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Mid-State Health Network

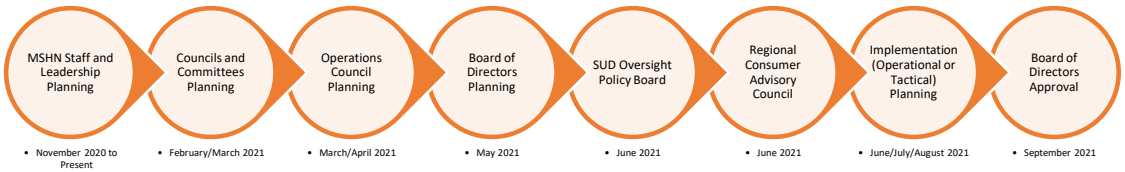
FY 2022 – FY 2023 STRATEGIC PLAN UPDATE

The pages that follow constitute the update to the Mid-State Health Network Strategic Plan covering fiscal years (FY) 2022 and 2023. This plan incorporates broad internal and external stakeholder input.

This strategic plan update represents a continuation of the strategic priorities of Mid-State Health Network to align with the "Quintuple Aim". The Quintuple Aim is the national framework for healthcare reform. This framework may be stated differently in the literature. For the Mid-State Health Network region, the quintuple aim includes these five strategic priorities: "*Better Health*", "*Better Care*", "*Better Value*", "*Better Provider Systems*" and new for this plan, "*Better Equity.*" These are referred to throughout the remainder of this document as our *strategic priorities*.

Of note, the previous MSHN regional strategic plan was extended for FY 21 due to the Coronavirus pandemic.

As depicted below, strategic priorities, strategic goals, and strategic objectives were discussed and developed with input from MSHN staff, various councils and committees, the MSHN Regional Consumer Advisory Council, the MSHN Operations Council, the MSHN SUD Oversight Policy Board, the MSHN Governing Board and the Michigan Department of Health and Human Services. Meetings and other activities to gather this broad input occurred from November 2020 through July 2021.



Based on this broad input, MSHN executive leadership extracted the strategic goals that emerged around common themes and which accurately correspond with its view of the accountabilities of the Mid-State Health Network, current environmental opportunities and threats, and its mission to support services within the 21-county region which best meet the needs of Medicaid, Healthy Michigan, Substance Abuse Prevention and Treatment (SAPT) Block Grant and Liquor Tax-Funded beneficiaries. MSHN's strategic goals and related strategic objectives are shown within the strategic priorities framework.

Our strategic plan is based on our *founding principles*, which include cooperative, open, and frank discussion of the strengths, weaknesses, and capacities of MSHN and each CMHSP partner as well as partnership with our SUD provider network; planning and operations that reflect a realistic evolutionary process; flexible and robust managed care operations not favoring any provider or any particular CMHSP or CMHSP service model; and many others. In partnership, MSHN and its CMHSP participants are committed to effective health integration activities, equity, and accountability.[1]

[1] Extracted from "Principles to Guide the New PIHP", MSHN Operations Council, December 13, 2012

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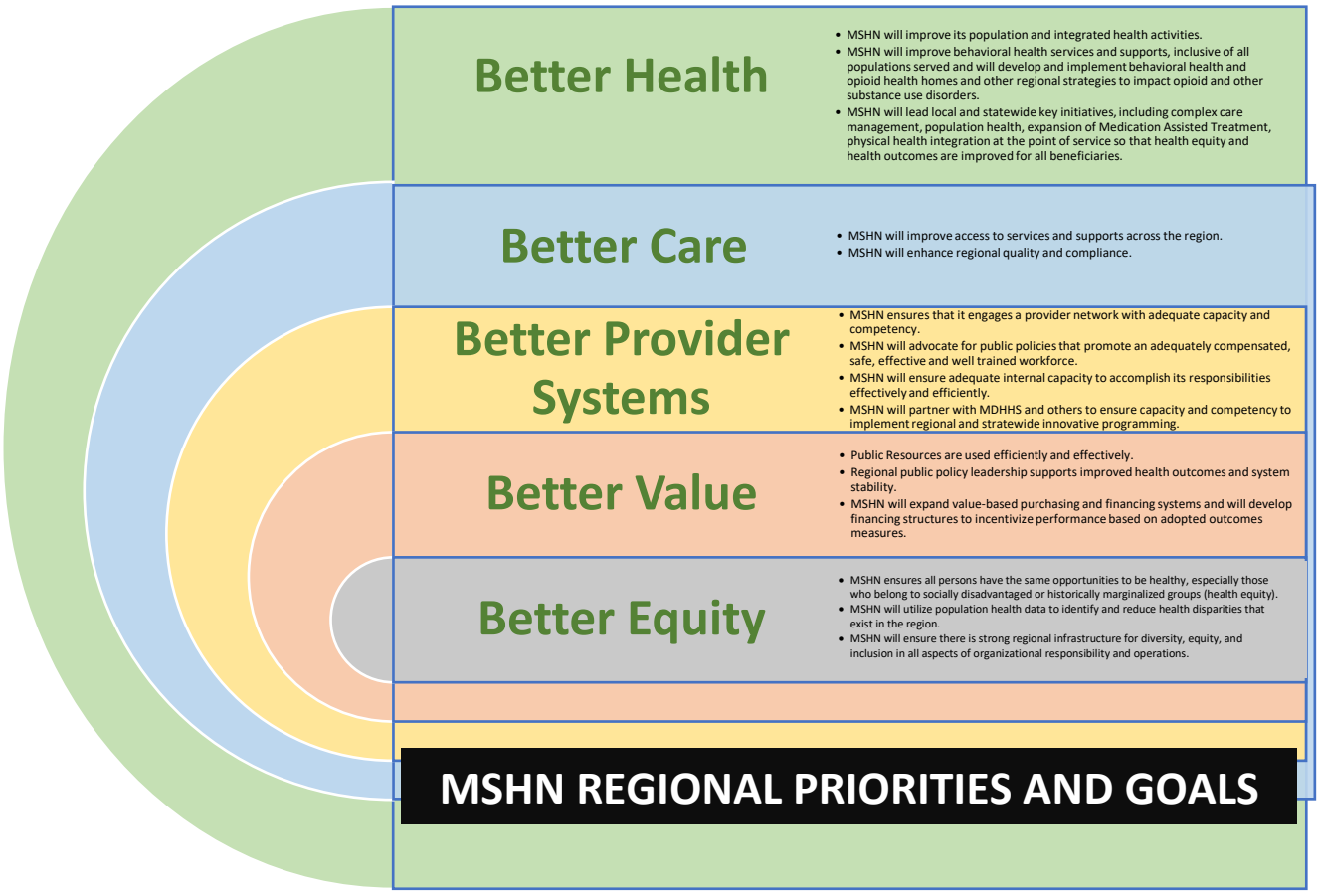
The following pages present the strategic plan elements for fiscal years 2022 and 2023. These include new priorities, goals, and objectives developed in the process described above and continued or revised strategies from the previous MSHN Strategic Plan.

The MSHN Strategic Plan is based on the Strategic Priorities identified in the graphic below. The MSHN Strategic Goals are identified on the right of this graphic. The remainder of this document includes this material as well as strategic objectives for the region.



There is a significant amount of crossover among the strategic goals that are placed within the strategic priorities framework. Assignment of a strategic goal to a particular strategic priority is therefore somewhat arbitrary but has been mostly guided by the expected outcome of achieving the strategic goal.

Significant themes have emerged in the process of strategic planning, in particular the need to *improve consistency*, *improve standardization*, and *improve cost-effectiveness*. We have used these themes as guideposts in our development of regional and MSHN-specific strategic goals, as we have since our inception.

PLANNING RESPONSIBILITY AND TIMELINES CHART

MID-STATE HEALTH NETWORK LEADERSHIP TEAM

Joseph Sedlock,
Chief Executive Officer

Amanda Ittner,
Deputy Director

Todd Lewicki,
Chief Behavioral Health Officer

Forest Goodrich,
Chief Information Officer

Dani Meier,
Chief Clinical Officer

Skye Pletcher
Director of Care and Utilization Management

Kim Zimmerman,
Chief Compliance and Quality Officer

Leslie Thomas,
Chief Financial Officer

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KEY ASSUMPTIONS AND KEY QUESTIONS FOR STRATEGIC PLANNING

Mid-State Health Network stakeholders developed what were considered to be important or key assumptions and questions to address in the strategic planning process. These can certainly be expanded and debated but represent the major themes revealed during the regional planning process. There were more key questions and assumptions (See Appendix 1), which have been narrowed down to the following top considerations:

KEY ASSUMPTIONS
Carve in remains a material threat even while a COVID-19 pandemic response is likely to continue well into FY 22 (and beyond). Legislation has been drafted (and introduced) that would eliminate Pre-paid Inpatient Health Plans (PIHPs) as the public managed care entities in Michigan.
By their own statements, MDHHS/BHDDA will not have the necessary staffing and other resources to drive major system reform/redesign. There continues to be legislative and advocate community desire to reform the public system. MDHHS/BHDDA wants reform, too, but is under-resourced to carry it out.
MSHN should lead reform, innovation, and collaboration efforts in the region and statewide. Unless there are changes to MSHN bylaws or regional endorsement to take on these roles, MSHN has no independent ability to pursue multi-PIHP or public/private partnerships, multi-regional or statewide opportunities.
Regional revenues will likely be pressured in future years. Revenue/Rates for FY21 and FY22 will likely be adjusted down due to low utilization during the pandemic, which should be an anomaly. • *May be offset by new federal funding under the MH and SAPT block grant and may require that the region conduct additional planning to effectively use these funds.* • *Strong commitment to Certified Community Behavioral Health Clinics (CCBHCs) and Behavioral Health Homes and Opioid Health Homes – may require additional planning to effectively implement and use these funds and may have implications for regional entity (MSHN) staffing.* • *KB lawsuit may have implications for financing and system design.* • *Post COVID utilization may increase (without necessary funding to support it).*
Performance matters. PIHP staff must be retained and MSHN must continue to fulfill (and exceed) expectations especially in light of the threat of elimination of PIHPs by the legislature/others.
Information technologies are expanding rapidly. The region may need better surveillance, awareness and participation in information sharing initiatives (such as eConsents, ADT feeds, EMR interoperability initiatives, electronic visit verification, and more).
Health integration, including behavioral/physical health integration, pressures our systems to look more like traditional healthcare delivery systems in spite of the fact that there are significant differences in the financing, delivery, and management models. Continued pressure to conform to traditional healthcare system structures and delivery modalities will have to be faced by the public behavioral health system.

KEY QUESTIONS
What is the role for MSHN and how should MSHN be preparing for CCBHC, State Innovation Model (SIM), Opioid Health Homes, Behavioral Health Homes? And to what extent does the regional delegation model impact future options and current effectiveness/efficiency?
Will MDHHS continue to seek to strengthen the existing public behavioral health system (even if "reformed") in a manner than retains the public nature of our system, keeps the county-based CMHSP structure, and the regional-entity managed substance use disorder prevention and treatment system structures largely intact?
To what extent should MSHN partner with like-minded PIHPs/Regional Entities to address key reform issues (i.e., "criticisms" upon which reform/redesign are largely based), address threats, leverage opportunities?
To what extent should MSHN position itself to partner with other entities (including Federally Qualified Health Clinics [FQHCs], Health Plans in and outside of Michigan, and other entities) in anticipation of future redesign initiatives, to address threats and leverage opportunities?
Should (National Committee for Quality Assurance, NCQA) accreditation for MSHN be revisited in light of current and predicted future environment (threats and opportunities)? (PIHPs/Regional Entities operating with accredited managed care operations include Detroit/Wayne, Southwest Michigan Behavioral Health, NorthCare, Oakland, Beacon Health Options). MSHN and CMHSPs are already stretched and should consider accreditation if it strengthens the public system and enhances support of various public system initiatives (such as CCBHCs, SIM, OHH, BHH and others).

ENVIRONMENTAL SCAN FOR STRATEGIC PLANNING

Mid-State Health Network stakeholders developed important environmental scan observations. These are arranged by strengths and weaknesses (internal-looking), threats and opportunities (external-looking). These can certainly be expanded and debated but represent the themes identified in the planning process. There are more strengths, weaknesses, opportunities, and threats that were identified (See Appendix 2), which have been narrowed down to the following considerations:

SUMMARY OF STRENGTHS AND WEAKNESSES:

Strengths:

MSHN INTERNAL STAFFING AND STRUCTURE:

- MSHN staff have a high workload capacity, are strong, dedicated, and competent who can work independently. In addition, they are highly effective in the remote work environment.

REGIONAL/STATEWIDE LEADERSHIP:

- The MSHN board has consistently demonstrated strength, fortitude and leadership, a high degree of cohesion, and a documented history of getting things done.

- MSHN maintains an excellent reputation in Michigan, is viewed as highly collaborative in-region and with external partners, and a statewide leader in many initiatives. MSHN is known to "listen" to the needs of the region and incorporate network feedback into services and operations. MSHN is a trailblazer in PIHP operations and state initiatives leading to positive impacts on people and their quality of life, health status, and more. MSHN has advanced public policy priorities as well as regional priorities to improve quality and effectiveness of services and supports.
- MSHN is developing its depth and governance in regional change management processes and communications.

MSHN OPERATIONS:

- MSHN has been a consistently high performing PIHP since its inception: Penetration rates, Medical Loss Ratio, Financial Stability and other standard performance on metrics have been exemplary; MSHN has earned 100% of its performance bonuses in all periods prior to FY 2020. Quality/performance metrics; Compliance to state requirements; and data reporting. Highly developed IT system and support infrastructure, including data analytics, have been exceptional. MSHN uses innovative techniques to accomplish objectives. Transparency in operations, providing a lot of data and metrics, and tracking a lot of data points are features of our day-to-day operations. MSHN has established an efficient administration/process. CCBHC participation in region is significant, with PIHP-level supports evolving.

PROVIDER NETWORK:

- MSHN has a strong rapport with the provider network which includes fiscal oversight, contract monitoring, and an especially strong and open communication strategy. This was noted during the COVID-19 pandemic where MSHN was envied among other regions related to a rapid response to provider needs including provider stabilization funds. In turn, MSHNs region boasts robust network adequacy.

Weaknesses:

MSHN INTERNAL STAFFING AND STRUCTURE:

- Even with a strong performance driven culture, at times, the capacity of MSHN staff is stretched due to a lean staffing model. At times, filling vacancies due to attrition can take several months as a candidate with matching credentials and experience is sought.

REGIONAL/STATEWIDE LEADERSHIP:

- MSHN endeavors to be a leading PIHP in Michigan though is not currently participating in all the possible state innovative projects and initiatives, like opioid health homes (because of State roll-out scheduling).

MSHN OPERATIONS:

- Although some see this as a strength or a feature of how MSHN was designed, MSHN lacks the ability to act independently, for example, the current provider governance model/operating agreement restricts its flexibility with financing our CMHSPs, a lack of local

PIHP funds. While this is recognized, because of lean operations we lack the required time and resources to complete change management (i.e., approval processes) in a timely manner.

- The MSHN PIHP is not accredited. (Since the NCQA readiness assessment was conducted several years ago, seeking accreditation in the near term may be more readily implemented and accepted in the region).
- There is limited CMHSP data sharing and lack of access of integrated health data within PIHPs. To that end, there is a deficiency of well-defined outcome metrics. For example, MSHN is tracking an abundance of data points without the resources to act (follow-through/monitor).
- The current MDHHS model and guidance related to CCBHCs is deficient (although a framework is expected in near future), MSHN requires additional direction related to rules and regulations and to ascertain impacts on MSHN operations (if any).

PROVIDER NETWORK:

- MSHN SUD Provider Network includes a significant level of duplication for some types of services due to delegated "no wrong door" access system. In addition, value-based purchasing (VBP) is under-developed and requires the providers understanding the concept and embracing the strategy to move in this direction. The SUD Provider network does not feel adequately compensated for the indirect/admin requirements. In addition, MDHHS encounter reporting system is not developed in this area. Case rates and other similar fiscal arrangements would be reported by the PIHP under specific Current Procedure Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS) codes which would not reflect the actual "service activity". MSHN has not conducted a regional review of how to better integrate services for SAPTR at the local level.
- At MSHN, and across all providers and CMHSP Participants, staff resources are strained in providing an abundance of technical assistance to providers who have an inconsistent level of performance and depth of knowledge.
- Workforce recruitment, retention, recognition, compensation, and related factors are causing a region (and state) wide workforce crisis.

SUMMARY OF THREATS AND OPPORTUNITIES:

THREATS:

SYSTEM REFORM/REDESIGN:

- Legislative and MDHHS system reform/redesign elements include the threat of carve in (including separately carving in the SUD benefit to Medicaid Health Plans (MHPs), which will likely be addressed in the MHP contract rebid concluding 09/30/2023), elimination of the PIHPs, of which MSHN is one (of 10), all of which could affect the service array, CMHSP operations, PIHP role and operations, and requires clarity on what the MSHN Board and regional CMHSPs will support MSHN being or becoming, including which potential

partnerships with physical health payers, partnerships with other PIHPs, and other initiatives, can take place and under what conditions.

RESOURCES:

- State budget shortfalls (due to COVID-19 and decreased service utilization during the pandemic response, federal changes to the ACA and/or federal appropriations), PIHP fiscal instability for some PIHPs, reductions in SUD block grant funding, lack of availability of MSHN local funds earned but fully distributed to CMHSPs per the Operating Agreement, reductions in rates associated with standard cost allocation initiative, perceived high costs, and other factors may influence how PIHP rates are set and may result in decreased revenue and pressure on the public system to drive costs down. The COVID pandemic response has increased awareness of mental health and substance abuse issues that may wane as the pandemic resolves. Funding may suffer as a result.
- Behavioral Health workforce shortages, attrition, retention, attraction and (especially with the SAPT workforce adequacy of compensation) will continue to pressure providers and resource SAPT network competency pressures to breaking points; MSHN capacity for adequate technical assistance and provider performance monitoring. An additional concern with legislative and other proposals to eliminate PIHPs is the potential for MSHN employees to leave and the ongoing ability of MSHN to carry out its responsibilities.

OPPORTUNITIES:

SYSTEM REFORM/REDESIGN

MDHHS has stated that it will not intentionally pursue system redesign, but the public system should take advantage of this opportunity to develop/implement reforms (even as legislative proposals call for elimination of PIHPs). MSHN and the region should prepare itself and delineate boundaries, if any, on MSHN latitude to pursue dialogs that may lead to partnerships that strengthen the region (such as complex care management for the unenrolled; partnerships with physical health payers, partnerships with other PIHPs and reducing health disparities). The MSHN Operations Council and the MSHN Board of Directors strongly supports MSHN continuously planning, researching, and developing strategic relationships and bringing forward proposals that would strengthen the public system, specifically CMHSPs, in the region.

RESOURCES

National healthcare reform is focused on the expansion of value-based purchasing and alternative payment models, which require the development of meaningful outcome measures associated with expanded evidence based practices, robust and inter-operable information technology and consent management systems capable of gathering and reporting data on physical and behavioral health conditions, social determinants of health, and health equity parameters and should result in a more standardized benefit, access criteria, and utilization management criteria within and between regions.

LEADERSHIP

MSHN has a history and experience being a leader on many initiatives among PIHPs in the state and should use this reputation to partner/collaborate on key initiatives, including population health, complex care management, physical health integration at the point of service, and influence the

outcomes of a variety of statewide initiatives (including but not limited to reducing health disparities and improving health outcomes for beneficiaries, collaborations with physical health payers, standard cost allocation, potential redesign/reform, expansion of Medication Assisted Treatment (MAT), Home and Community Based Services (HCBS) systems, etc.).

STRATEGIC PRIORITIES:

- MSHN has five strategic priorities. Strategic Priorities are the broadest strategic statement and require board approval:
    - Better Health

      Improve the health of the beneficiary population in the Mid-State Health Network region by supporting evidence-based interventions and other innovations to address behavioral, social, and environmental determinants of health.

    - Better Care

      Improve the overall experience of persons in services and the quality of services and supports by ensuring services and supports are person centered, family driven/youth guided, reliable, accessible, safe and effective.

    - Better Value

      Increase value for resources used by achieving balance between quality, cost, and outcomes and providing where permitted incentives to achieve better value.

    - Better Provider Systems

      Ensure availability of and beneficiary access to an adequate, competent, capable, broad, accessible, well-compensated and satisfied provider system and workforce members.

    - Better Equity

      Reduce and work toward the elimination of disparities – whatever their causes – so that communities and individuals can achieve their highest desired level of health.

STRATEGIC GOALS:

Like Strategic Priorities, Strategic Goals are board approved. The following tables are formatted to show the Strategic Priority followed by an indented Strategic Goal, followed by another indented Strategic Objective and tasks/activities. Strategic Objectives and related activities are management developed prerogatives about which the board advises.

MID-STATE HEALTH NETWORK
STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
FY 2022- FY 2023

STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
BETTER HEALTH						
	MSHN will improve its population health and integrated care activities.				Director of Utilization and Care Management	09/30/23
		MSHN will explore initiatives to address social determinants of health that contribute to undesirable health outcomes for persons served.	Director of Utilization and Care Management	MSHN will identify strategies to improve access to care such as telehealth, transportation assistance, and others.	Director of Utilization and Care Management	09/30/22
				MSHN will explore the use of geographic information systems in order to better understand neighborhood-level characteristics and areas of need.	Director of Utilization and Care Management; Chief Information Officer	09/30/22
				MSHN will work with its partner CMHSPs to develop a standardized process for collecting and sharing data related to social determinants of health.	Director of Utilization and Care Management; Chief Information Officer	09/30/23
	MSHN will improve behavioral health services and supports, inclusive of all populations served and will develop and implement behavioral health and opioid health homes and other regional strategies to impact opioid and other substance use disorders.				Chief Behavioral Health Officer	09/30/23
		MSHN will ensure regional readiness for implementation of opioid health homes.	Chief Clinical Officer	MSHN will complete a review of the requirements for opioid health homes and designate a point person to oversee the project.	Chief Clinical Officer	09/30/22
				MSHN will assess regional readiness for implementation of opioid health homes.	Chief Clinical Officer	09/30/22
				MSHN will develop a workplan for identified areas of improvement based on assessment results including meeting with Region 2 to determine implementation successes and barriers.	Chief Clinical Officer	09/30/22
				MSHN will use a procurement process to select an Opioid Health Home within the region ensuring they meet all the requirements identified by the MDHHS and SAMHSA.	Chief Clinical Officer	09/30/23

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STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
		MSHN will ensure regional readiness for implementation of behavioral health homes.	Chief Behavioral Health Officer	MSHN will complete a review of the requirements for behavioral health homes (including what, who, by when, related metrics (if any).	Chief Behavioral Health Officer	09/30/22
				MSHN will assess regional readiness for implementation of behavioral health homes (including what, who, by when, related metrics (if any).	Chief Behavioral Health Officer	09/30/22
				MSHN will develop a workplan for identified areas of improvement based on assessment results (including what, who, by when, related metrics (if any).	Chief Behavioral Health Officer	09/30/22
				MSHN will use a procurement process to select a behavioral health home within the region ensuring they meet all the requirements identified by the MDHHS and SAMHSA.	Chief Behavioral Health Officer	09/30/23
		MSHN will discuss and identify any other regional strategies to impact opioid and other substance use disorders.	Chief Clinical Officer	MSHN will monitor its Provider Network to ensure Evidence Based Practices are included in substance use disorder treatment as part of the annual site review process.	Chief Clinical Officer	09/30/23
				MSHN prevention team will work with community partners to increase awareness of opioid use in older adults, including risk for overdose when prescription opioids are mixed with alcohol.	Chief Clinical Officer	09/30/23
				MSHN will add information on obtaining free Naloxone and the link to order Naloxone to our website to ensure people in the region have access to life saving medication.	Chief Clinical Officer	09/30/23
				MSHN will work to increase access to re-entry services and will work with contracted providers to expand access to services within the jail setting.	Chief Clinical Officer	09/30/23

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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
	MSHN will lead local and statewide key initiatives, including complex care management, population health, expansion of Medication Assisted Treatment, physical health integration at the point of service so that health equity and health outcomes are improved for all beneficiaries.				Deputy Director	09/30/23
		MSHN will support care coordination and complex care management for the unenrolled population within the region.	Deputy Director	MSHN will develop a standard data validation and reporting on the unenrolled population, including frequency and distribution to the network via ICDP.	Chief Information Officer	09/30/22
				MSHN will review/determine risk stratification criteria and desired improvement metrics that include both process and outcome metrics.	Deputy Director	06/30/22
				MSHN will track and monitor improvement efforts, identify barriers and reassess initiatives annually through CLC, UMC and QIC.	Chief Behavioral Health Officer, Director of Utilization and Care Management, Quality Manager	03/31/22
		MSHN will review the region's Population Health via standardized, nationally recognized metrics, to update (replace, remove or add) the region's process and outcome strategies to improve access to care and overall health.	Director of Utilization and Care Management	MSHN will increase regional use of information technology data systems to support population health management.	Chief Information Officer	04/30/23
				MSHN will pursue e-consent management opportunities to improve care coordination between behavioral health, physical health, and SUD systems of care.	Chief Information Officer, Director of Utilization and Care Management	09/30/22

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STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
BETTER CARE						
	MSHN will improve access to services and supports across the region.				Chief Behavioral Health Officer	09/30/23
		MSHN ensures a consistent service array (benefit) across the region and improves access to specialty behavioral health and substance use disorder services in the region.	Chief Behavioral Health Officer	MSHN will review and determine SUD screening and access needs and recommend improvements as appropriate.	Director of Utilization and Care Management	09/30/22
				MSHN will review and address need for increasing access to children's acute care services.	Chief Behavioral Health Officer	09/30/22
				MSHN will participate in PRTF discussions through MDHHS planning workgroup as appropriate.	Chief Behavioral Health Officer	09/30/22
				MSHN will review and determine capacity needs for ABA services and work with region and providers.	Waiver Manager (BG)	09/30/22
		MSHN takes actions to improve access to psychiatric inpatient care, reduce denials and improve emergency and crisis support continuum of care available in the region and across the State.	Chief Behavioral Health Officer	MSHN to review the use of a psychiatric inpatient denial database.	Director of Provider Network Management Systems	03/01/22
				MSHN will implement a regionally-operated crisis residential unit.	Chief Behavioral Health Officer	03/01/22
				MSHN will monitor mobile crisis response (intensive crisis stabilization services) activities, and suggest process and outcomes metrics.	Chief Behavioral Health Officer; Director of Utilization and Care Management	09/30/22
				MSHN will work with MDHHS to determine readiness to bring the Michigan Crisis and Access Line (MiCAL) function to the region and establish workplan.	Chief Behavioral Health Officer; Director of Utilization and Care Management	04/30/22
				MSHN will work with MDHHS to implement relevant process and outcomes measures for MiCAL.	Director of Utilization and Care Management	12/31/22
				MSHN will monitor the number of emergency room visits and the time spent in emergency room for substance use in the Jackson community to measure the reduction of emergency room services now that the Engagement Center is open.	Chief Clinical Officer	03/31/22
				MSHN will monitor the amount of project ASSERT screenings that are completed in the emergency department that result in substance use disorder and behavioral health referrals and track the percentage of referrals that attend a referred service within the MSHN network of providers.	Chief Clinical Officer	12/31/22

MID-STATE HEALTH NETWORK
STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
FY 2022- FY 2023

STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
		MSHN's network of providers establish processes to assist individuals served in establishing and maintaining eligibility for Medicaid and/or Healthy Michigan Program coverage.	Chief Compliance and Quality Officer	Coordinate a review of individuals whose services are funded by Block Grant and connect those who are not Medicaid or Healthy Michigan covered to DHHS for eligibility review.	Customer Services Specialist	09/30/22
		MSHN ensures expanded SAPT and CMHSP service access and utilization for Veterans and Military Families through implementation of the regional and statewide Veteran and Military Family Member strategic plan.	Chief Clinical Officer	Provide trainings to improve Military Cultural Competency in the provider network and reduce the stigma associated with accessing treatment services and support for behavioral health and substance use disorders.	Veteran's Navigator	09/30/23
				MSHN will increase access to services for veterans by monitoring data regarding the number of veterans in MSHN's network who connect with the Veteran Navigator and developing strategies to connect veterans to services either through the VA or MSHN's BH/SUD network.	Veteran's Navigator	09/30/23
				Reduce veteran suicide within the MSHN region through participation in local suicide prevention coalitions.	Veteran's Navigator	09/30/23
				MSHN will increase access to veteran peer specialist, veteran peer recovery coaches, and veteran recreation therapy to increase access and engagement in treatment and recovery services for veterans and military families.	Veteran's Navigator	09/30/23
	MSHN will enhance regional quality and compliance				Chief Compliance and Quality Officer	09/30/23
		MSHN will provide leadership on improving the consistency and implementation of person-centered planning, self-determination, conflict free case management, and independent facilitation in the region.	Chief Compliance and Quality Officer	PCP toolkit/training resource will be updated on a quarterly basis and made available to the provider network.	Chief Compliance and Quality Officer	06/30/22
				Identification of additional training(s) and resources will be based on findings/outcomes from annual internal (DMC) and external (MDHHS) site reviews.	Chief Compliance and Quality Officer	12/31/22
				MSHN will provide templates, formats and/or guidelines as identified through semi-annual review by CLC and QIC.	Chief Compliance and Quality Officer	03/30/23

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STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
FY 2022- FY 2023

STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
		On a regional basis, effectively engage like-minded partners in leading initiatives to address system reform objectives, especially those that improve beneficiary access to and benefit from services and to promote long-term stabilization of the public behavioral health system.	Chief Behavioral Health Officer	MSHN through its CLC, UMC, and QIC, will identify relevant system reform objectives (including what, who, by when, related metrics (if any).	Chief Behavioral Health Officer; Director of Utilization and Care Management; Quality Manager	04/30/22
				MSHN will identify the group most appropriate to address system reform objectives (including what, who, by when, related metrics (if any).	Chief Behavioral Health Officer; Director of Utilization and Care Management; Quality Manager	09/30/22
				MSHN will work with its partners to establish a workplan to address system reform objectives (including what, who, by when, related metrics (if any).	Chief Behavioral Health Officer; Director of Utilization and Care	09/30/23
		Expand penetration rates in specialty populations (in particular, older adults, adolescents and veterans).	Chief Behavioral Health Officer	MSHN will establish baseline penetration rate for its specialty populations including utilization rates of SUD and BH services.	Chief Behavioral Health Officer; Chief Clinical Officer	09/30/22
				MSHN will identify strategies to address increased penetration rates for adolescents and older adults (including what, who, by when, related metrics (if any).	Director of Utilization and Care Management; Quality Manager	09/30/22
				MSHN will work with substance use disorder providers to engage community partners such as schools, senior centers, MDHHS, courts, faith-based agencies, etc. to establish a support network for adolescents and older adults in services and to build relationships to increase referrals for people who need substance use disorder services.	Lead Treatment Specialist; Lead Prevention Specialist	09/30/23
				MSHN will increase access to services for veterans by monitoring data regarding the number of veterans in MSHN's network who connect with the Veteran Navigator and developing strategies to connect veterans to services either through the VA or MSHN's BH/SUD network.	Veteran's Navigator	09/30/23

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STRATEGIC PLAN LEADERSHIP AND DASHBOARD TRACKING WORKSHEET
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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
		MSHN will have well established compliance processes that are recurring, consistent and measurable and aimed at preventing, detecting, and deterring fraud, waste and abuse.	Director of Quality, Compliance and Customer Services	The Medicaid Event Verification site review results will be analyzed for trends of non-compliance with required standards on a quarterly basis and utilize MSHN's Compliance Committee and the Regional Compliance Committee to develop processes/education/training to promote compliance.	Chief Compliance and Quality Officer	12/31/22
				Develop a compliance webpage on MSHN's website providing current information on healthcare rules and regulations, education on current trends of non-compliance as identified through internal and external site reviews and identification of trainings on compliance related activities. The webpage will be updated as new information is available.	Chief Compliance and Quality Officer	12/31/22
				Identify trends of non-compliant activities as reported on the Office of Inspector General quarterly activity report and utilize MSHN's Compliance Committee and the Regional Compliance Committee to develop processes/education/training to promote compliance.	Chief Compliance and Quality Officer	12/31/22
				Research options and determine feasibility for the completion of a compliance risk assessment region wide.	Chief Compliance and Quality Officer	12/31/22

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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
BETTER VALUE						
	Public Resources are used efficiently and effectively.				Chief Financial Officer	09/30/23
		MSHN will participate in the State's development of various monitoring and reporting processes to ensure continual input and outcomes that are supportive to the MSHN region and its system. State-engineered systems for financing and determining value (such as Behavioral Health Fee Screens, Standard Cost Allocation Models, Rate development, and others) require full MSHN regional participation to shape them appropriately.	Chief Financial Officer	MSHN will ensure through the work of its regional Finance Council each CMHSP implements all MDHHS fiscal guidelines. Finance Council will engage in monthly discussions and problem solving to ensure standardization and consistency.	Chief Financial Officer	09/30/22
				MSHN's Fiscal Officers will ensure MDHHS feedback regarding State changes are addressed and corrected in a timely manner.	Chief Financial Officer	09/30/22
	Regional public policy leadership supports improved health outcomes and system stability.				Chief Executive Officer	09/30/23
		MSHN continues to evaluate the feasibility and appropriateness of pursuing NCQA (or other) accreditation in light of system redesign initiatives, potential for partnerships in the future and the potential for long-term value added to the region.	Deputy Director	MSHN will assess new design initiatives for application/appropriateness of accreditation of the PIHP.	Deputy Director	09/30/22
				MSHN will assess long-term planning and readiness for accreditation.	Deputy Director	03/30/23
		MSHN will ensure consistent, standardized, and cost-effective operations and will position the region for continued success regardless of payer structure – MDHHS processes for standardized cost allocation and independent rate models once promulgated will be followed to promote regional consistency.	Chief Financial Officer	MSHN will ensure through the work of its regional Finance Council each CMHSP implements all MDHHS fiscal guidelines. Finance Council will engage in monthly discussions and problem solving to ensure standardization and consistency.	Chief Financial Officer	09/30/23
				MSHN and its Regional Finance Council will monitor budget trends to evaluate cost-effectiveness.	Chief Financial Officer	09/30/22

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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
		MSHN will advocate for public policies, statutes and financing necessary to advance beneficiary health outcomes improvements that demonstrate good stewardship of public resources and partnership with persons served and their advocates.	Chief Executive Officer	MSHN will participate in MDHHS and State Government meetings as necessary to ensure structured advocacy occurs for Behavioral Health and Substance Use Disorder persons served.	Chief Executive Officer	09/30/23
				MSHN will engage with providers to develop strategies to improve outcomes for persons served. The success of this task will require cross functional department efforts.	Chief Executive Officer	08/01/22
		MSHN will expand value-based purchasing and financing systems and will develop financing structures to incentivize performance based on adopted outcomes measures.	Chief Financial Officer	MSHN will expand its Value Based purchasing efforts mutually agreeable outcomes and measures are developed with providers.	Chief Financial Officer	09/30/23
				MSHN will evaluate, at least annually, existing Value Based purchasing agreements to determine efficacy and identify updates to improve persons served outcomes or better service value.	Chief Financial Officer	09/30/22
		Increase overall efficiencies and effectiveness by streamlining and standardizing business tasks and processes as appropriate.	Chief Compliance and Quality Officer	Identify capacity within REMI for building reports, data collection, and reporting.	Chief Information Officer	04/30/22
				Develop list of available reports in REMI inclusive of the purpose (what is the intended purpose, what data is included, who the intended audience is, etc.), source(s) of data, frequency data is updated, and how this will be communicated to staff.	Chief Information Officer	09/30/22
				Identify if there are similar reports that could be combined, discontinued, etc. and any needed additional reports.	Chief Information Officer	09/30/22
				Develop and implement of standardized Plans of Correction template and process.	Chief Compliance and Quality Officer	03/30/23
				Develop a process map to include how plans of correction are developed, implemented, and utilized for providers. Include required plans of corrections for internal and external reviews inclusive of DMC, department reviews, HSAG, MDHHS, etc. to eliminate/reduce duplication of plans of correction.	Chief Compliance and Quality Officer	03/30/23
				Identify a centralized place to store plan of correction that is easily accessible by MSHN staff.	Chief Compliance and Quality Officer	06/30/22
				Develop a consistent internal communication process that is meaningful and accessible.	Chief Compliance and Quality Officer	09/30/22
				Review current types of information being shared with all staff and identify if any additional types of information should be shared.	Chief Compliance and Quality Officer	09/30/22

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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
				Review current methods for sharing relevant information to MSHN Staff. Determine if information is being shared in a meaningful and easily understandable manner and determine whether other methods of disseminating information be used.	Chief Compliance and Quality Officer	12/31/22
				Review internal (DMC) site review standards.	QAPI Manger; Quality Manager	12/31/22
				Complete a crosswalk of review elements to other internal (annual plans, etc.) and external (HSAG, MDHHS, etc.) reviews to eliminate redundancies.	QAPI Manger; Quality Manager	03/30/23
				Identify content expert staff involvement per content area as well as staff responsibility for plan of correction review and approval, implementation and effectiveness.	QAPI Manger; Quality Manager	12/31/22
				Review use of management systems to increase efficiency with completing required functions.	QAPI Manger; Quality Manager	12/31/22
				Develop process for when to discontinue monitoring of a standard, how it is communicated to staff and the provider network.	QAPI Manger; Quality Manager	09/30/22
				Define internal processes that drive workflows; Develop workflows for job functions/tasks for MSHN positions, inclusive of communication lines; Identify functions to be automated for efficiency/effectiveness.	QAPI Manger; Quality Manager	06/30/23

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BETTER PROVIDER SYSTEMS						
	MSHN ensures that it engages a provider network with adequate capacity and competency (and addresses any network adequacy deficiencies) in partnership with its CMHSP participants and providers.				Deputy Director	09/30/22
		Ensure MSHN's network is adequate to meet consumer demand.	Deputy Director	Address recommendations from the Annual Network Adequacy Assessment (NAA) FY21.	Contracts Specialist	09/30/22
				Conduct Geomapping analysis.	Database and Reports Coordinator; Deputy Director	01/31/22
				Revise and update NAA FY22.	IT Reports Manager; Deputy Director	04/30/22
		Ensure MSHN's network is competent to provide quality services with positive outcomes for individuals served.	Deputy Director	Review quarterly/annual QAPI summary results and develop training based on low performing areas.	Chief Clinical Officer	09/30/22
				Review quarterly/annual QAPI summary results and develop performance incentives based on low performing areas.	Chief Financial Officer; Deputy Director	01/31/22
				MSHN will conduct an assessment of Certified Clinical Supervisor (CCS) capacity within the region for licensed SUD treatment programs.	Deputy Director	03/31/22
				MSHN will request feedback through the SUD Providers to develop a workplan to increase CCS capacity and competency within the region.	Deputy Director	06/30/22
		MSHN will advocate for public policies that promote an adequately compensated, safe, effective and well-trained workforce.	Chief Executive Officer	Advocate to make the direct care workforce wage increase permanent to address the long-standing staffing crisis created by low wages and high turnover among direct care workers and develop a regional strategy to address the continuation of direct care worker wage increases initiated during the COVID pandemic response and make recommendations for consideration by the regional CMHSP participants and the MSHN governing board.	Chief Executive Officer	03/01/22
				Advocate for long-term funding and other supports to reduce turnover, improve retention and ability to attract new workers into the regional workforce.	Chief Executive Officer	03/01/22
		To the extent required under or necessary to fulfill its contractual obligations, MSHN will ensure adequate internal capacity to accomplish its responsibilities effectively and efficiently.	Deputy Director	MSHN will ensure sufficient internal resources by evaluating current requirements/new requirements and external network capacity, including the proposed system redesign.	Deputy Director; Chief Executive Officer	07/01/22
				FY22 Contractual requirements will be assessed to determine implementation of 1115 Waiver responsibilities -SIS Child, Waiver Supports.	Chief Behavioral Health Officer	07/01/22
				Assess proposed system redesign for changes to the PIHP role and responsibilities, including possible closeout through staff retention planning.	Deputy Director; Chief Executive Officer	09/30/22

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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
BETTER EQUITY						
	MSHN and its regional provider and CMHSP partners ensure all persons have the same opportunities to be healthy, especially those who belong to socially disadvantaged or historically marginalized groups (health equity).				Director of Utillization and Care Management	09/30/23
		MSHN will increase access to health services for historically marginalized groups by monitoring penetration rate data and developing initiatives around outreach and engagement to underserved individuals & communities.	Director of Utilization and Care Management	MSHN will identify other underserved populations for which penetration rate data is not currently collected/monitored and develop strategies to obtain data that more accurately represents diverse populations in our region.	Director of Utillization and Care Management	04/30/22
				MSHN will obtain input from the affected populations around barriers to engaging in treatment and effective outreach strategies.	Director of Utillization and Care Management	09/30/22
		MSHN will plan and develop a regional Health Equity Advisory Committee to guide its health equity and inclusion activities.	Chief Clinical Officer	Consult with other stakeholders in the region who have existing Diversity, Equity, Inclusion (DEI) committees or workgroups in the development of the MSHN Health Equity Advisory Committee Charter.	Chief Clinical Officer	03/31/22
				Develop outreach strategies to ensure that committee composition is inclusive of diverse representation and lived experience.	Chief Clinical Officer	06/30/22
				Identify scope of committee's responsibilities and develop processes for the committee to inform MSHN health equity initiatives.	Chief Clinical Officer	06/30/22
		MSHN will utilize population health data to identify and reduce health disparities that exist in the region.	Director of Utilization and Care Management	MSHN will ensure adequate data is collected about persons served, their health status and needs, social determinants of health (SDOH), and other impactful variables in order to better focus interventions.	Director of Utillization and Care Management	09/30/22
				MSHN will conduct a thorough assessment of existing data points that are already collected in order to reduce potential duplication and identify information that is missing.	Chief Information Officer	06/30/22
				Build capacity at PIHP for increased data sharing with CMHSP and SUDSP partners.	Chief Information Officer	09/30/22
				MSHN will use predictive modeling to identify at-risk groups and individuals in order to offer targeted prevention and intervention (including review of related software tools/products).	Director of Utillization and Care Management; Chief Information Officer	09/30/22

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STRATEGIC PRIORITY	STRATEGIC GOAL	STRATEGIC OBJECTIVE	CHAMPION	TASK/ACTIVITY	MSHN Lead	TARGET DATE
		MSHN will ensure there is strong regional infrastructure for diversity, equity, and inclusion in all aspects of organizational responsibility and operations.	Chief Clinical Officer	MSHN will engage in an organizational diversity, equity, inclusion (DEI) self-assessment and develop a workplan to address areas for improvement.	Chief Clinical Officer	06/30/22
				MSHN will conduct a review of organizational assessment tools and identify one or more that can be applied to behavioral health systems of care.	Chief Clinical Officer	06/30/22
				MSHN will assess the feasibility of applying standards related to DEI competency within its provider networks.	Chief Clinical Officer	09/30/22
				Assess the training needs of the provider networks related to increasing competency in the areas of diversity, equity and inclusion.	Chief Clinical Officer	09/30/22
				Once training needs have been identified develop a workplan to address gaps in knowledge/competency.	Chief Clinical Officer	03/31/23

Appendix 1 – Key Questions and Key Assumptions

Mid-State Health Network leadership developed what the team considered to be important or key assumptions and questions to address in the strategic planning process. These can certainly be expanded and debated but represent the best judgment and point of MSHN leadership.

KEY QUESTIONS	KEY ASSUMPTIONS
External System Reform/Redesign:	
Will the Specialty Integrated Plan (SIP) proposal made by MDHHS materialize?	MDHHS will not have the necessary staffing and other resources to drive major system reform/redesign.
Will MDHHS pursue management of the Medicaid unenrolled population through all or a single PIHP?	Carve in remains a material threat.
Should MSHN implement coordination and improvement efforts related to unenrolled population?	PIHP/Re-consolidation is favored (regionalism is not).
To what extent should MSHN partner with like-minded PIHPs/Regional Entities to address key "criticisms" upon which reform/redesign are largely based?	Autism benefit is placing a strain on the state budget despite continued increase in eligible cases.
To what extent should MSHN position itself to partner with Health Plans in anticipation of future redesign initiatives?	HCBS Final Rule requires that individuals receiving Medicaid services have full access to their community, including opportunities to seek employment and work in competitive, integrated settings.
What will be the future of CMHSPs?	
What key lessons were learned during the 298 and subsequent redesign discussions that we should be responding to as a regional PIHP collaborative?	
Internal Key Redesign Questions:	
Does MSHN Board and CMHSPs still support MSHN's effort to be the Premier PIHP? If so, what does that mean to them?	PIHP staff must be retained and MSHN must continue to fulfill (and exceed) expectations.
Is there value in other regional approaches to service delivery to demonstrate MSHN/PIHP as an efficient, coordinated, successful PIHP?	Regional finances will likely be pressured in future years (unlike prior years).
Will the CMHSPs in the MSHN region support MSHN pursuing:	Unless there are changes to MSHN bylaws, MSHN has no independent ability to pursue

KEY QUESTIONS	KEY ASSUMPTIONS
	multi-PIHP or public/private partnerships, multi-regional or statewide opportunities.
• a partnership with a physical health payer?	
• Partnerships with likeminded PIHPs to address key "criticisms" upon which reform/redesign are largely based?	
Does NCQA Managed Behavioral Healthcare Organization (MBHO) accreditation for MSHN bring value to PIHP and CMHSPs? And should NCQA accreditation be pursued anticipating that it will be required of the PIHP or by a future potential partner of the PIHP?	
What is the role for MSHN and how should MSHN be preparing for CCBHC, SIM, Opioid Health Homes, Behavioral Health Homes?	
If PIHPs are no longer contracted to MDHHS due to System Reform/Redesign, what role does the region envision for MSHN? What eventualities should MSHN be planning for?	
How does the region and the MSHN Board view MSHN engaging in partnerships that may expand its role, including geographic considerations?	
External Policy Issues:	
Will MDHHS continue delegating responsibilities for monitoring and oversight of key/new initiatives (i.e., 1915(i), HCBS Rule, etc.)?	HCBS Final Rule requires that individuals receiving Medicaid services have full access to their community, including opportunities to seek employment and work in competitive, integrated settings.
Will MDHHS alter autism budgeting/services due to continued benefit growth rate?	Autism benefit is placing a strain on the state budget despite continued increase in eligible cases.
Will MDHHS seek to strengthen a partnership between MRS and the PIHPs to increase efforts to improve beneficiary employment?	
Will MDHHS consider increasing attention and oversight on beneficiary rights and protections as person-driven initiatives and systems are implemented?	
How will MDHHS measure "success" for Healthcare Effectiveness Data and Information Set [HEDIS] and other quality measures when pandemic conditions impact performance?	

KEY QUESTIONS	KEY ASSUMPTIONS
Financing:	
How did the pandemic change our view on service delivery? And planning for service demand increases with expected reductions in rates (due to low utilization in FY20/FY21)?	Rates for FY21 and FY22 will be adjusted down due to low utilization during pandemic.
Other:	
What goals/objectives should be developed to promote diversity, equity and inclusion and where should that work be focused?	
How will the ongoing pandemic response affect internal and regional operations?	Pandemic response will continue at least through FY 21 and may carry over to FY 22
How will a PIHP/Re-attract replacement workers if staff move to other jobs (outside of the PIHP)?	
To what extent does the regional delegation model impact future options and current effectiveness/efficiency?	
Credit for our work and efforts. Concern that mental health on a whole needs an upgrade. Our workers are front-line workers that do not get appropriate appreciation outside of the mental health system. It is vital and needs to be a higher priority. The media coverage we do get seems to be negative. We could use getting more good stories covered.	
Performance Matters. Health systems are experts on looking and promoting the good things that they do based on universally accepted measures. We need to show the metrics that matter. That whole way of measuring performance for behavioral health is an area that the Health Plans are great at – marketing how they do well. MSHN is a leader of the PIHPs on virtually every metric the state and others say is important. We should promote this.	
Opioid engagement. We do need to see what is being done to honor our commitments to our clients addressing the opioid addiction epidemic.	
MSHN should lead reform, innovation and collaboration efforts in region and statewide efforts. Right now, it requires approval by the counties. Our bylaws require their approval, and	

KEY QUESTIONS	KEY ASSUMPTIONS
we need to do our best to get everyone on the same page.	
There is a significant stigma against the people we serve. For years, persons served were not considered important until there was substantial money poured into Behavioral Healthcare.	
The political leadership/environment that will be changing in our state. This can cause changes in how we are seen and how things are handled with future opportunities/threats.	

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APPENDIX 2: Environmental Scan - Strengths, Weaknesses, Opportunities and Threats

Mid-State Health Network leadership developed what the team considered to be important environmental scan observations. These are arranged by strengths and weaknesses (internal-looking), threats and opportunities (external-looking). These can certainly be expanded and debated but represent the best judgment and point of view of MSHN leadership.

Priority	STRENGTHS	Priority	WEAKNESSES
A	High capacity, strong, dedicated and competent staff. Strong in independent work.	A	Too much duplication in region.
A	Consistently high performing PIHP: • Financial Stability • Quality/performance metrics • Compliance to state requirements • Data reporting	A	Value based purchasing is under-developed; lack of provider availability and understanding this move toward value-based purchasing; lack of acceptance to general outcomes (limited by funding streams-esp. SUD- that apply here/ lack of incentive $$) – Please see page 7 for additional details.
A	Highly collaborative in region and with external partners, a statewide leader in reciprocity. Listen to needs of region and incorporate network feedback.	A	MSHN lean staffing model.
A	Seen as a leader among PIHPs by many external stakeholders. Leader in new state waiver initiatives: HCBS, Autism. Influence, leading to systems change.	A	Governance model/operating agreement restricts our flexibility with financing our CMHSPs. Lack of ability to act independently.
A	Excellent reputation	A	Limited CMH data sharing/lack of access of integrated health data with PIHP.
A	Highly developed IT system and support infrastructure, including data analytics	A	Lack of well-defined outcome metrics.
A	MSHN provides strong fiscal oversight of provider network.	B	PIHP is not accredited.
A	Strong monitoring of provider network.	B	Inconsistent level of performance and depth of knowledge across provider network. Strains staff resources.
A	Innovation. We have the only Mobile Care Unit (MCU) providing	B	Lack of local PIHP funds.

Priority	STRENGTHS	Priority	WEAKNESSES
	Medication Assisted Treatment (MAT) in MI.		
A	Highly effective in remote work environment. Agile in our environment.	B	Much time and effort in getting things done related to change management (i.e., approval processes).
A	Developed strong communication with providers, especially during the COVID-19 pandemic. Envied among other regions. Including provider stabilization funds.	B	SUD Provider network does not feel adequately compensated for the indirect/admin requirements.
B	Established and efficient administration/processes	B	Inconsistency within MSHN departments related to how MSHN shares/monitors requirements to provider network (Site reviews, monitoring, etc.).
B	Network Adequacy	C	Tracking too many data points- ability to act on them/follow-through/monitoring
B	Transparency in operations, providing a lot of data and metrics; tracking a lot of data points	C	Not currently participating in state innovative projects, like opioid health homes.
C	Developing strength in regional change management processes, communications.	C	Challenges with attracting qualified staff to PIHP.
C	CCBHC participation in region.	C	Too many initiatives
	State keeps asking for more and more. We've tried to keep providing this information. If this were a private health plan, they would demand more money. We absorb too many responsibilities and new requirements without asking for more money. Unfunded mandates are a real issue.	C	Lack of CCBHC clarification, we don't know enough about the rules and regulations. Department hasn't provided guidance/model.
	CCBHC includes all populations and care needed. Mild/moderate services are opportunities – need to leverage the federal funds and new payment models of CCBHCs. PIHP needs to keep on top of this.		
	Opportunity to co-locate/co-operate integrated healthcare services. Supportive of health homes, PIHP initiatives that are already being promoted by the state. Supportive of expanding populations. But we need		

Priority	STRENGTHS	Priority	WEAKNESSES
	to truly "become" a medical home. Need to promote more physical health services. Get imaginative regarding how we can address individual's physical health care and develop a plan for caring for these individuals.		
	FQHCs and other funders may be able to help us understand how we can continue centering care around persons and family members served.		

PRIORITY	THREATS	PRIORITY	OPPORTUNITIES
A	Medicaid Health Plans continue to pursue carve in.	A	Expand value-based purchasing.
A	Some CMHSP (and some SAPTR) costs are high/above "market"; overhead costs have been considered high by some.	A	Statewide (and/or multi-regional) leadership opportunities for MSHN/PIHPs.
A	Effort to 'carve in' SUD benefit to health plans .	B	Further work to improve health integration at the point of service, especially in the SAPTR system but also in our CMHSP systems.
A	MHP mandatory "Rebid": 09/30/2023 – would likely start in FY 22.	C	Regional v. Statewide SIPs (or similar Public/Private arrangements).
A	If carve in, CMHSPs will not be able to continue status quo – what would change and …	B	…how can/should MSHN position itself to be of value to CMHSPs?
A	Milliman Fee Schedule project could be a threat to the system, their rate models and schedules are guides. They are not going to use this info and potential to drive how the PIHPs rates are set. (RE: Cost caps; Not recognizing full cost.) May be accelerated by budget shortfalls.	B	Standard cost allocation workgroup to reduce rate variance.
A	State budget shortfalls result in less available funding.	A	Example from above: (COMBINE INTO SINGLE REFORM/REDESIGN ITEM).
A	Reduction is rates due to COVID 19 service utilization decreases.	B	Health IT integration consent systems; can lead to expanded data sharing between physical/behavioral health payers.

PRIORITY	THREATS	PRIORITY	OPPORTUNITIES
C	ACA remains under threat- even under Biden administration as states challenge constitutionality (Medicaid Expansion, HMP, remains at risk). Track/monitor/react	B	Data sharing Social Determinants of Health (SDOH) with local health departments, MHPs other potential service providers.
A	Behavioral Health workforce shortage, attrition (institutional knowledge leaving org) due to COVID-19 pandemic. Retention strategies don't exist or can't be financially supported. • SUD labor force under compensation relative to CMHSP workforce.	B	MSHN can partner/collaborate demonstrate leadership to other PIHPs/regions and State regarding health equity and reducing health disparities.
B	IT-EMR-The physical health care systems are propriety and so much larger in nature/more robust versus the BH IT EMR are customized that makes data sharing difficult/impossible.	A	Lead development of legislature education strategy.
C	Parity isn't well understood and applied in the BH system even more impact on the person-centered planning, processes.	B	PIHPs should work toward a standardized benefit, access criteria across the region and among/between regions.
C	PIHPs fiscal health remains a concern statewide- MSHN is current exception.	C	EBPs introduce the opportunity for MSHN to be more data and outcomes driven. MSHN can partner/collaborate demonstrate leadership to other PIHPs/regions.
A	Lack of clarity regarding regional partners will support MSHN being or becoming. • Many of these threats described can lead to increase in compliance related activities (investigations, sanctions). Supervision of staff may be insufficient. Funding pressures lead to increase in sanctions/investigations.	A	MSHN can be more of a leader with physical health payers collaboration, including broadening/deepening population health initiatives.
B	State initiatives (such as MiCAL, etc.) may create more complex, less accessible public systems. State is making decisions and creating processes that are typically the responsibility of the PIHPs/CMHSPs		MSHN may get into a position to broaden services/supports provided to our regional partners.

PRIORITY	THREATS	PRIORITY	OPPORTUNITIES
	being assumed/orchestrated by the State. May create a more complex, less accessible public system.		
A	Legislature and their lack of understanding of public health and behavioral health systems.		
A	Reductions to SUD block grant may impair access for individuals and families to the SUD benefit.	B	Assess/evaluate delegated functions (esp. SUD system, but including CMHSP) to determine whether we can improve efficiency, effectiveness, value, equity.
C	Reduction/reticent to engage in activities that are not required in the MDHHS/PIHP contract that limit advances the region could be making in many areas.		
B	Continued issues with access of beneficiaries to psych inpatient care.		
B	SUD providers increasingly rely on MSHN for direction on how to perform, what to perform ("how to do their job"), lack of certified clinical supervisors, lack of access to best practices and published guidelines, technical assistance, required exceeds MSHN capacity.		
	Threats: Public system keeps trying to serve clients in a better more efficient way. If the health plans are the payers, they don't want to hear about problems or how to make things better. It will be all about the money.		

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APPENDIX 3: Additional Stakeholder Input of Note

- Incorporating that we help consumers to be more self-reliant. Include this under better care.
- Helping the community. Need to reflect to how we help our communities. Connects very well to the population health activities to lift ALL the boats in the community up.
- Focus on consumer care, communities, and helping people. We are part of the community, and this will be lost in a privatized market.
- CMHSPs need to be able to continue to receive the money necessary to do their job. The primary focus of the PIHP should be to save the public system.
- Important to bring community care to people in a mental health crisis. Allows for people to have great access. We must remain accountable to the communities that we serve, especially the consumers and family members in the communities we serve.
- High percentage of minority kids do not like the public mental health system and how they are seen, talked to, and addressed. They dislike this system, and we have to fix that.
- Need to sit down at the table and have good, honest dialogs with people. Some of the best solutions have not been easy, but it comes out of being honest with each other and sharing your plans.
- PIHPs were created by the CMHSPs to hold off the last attack against the public system. Bottom line should be the continuation and protection of the public system. Every time we address the concerns, we give away the firm. Most CMHSPs will be challenged to continue the system.
- Need to protect capitation otherwise you won't be able to keep them in place. We need to convince the legislators that we're the best bang for the buck. We have to say we want a public system. It's the only thing that works for our consumers.
- Metrics –Are there programs in other regions that we could use to model our metrics? MSHN was actually tracking these initiatives and metrics before some other PIHPs and are seen as a model across the state. Metrics include how people access care, initiation and engagement, what care they are accessing, how long do they stay in care, health risks and how those are addressed, outcomes of care, and differences in outcomes based on race, age, etc.
- Standardized national measures – we are more and more tracking HEDIS measures and other national metrics so we can compare ourselves easily to other health plans.
- Is this data something that can be easily accessed? MSHN data is published on the MSHN website and you can see this in an aggregated manner in very accessible ways. Data is also available to the CMHSPs at a more granular level.
- Transportation is such a huge issue. Need to consider this as we look at "access to better health".
- Data collection – It's sometimes good to go back and look at what is already collected, so we are not always adding new things to measure.
- Dialog regarding how aggressively can we pursue an organization if something is not happening according to our standards or expectations. (i.e.: gaps in care, lack of follow up). MSHN noted we can and do assertive outreach based on alerts. At times it's the CMHSPs that really need to act on these things.
- The data metrics, tracking, identifying gaps in care, HEDIS measures, and clinical care pathways MSHN is discussing are all very consistent with the CCBHC model.

- Concerns about children – at risk youth – need to focus on prevention initiatives and kids who are underserved.
- Occasionally CMHSP will obtain/provide services to other CMHSPs and they note significant cost differences. Rate variation is certainly a threat to our system. Will be talking about that next session and where there may be "undesired cost variation". Big risks for the system related to rates that would be paid for under a health plan model.
- Concerns expressed regarding standardized benefits and costs – no one size fits all across all of these organizations. May even "punish" innovative programs and CMHSPs. May result in reducing everyone to the floor.
- The more we expand and innovate into the community -schools, police, and expand our reach, the more we demonstrate that we are different than a health plan.
- Need to be more visible and share what we're doing and the impacts we are having. Walk a Mile – positive stories of recovery, impacts, etc.
- Acknowledgement that this was a very complex and detailed area.
- Veteran's. It was raised that we need to center on Veteran's, many of whom are coming home at grave risk for mental illness.
- Accountability. These measurements and goals help identify and promote accountability of this public system. This is especially important in the times of privatization threats.
- Compliance Processes. Appreciation expressed for the goals of creating systems that detect and identify fraud and waste.
- Crisis Residential/Inpatient: Criteria is very similar. MSHN has led the state in providing access to psych inpatient, as the first region to quantify the number of denials. There were 19-21 per person per episode before admission. A statewide light was shown on the situation as the organization providing the initial energy to improve this problem across Michigan.
- Beds for Crisis/Inpatient: Has there been an increase or decrease? For children, it has decreased. Sometimes, it is about "who a hospital will take" – and were not about bed availability, but the level of acuity is too high for the unit. In some ways, this says "we don't want to take *your* referral". This is a significant civil rights issue for our system today. We would never do that for a stroke or cardiac issue.
- Education Regarding Services: Need more information and awareness for our citizens. Wonder if our strategic plan has an education and outreach component. Michigan is saying that it's important to have a crisis continuum within each community. MICAL is working on a statewide initiative to unify crisis efforts for PIHPs and CMHSPs.
- Integration of other services with crisis needs: What are we doing to address integration across served populations, include veteran's and those that would choose to commit 'death by cop'. Mobile crisis and other models are established. The relative degree of engagement has been negatively impacted by the pandemic.
- Measuring Consistency: How are we measuring consistency in the region? How are we comparing CMHSPs in MSHN? We have similar intakes across the counties. We also use standardized assessment tools (e.g., CAFAS, SIS, LOCUS, etc.) to aid in identifying need throughout the region. Depending on the area, there may be certain local features where service provision may be different based on the community.
- Our CMHSPs and portals of entry are operating under the same set of criteria for admission. A person admitted in one county is likely to be admitted by another CMHSP. Now it's important to consider how much services they get – amount, scope and duration – is individualized and could vary from place-to-place depending on a number of factors. Need to ensure care meets standards without losing its person-centeredness.

- Support for compliance areas – Confidence in the monitoring and oversight that is in place.
- How does MSHN define Better Value ---answer – value proposition = Quality /Cost and Outcomes. This is a weakness overall in public mental health system. We don't always look at our financial performance.
- Unpredictable costs ----cost of "habilitation", cost of "recovery" is difficult to quantify.
- Concerns about how we define this in an area without competition. Concerns regarding having to compete on costs.
- How do we help prepare the CMHSPs and/or the Providers for a potential future with a private payer? This should not be an area of focus. We should focus on implementing the advocacy plan, fight and see what happens.
- General Support for goals/objectives as presented.
- Keep doing what we're doing… be a shining star… show the state that it really does work. We have numbers to show that we're performing.
- Concerns about spending too much time focusing on the threat and potential things that might happen. If anything, we need to talk about putting up a fight, and in the meantime do the job we do.
- Value Based pricing – not clear how that could be helpful at this time given the current payment models. For SUD, there is more opportunity for this.
- Clarification that at times the PIHP has and will address spending concerns if a CMHSP is out of budget.
- Support for what MSHN is doing ---keep it up.
- Need to consider both the politics plus the marketing to support a public system
- How are we affirming/confirming how we're doing at the individual provider/health home level? There are a TON of direct care/support workers in this region. With the exception of the SUD providers, it is all delegated to the CMHSP, and there is no state reporting on this. This is especially challenging for direct care workers.
- How is this different than the rest of Michigan's workforce? Is the culture of the workforce part of the problem? It is challenging… What do we do to prevent burnout? How do we continue to support? What can we do to address the issues (i.e., funding, Fee For Service (FFS), staffing shortages, etc.)? We can listen well, assist with administrative functions where we can, create career pathways and ladders, help them to compete, etc.
- As we look at equity issues, it's important to carefully consider - Why does this matter and what can we do about it? Need to look carefully at what's happening within the service delivery within MSHN. What are the actual impacts of the system we have created? (i.e.: lack of follow up care? Discrepancies in prescribing patterns?)
- Need to better understand the causes for the inequities. Why isn't follow up after DC happening consistently for all? Need to get to the bottom of this and understand the root causes.
- Very supportive of this initiative. Difficult to know where to start.
- Taking some good first steps in being honest with each other and really looking at the data.
- Starts with understanding and creating safe spaces.
- Goals may need to be modified based on input from people in the community and insights of the advisory panel. Focus on the population data and what we can learn about the inequities.
- Seek first to understand. Then take actions within the scope of our responsibilities.
- Consider fewer goals/objectives and focus on the things that are within MSHN scope/ability to impact.