Elevate, Then Operate

Seven patterns from behavioral health's strongest operators in 2026

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Recently, more than 300 behavioral health leaders gathered for Elevate, Kipu Health's first customer conference. The agenda was full: keynotes, panels, workshops, executive sessions, and an Innovator Awards stage, where operators described what they were actually running and where they had taken hits.

Beyond that, some of the most remarkable experiences happened off stage: operators with thirty facilities and operators with one swapping payer notes around firepits, clinicians comparing documentation strategies in hallway exchanges, and billing managers auditing each other's denial rates over coffee with the ease of old colleagues.

Across both, seven patterns emerged:

01 A market split where strong operators are pulling ahead

02 Diversification across services, payers, geographies, and care settings

03 AI deployed as a retention strategy

04 Admissions treated as the financial nerve center

05 Revenue cycle run as a CEO discipline

06 Growth built on transplanted culture

07 Compliance and outcomes turned into competitive moats

Without a doubt, though, the most important pattern that emerged was generosity. Operators shared what was working and what wasn't with peers who could actually use the information. That generosity is one of the most valuable assets the behavioral health industry has. The reason these patterns are about to spread faster than they otherwise would is that the operators running them stood on stages and around firepits and described them in detail to anyone who asked.

We'll help you unpack those patterns, starting with the market reality the other six are all responding to.

01

The market is changing, and it's changing **fast**.

Financial scrutiny is getting more intense, increasing payer pressure is landing with real consequences, and the operators clearing diligence are the ones with documented unit economics behind them. Knowing where you sit on that change is the prerequisite for every move that follows.

The operators pulling ahead have diversified payer mixes, clean documentation, deep management benches under the CEO, and actual attribution data on every marketing dollar. The operators falling behind have payer concentration risk, unclear unit economics, manual reconciliation processes, and compliance gaps that show up in audits.

The numbers tell the same story. Payer contracts have been cut, in some cases by half. Kentucky operators absorbed a 20% Medicaid reduction last October, and Affordable Care Act reductions are landing in other states. Denials and eligibility churn are climbing. A behavioral health professional shortage now stretches across 150 million Americans. Of the 50 million people who need substance use disorder treatment this year, only about 15% will seek it.

Capital is still moving, and the underwriting bar has moved with it. Dan Davidson at NorthBorne Partners put it plainly: *"One thing you can't do to get capital is cut your way to a premium valuation."*

The operators pulling ahead aren't waiting for ideal circumstances.
They're rebuilding the operating model their organizations run on, in six places.

Each of the next six sections is one of them.

02

Diversification is the new resilience math.

Most behavioral health organizations are more concentrated than their leaders realize. The operators who absorbed the 2025 round of cuts were the ones running diversified portfolios across service lines, payers, geographies, and care settings. Concentration is a quiet financial risk that compounds until a single payer or state move forces it into the open. Diversification, run well, is what stops that move from being existential.

Glenn Hadley of JG Healthcare Solutions described the model his company is built on: $60 million in assets across kids psychiatric inpatient, adult residential mental health, PHP transitional care, a consulting business, and a payment processing company. Glenn built that breadth on purpose, as insulation against any single service line, payer, or state shifting underneath him.

Here are the three common traits of the most successful, diversified models operating now:

01

The strongest operators are running across the continuum of care, not in one slice of it.

Alex Williams of Spark Recovery added a workforce reentry vocational school (welding certifications, job readiness training) to a 6-month substance use program, then opened an adolescent residential facility in a second state. When Kentucky's 20% Medicaid cut landed, that diversified portfolio absorbed the shock; service-line concentration would have been fatal. The Goodwill partnership Spark built alongside the program added a $4 million revenue stream that didn't exist 12 months earlier.

02

Geographic expansion works when it follows a criteria framework, not opportunistic grasping.

Glenn described a 15-state expansion plan ranked on real estate availability, MCO relationship quality, regulatory environment, and reimbursement rates. The plan deliberately includes states that don't yet offer the service line, with the assumption that "blazing trails" pays off year over year. His framing: *"If we're exploring 15 states at a time, then we know that we're going to have a growth plan that will at least have seven or eight."* Operators chasing states one opportunity at a time tend to land far fewer activations and spend more energy doing it.

03

Telehealth is the most underused expansion lever in behavioral health today.

Osborne of Recovery Unplugged was direct: *"I think we've still only scratched the surface."* The infrastructure exists, the clinical model is established, and the margin is favorable. What's missing in most organizations is the operator imagination to combine telehealth with in-person and residential continuums, especially in rural geographies where access is scarce. Riley's framing of the opportunity: deliver top-quality care into the home of someone in who'd doesn't have access to that level of care locally.

What this means for CEOs and COOs.

Map your concentration risks now: payer mix, state mix, service mix, and care-setting mix. Where you're concentrated is where you're exposed.

Build a multi-factor criteria framework for new markets before you need it. Reactive expansion lands worse than planned expansion.

Pressure-test the portfolio annually against a 20% cut in your largest state. If the model collapses on paper, diversification work is your top priority

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Treat telehealth as a margin and access strategy, not a side project.

03

AI is a retention strategy before it's a productivity strategy.

The clinician shortage isn't going away. The operators with the best retention are the ones who deployed AI for a specific reason: to give clinicians their evenings back. The retention shows up in the numbers, and the revenue protection shows up downstream.

Kara Bishop of Banyan Treatment Centers laid out the underlying problem on the AI panel: *"We entered the field to save lives. And so ultimately, if someone feels like they're failing at both [documentation and patient care], they leave."* Clinicians are quitting because they can't reconcile the time their patients need with the time their charts demand. The right AI takes the second half of that conflict off the table.

At Banyan, that meant cutting documentation time 60 to 62% at maturity across seven sites. Clinicians started going home on time. Compliance targets jumped from 85% to 90% and held without burnout. The AI-assisted utilization review tool recovered 29 additional residential treatment days within three days of deployment. Across Kipu's customer base, more than half of organizations are running AI in production today, with documentation time down 60 to 65% on average and clinician onboarding time down roughly 60%.

There's a second reason to move now: payers are using AI on the other side of the table. *"Documentation integrity," Kara said. "It isn't that AI is on both sides of the table that's coming. It's here."* If a payer's AI is going to adjudicate your charts, the only durable defense is unimpeachable documentation.

> *"The only defensible position that providers can take is to ensure that their documentation is absolutely unimpeachable."*
>
> Kara Bishop | Banyan Treatment Centers

Three principles came up across every operator who has scaled AI well. It works best as a process improvement tool rather than a *"transformation."* It can't replace clinical judgment. As Nick Stavros of Community Medical Services said: *"You can't outsource your thinking."* And adoption is several times faster when AI lives inside the EMR, where the clinician already works, rather than in a separate system that requires a separate login.

What this means for CEOs and COOs.

Frame AI to clinical staff as a retention investment rather than a productivity demand. The hours you save are theirs.

Build a documentation integrity standard now and measure to it. The day will come when a payer's AI flags a chart of yours, and you want the answer ready.

Run AI inside the EMR rather than as a sidecar. The adoption curve is several times steeper.

04

The front door owns the financials.

Up to 85% of revenue cycle errors trace back to admissions. The strongest operators are running their front door as the financial nerve center of the organization, not as a marketing function. The payoff is fewer denials, a cleaner cash conversation, and admissions that actually fund the organization.

The line that did the most work at Elevate came from Tracy Rogers, CEO of Stanford Behavioral Health: *"60 to 85% of errors happen at the front door. The claims can't be clean if the front door isn't clean."* That reframes admissions as a financial workflow, with three implications operators are now acting on.

First, not every admission is equal. DJ Prince of Guardian Recovery pressed this point: revenue per admission varies sharply by payer mix, geography, and service tier. An admission an organization celebrates on day one can be a loss on day thirty. Without attribution by channel and revenue weighting by admission type, the marketing dollar gets spent blind. As DJ put it: *"If you're spending a bunch of money on a marketing channel but can't attribute where those admissions come from, you're not marketing smart."*

Second, alumni and readmission rates are a leading indicator of clinical model health. Robert Harrison of Recovery Unplugged set the benchmark: 25 to 40% of admissions should come from alumni referrals and readmissions. At one facility he advises, the rate was running 10 to 15%. Below 25%, the work to do is in the care continuum and the recovery community, not the marketing budget. One alumni engagement platform deployment moved activation rates from 21% to 47% across 186 facilities.

Third, predictive signals and AI in the call center are no longer optional. Colton Morgan of Team Recovery Technologies (now part of Kipu) described a relapse-risk scoring approach that generates real-time alerts on at-risk alumni and routes them back into admissions: *"We're pushing 10% of annual treatment episodes in critical alerts month over month."* On the call center side, Robert's organization runs 10,000 to 12,000 inbound calls per month and was missing 30% at peak hours. An AI call-answering layer picked up roughly 10 first-time-caller admissions per month that would have been missed.

What this means for CEOs and COOs.

Build a daily executive dashboard with three lines: census by location, calls by source, and payer mix in red, yellow, or green.

Separate the financial conversation from the admissions conversation. Admissions builds rapport; a dedicated financial engagement team protects margin.

Measure alumni and readmission rate as a clinical indicator, not a marketing one. Below 25%, the work is in the continuum.

05

Revenue cycle is a CEO discipline.

Most CEOs can't produce their cost per admission on demand. The ones who can are winning the cash conversation, surfacing leaks earlier, and walking into capital diligence with the numbers buyers want to see.

The bluntest line of the RCM session came from Drew Laboon, COO of Pathway Recovery Centers: *"If you don't know your true cost per admission, you're completely unqualified to make any leadership decisions as it relates to revenue cycle."* Several CEOs in the conversation that followed acknowledged that they couldn't produce the number.

The most common forecasting error in operator plans this year is treating contracted rate as cash. Real cash, after deductibles, coinsurance, payment plans, and payer delays, often lands 20 to 40% below contracted. Pathway's threshold is that cost per reimbursement must run at least 20% above cost per admission for the model to work. That math is a CEO conversation because the inputs cross marketing, admissions, clinical, and finance.

Three operational fixes surfaced as the highest-impact across the room. The first is daily census reconciliation: a two-year audit at one organization Tracy described surfaced $1.4 million in revenue leaked from authorized days that went unused. The fix was clinical and revenue cycle teams reconciling census daily, weekly, and at month-end, with a 9 AM dashboard cutoff and a daily cash meeting. The second is demographics accuracy: manually-tracked eligibility is wrong roughly 75% of the time in Tracy's experience, and nightly chart audits moved one organization from 45% to 100% accuracy. The third is the 21-day clean claims letter, sent before the 30-day federal deadline, citing the law and the claim. Some payer contacts now flag the letters by name when they arrive. Tracy's team recovered several hundred thousand dollars in interest penalties from one repeat-offender payer in a year.

What operators are watching weekly: AR over 30, AR over 90, clean claims rate, denial rate, collection rate, total outstanding AR, reimbursement per admission, claims per biller, and days to pay by payer. If those aren't on the executive dashboard, the finance team is reactive by definition.

What this means for CEOs and COOs.

Ask for cost per admission and cost per reimbursement at the next leadership meeting. If they can't be produced on demand, that's the first project.

Move the financial conversation off of admissions and onto a dedicated team.

Standardize the 21–day clean claims letter and track which payers fall in line and which don't.

06

Growth that scales is built on culture, not acquisition velocity.

Capital isn't what's stopping operators from scaling. Culture is. The operators growing successfully are transplanting culture into new sites before they open, hiring across both operational and marketing fluency, and running M&A as a continuous discipline rather than a one-time event.

Glenn at JG Healthcare was direct on the growth panel about the mistake he wished he'd avoided. He described it as failing to transplant culture early, meaning physically moving a leader who eats, breathes, and lives the program into a new site for the first six to twelve months, rather than relying on policy documents or remote training. In his words, doing this right has shortened ramp time at his organization by *"literal years."*

Riley at Recovery Unplugged extended the point to M&A: *"You have to be a phenomenal operator and a phenomenal marketer to achieve that dream."* Operators holding only one of those beliefs are losing in the current market. The talent investment has to cover both halves.

A third pattern came through repeatedly from the capital partners on stage: M&A discipline starts before the deal. The data room shouldn't be assembled at sale but maintained continuously, so the metrics, documentation, and governance buyers want are already in place year over year. Operators who know their exit perspective from day one walk into diligence with the math ready, which translates into faster closes and higher multiples.

What this means for CEOs and COOs.

Before signing a new site, identify the culture leader who will be transplanted for the first six to twelve months. If no one can be named, hold the site.

Hire and retain for operational rigor and marketing fluency together. The market no longer rewards one without the other.

Maintain the data room continuously. Decide today what the exit narrative would be, and back-build the metrics.

07

Compliance and outcomes are the new competitive moats.

Compliance run as a defensive cost burns out the team and exposes contracts to denial risk. Compliance run as a daily operating rhythm protects revenue, retains staff, and turns accreditation cycles into routine work. The operators with the best records are running it the second way, and the outcomes conversation is starting to reward them for it.

Devin Waite of Circa Behavioral Healthcare Solutions described the operating posture: *"Compliance really permeate the entire facility so that when changes or things come, that is not a panic attack."* The contrast he drew was between organizations that distribute compliance work across daily operations and organizations whose small compliance team is chasing audit findings after the fact.

The working cadence came up repeatedly: daily site-level tasks, monthly reviews, quarterly reflections, and biannual evaluations of the system itself. With that rhythm in place, regulatory changes and accreditation cycles stop being events and start being routine.

The rhythm matters most when it's paired with culture. Navdeep Sagu, director of compliance at Roeverse Teen and Parent Wellness Center, paired the operating cadence with how her organization treats its clinical and operational staff: *"We treat them like family, with love and integrity. There is more trust. They're happier. The clients buy in."* The link between staff wellness and compliance integrity is direct. Staff who feel safe to surface problems will, and staff who don't, won't.

The next frontier is AI governance. States are beginning to legislate it, and human-in-loop mandates are taking shape. PHI cannot be fed to unapproved systems. Vendor diligence is now a compliance activity. Operators who build AI governance now will have a far easier time when the regulators arrive.

The outcomes conversation is shifting at the same time. Michael Castanon, founder of Alter Behavioral Health, framed the industry change on the Trailblazers panel: *"Now it's durability of revenue."* When patient experience signals (engagement rates, real-time satisfaction, and outcome improvement) are tracked together, operators can predict adverse outcomes before they happen. Eric Gremminger of ERP Health described one example: a patient who completed a PHQ-9 in ten seconds against a 60-second baseline triggered an alert that surfaced a real care risk. The Behavioral Healthcare Outcomes Consortium convening in September 2026 is the industry's first concerted attempt to align on outcome definitions. Payer-provider relationships are beginning to reward measured outcomes rather than mandate them.

What this means for CEOs and COOs.

Move compliance from a department to a rhythm: daily, monthly, quarterly, biannual.

Pair the system with a culture of safety, because staff who can surface problems are the most valuable compliance asset an organization has.

Establish AI governance now, including vendor diligence, PHI guardrails, and documented human-in-loop requirements.

Pick one or two outcome measures and track them rigorously, because the conversation with payers and capital partners is shifting toward operators who can.

What the patterns add up to.

The operators pulling ahead are winning by treating the seven patterns above as one connected operating model rather than as seven separate projects.

The portfolio works because the concentration risks were mapped before the cuts arrived. The AI strategy works because it's embedded in the clinical workflow inside the EMR. The front door works because the financial engagement team is separate from the admissions conversation. The RCM discipline works because the front door is feeding it clean demographics. The growth strategy works because the culture leaders are transplanted before the doors open. The compliance posture works because it's a daily rhythm, not a quarterly panic. The outcomes story works because the data has been clean from intake forward.

Each one supports the others, and pulling on any single one in isolation is harder than pulling on all of them in coordination.

There's a second pattern underneath these seven, and it's worth naming directly. The operators who came to Elevate didn't treat what they had learned as proprietary. They described their wins and their failures in front of competitors, advisors, and capital partners. They sat with peers around firepits and told them what to try and what to skip. That generosity is the multiplier that makes the seven patterns above travel faster than they otherwise would, and it is the most underrated competitive asset the behavioral health industry has right now. The headwinds are real. The community is what gives operators a chance against them.

This is the moment behavioral health is in. The operators pulling ahead are running the same industry on a different operating model, supported by a community that shares what works. Build that model, stay close to that community, and the next twelve months get easier than they would otherwise be.

About this paper.

This paper synthesizes insights from the Elevate 2026 customer conference hosted by Kipu Health. More than 300 behavioral health leaders gathered for three days of keynotes, panels, executive sessions, and informal peer exchange. Eight executive sessions on AI, RCM, the front door, capital, growth, regulatory change, customer acquisition, and the Trailblazers panel provided the on-the-record source material. Where operators are cited by name, the source is their on-the-record participation in those sessions. Where aggregate numbers appear, the source is Kipu's customer base, which now serves more than 6,000 behavioral health facilities, or third-party reporting.

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