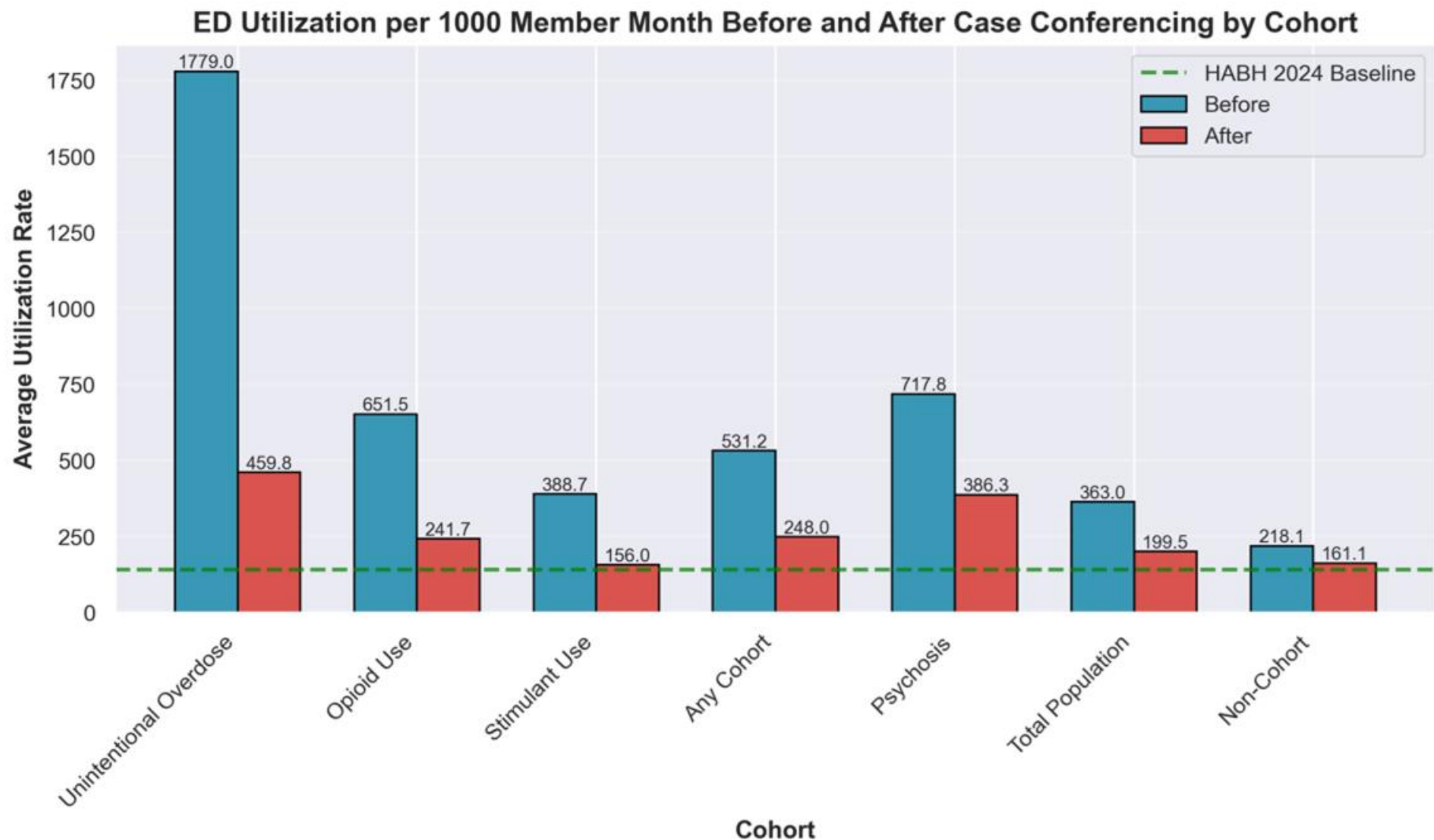
Cross Sector Case Conferencing

Cross Sector Case Conferencing Successes

- 400 individuals served
- Serves all insurance types, or no insurance
- Improved cross-sector knowledge of practitioners
- Early data indicates a decrease of avoidable ED utilization
- Individuals efficiently linked to resources, saving considerable time
- Increased health care navigation skills for homeless services providers
 - Over 350 homeless services providers trained in Medicaid 101

High Acuity Behavioral Health Cohort

Cross Sector Case Conferencing Initial Findings



Cross-Sector Case Conferencing



Client Story - Wrap Services Around Member to Avoid Eviction

- A 56-year-old African American woman residing in permanent supportive housing faces potential eviction linked to challenges related to her substance use.
- In all 4 HABH cohorts
- Referred for access to culturally responsive care
- In conference, assigned to a **culturally responsive** SUD care coordination program
- Case Manager connected to high acuity behavioral health outpatient team

Case Conference Outcome

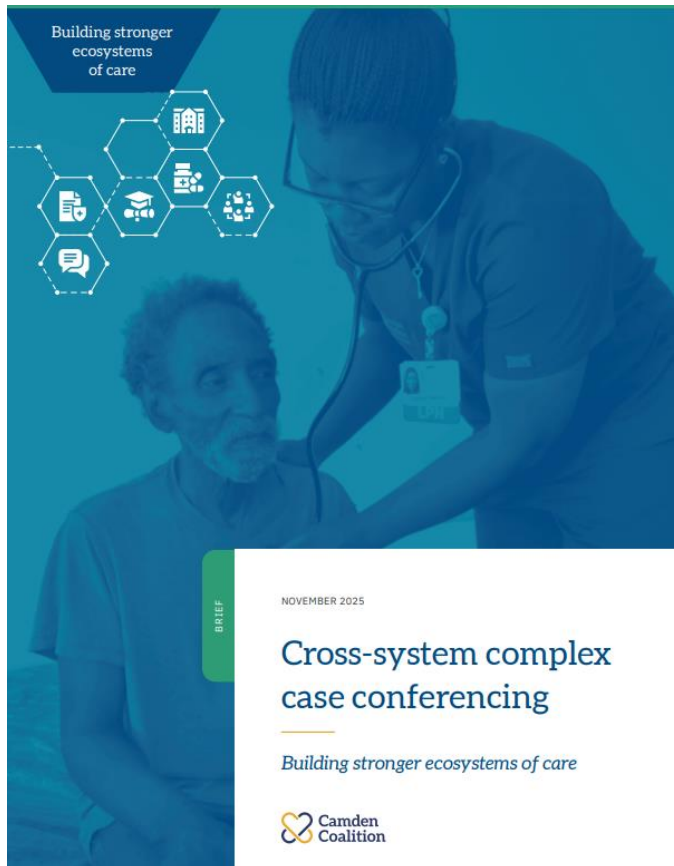
She maintained housing thanks to additional supports

Discussion

Submit your questions using
the Q&A feature

Read the brief

Cross-system complex case conferencing





Still have questions?

Feel free to reach out:

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