MSHN
Mid-State Health Network



# FY 2024 – FY 2025 STRATEGIC PLAN UPDATE

The pages that follow constitute the update to the Mid-State Health Network (MSHN) Strategic Plan covering fiscal years (FY) 2024 and 2025. 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 board adopted strategic priorities: **"*Better Health*", "*Better Care*", "*Better Value*". "*Better Provider Systems*" and "*Better Equity.*"** These are referred to throughout the remainder of this document as our ***strategic priorities***.

As depicted below, goals were discussed and developed with input from MSHN staff, various regional councils and committees, the MSHN Regional Consumer Advisory Council, the MSHN Operations Council, the MSHN Substance Use Disorder (SUD) Oversight Policy Board, the MSHN Governing Board and the Michigan Department of Health and Human Services (MDHHS). Meetings and other activities to gather this broad input occurred from January 2023 through August 2023.

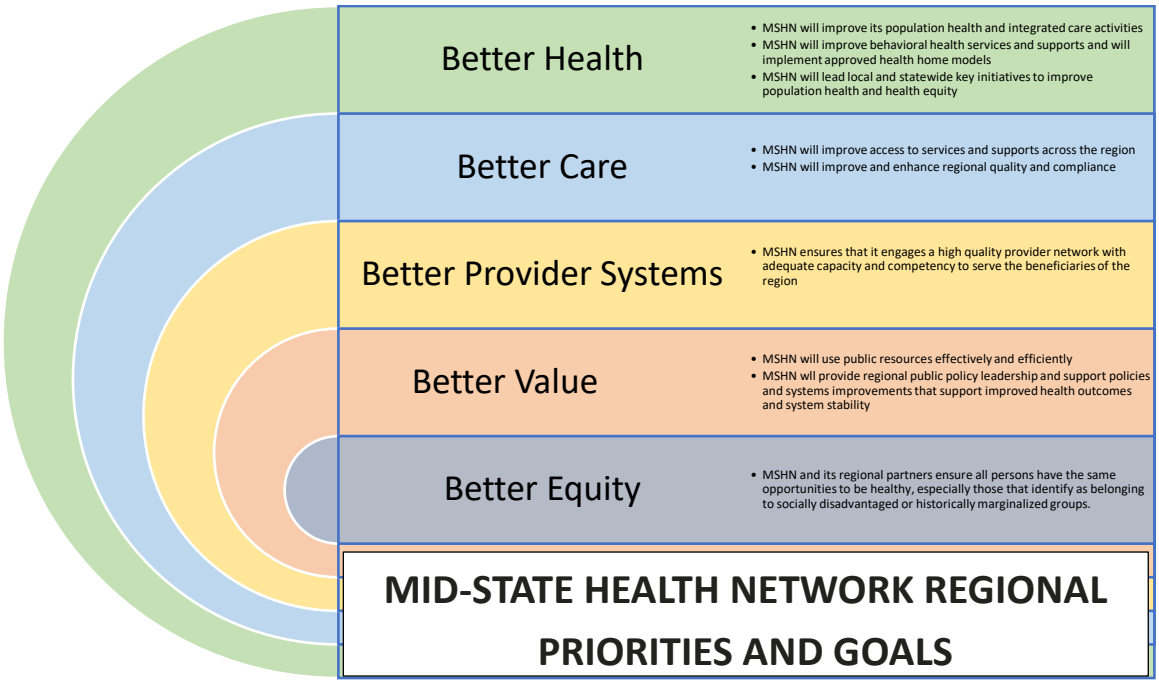

Based on this wide input, MSHN executive leadership extracted the strategic goals that emerged around common themes and which accurately correspond with its view of the accountabilities of the Mid-State Health Network, current environmental opportunities and threats, and its mission to support services 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 and the communities in which they live and work. MSHN's strategic goals 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 Community Mental Health Service Provider (CMHSP) partner; planning and operations that reflect a realistic evolutionary process; flexible and robust managed care operations not favoring 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]

The following pages present the recommended strategic plan for fiscal years 2024 and 2025. These include new goals developed in the process described above and also continued or revised strategies from the previous MSHN Strategic Plan.

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

The MSHN Strategic Plan is based on the Strategic Priorities identified at the left 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* across the region. We have used these themes as guideposts in our development of regional and MSHN-specific strategic goals.

## MID-STATE HEALTH NETWORK LEADERSHIP TEAM

Todd Lewicki,
Chief Behavioral Health Officer

Steve Grulke,
Chief Information Officer

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Chief Compliance and Quality Officer

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Skye Pletcher
Director of Care and Utilization Management

Trisha Thrush,
Director of SUD Services

Amanda Ittner,
Deputy Director

Leslie Thomas,
Chief Financial Officer

Joseph P. Sedlock,
Chief Executive Officer

## KEY ASSUMPTIONS AND KEY QUESTIONS FOR STRATEGIC PLANNING

With input from the region, Mid-State Health Network staff and leadership developed what our teams considered to be important or key assumptions and questions to address in the strategic planning process. We have provided a comprehensive list of all assumptions (see Appendix A) and narrowed this list down to what regional leadership considered the most pressing or important. These can certainly be expanded and debated but represent the best judgment of regional leadership.

| KEY ASSUMPTIONS |
|---|
| MDHHS Priority: Children in Foster Care is a focus of MDHHS; depth of understanding roles and responsibilities and needs vary across the region and across the public behavioral health system. |
| MDHHS Priority: Continued effort to improve Access to services. |
| MDHHS Priority: Expansion of Certified Community Behavioral Health Clinics (CCBHCs) and Behavioral/Opioid/Substance Use Disorder Health Homes. |
| MDHHS Priority: Expanding MDHHS oversight of Prepaid Inpatient Health Plan (PIHP) managed care operations will add administrative burdens (and cost) and may complicate regional operations and delegation arrangements. |
| Medicaid Health Plan rebid may have significant impacts on public behavioral health services. |
| Conflict Free Access and Planning will likely have significant impacts on MSHN, Participating CMHSPs and providers across the region and the state and may require PIHPs to centralize certain managed care functions that are currently delegated. |
| There will be major, but unknown, changes in the public behavioral health system. We should be drivers of those changes and not passive. |
| Workforce shortages will continue to be a critical issue. Staffing shortages may cause reductions in services or closures of provider organizations (especially in the SUD provider network). |

## ENVIRONMENTAL SCAN FOR STRATEGIC PLANNING

With regional input, Mid-State Health Network staff and leadership developed what they 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 staff and leadership. Please see Appendix B for a complete list of all noted strengths. Please see Appendix C for a complete list of all noted weaknesses.

| STRENGTHS |
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| Focus on doing the right thing(s) for consumers is central to all MSHN and CMHSP Participant operations. The region is a strong advocate for consumers. |
| MSHN provides excellent support, resources, and technical assistance to our SUD provider network, as evidenced by affirming feedback from many providers who contract with multiple PIHPs. |
| Great employee retention rate; onboarding process and HR policies/procedures are well-defined |
| Transparency in operations (both internal and with provider network); many opportunities for employees and stakeholders to provide input into processes that directly affect them. |
| Strong communication both internally and externally. |
| MSHN is viewed as a strong leader in the State for many different initiatives and areas of expertise. Strong collaboration with MDHHS. |

| STRENGTHS |
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| Dedicated, committed, high-performing, and efficient staff. |
| High level of cohesion and collaboration with and among regional CMHSP participants and MSHN. |
| Financial strength of the organization and financial leadership at the PIHP level. MSHN and CMHSPs are committed to the fiscal health of the region and holding one another accountable. |
| MSHN anticipates and prepares for changes in the system. |
| Good diversity of thought influenced by diverse backgrounds. |
| Strong and effective regional Board of Directors. |
| Strong and effective regional councils and committees. |

Please see Appendix B for a complete list of all noted strengths.

| WEAKNESSES |
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| Decentralized access for SUD services has led to individuals receiving wrong services/incorrect level of care. Provider feedback that access process is duplicative and inefficient. |
| Lengthy process for needed changes to be decided and implemented. |
| No local funds at PIHP level. |
| Departments can become siloed creating communication and collaboration issues. |
| Large number of performance measures being implemented and monitored that are not outcome focused but rather focused on process and compliance. |
| Lack of standardization and centralization among the region's providers. |
| Implementation of new standards is not always coordinated among all the involved staff/departments leading to inefficiencies and at times duplication of work/efforts. |
| Lack of diversity in MSHN staff and in MSHN's provider networks. |
| Interdepartmental communication is sometimes problematic and complicated leading to some providers "answer shopping." |
| Effect of Conflict Free Access and Planning on systems of care-CMHSP and SUD. |

Please see Appendix C for a complete list of all noted weaknesses.

| OPPORTUNITIES |
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| While also a threat, Conflict-Free Access and Planning requirements may present many opportunities to improve our services and their management. This will also have redesign implications for SUD access. |
| Better marketing/messaging strategies about the success and strength of the public mental health system (particularly PIHPs) to combat prevalent narratives in mainstream media – be proactive; not just reactive. |
| Education for public and provider systems about roles/responsibilities of PIHP vs Medicaid Health Plans; most Medicaid enrollees, stakeholders, and general public don't understand the role of the PIHP and specialization. |
| Opioid Settlement Funds present many opportunities to improve and expand services for residents of the state struggling with opioid addiction. |
| Continued expansion of integrated health initiatives [Behavior Health Homes (BHH), CCBHC, Opioid Health Homes (OHH), SUD Health Homes, etc.]. Expansion in both sites and number of individuals enrolled. |
| MSHN should explore more Value Based Purchasing (VBP) opportunities that incentivize improving outcomes and/or quality of care. |

| OPPORTUNITIES |
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| A regionally operated crisis continuum (crisis residential, crisis stabilization, psychiatric residential treatment facilities, etc.) can be value added for the region. |
| PIHP-level, regional recruitment efforts to address workforce shortages across the region. |
| Propose new initiatives and partnerships to address state priorities with children services, foster care, crisis services, and other areas where need is acute. |
| Focus on underprivileged communities. |
| Consistent, ongoing plan for SUD services in rural communities. |
| Ensure coordination with counties and state regarding opioid settlement funds. |
| Develop SUD County plans that are replicable for other counties to implement. |
| Review Medicaid requirements and PIHP requirements to reduce, where possible, nonvalue added functions. |

Please see Appendix D for a complete list of all noted opportunities.

| THREATS |
| --- |
| New/Ongoing legislative proposals to integrate behavioral health and physical health. System redesign and ever-changing political environment. |
| Health plan rebid may cause significant public behavioral health systems changes. |
| Conflict Free Access and Planning models could fundamentally change how the public mental health system operates, can increase complexity for beneficiaries, and alter regional dynamics and arrangements. |
| End of COVID-19 Medicaid continuous enrollment could negatively affect financial resources. |
| Statewide behavioral health workforce shortages continue to stretch all provider systems (SUD Service Provider and CMHSP) to breaking point despite best efforts toward recruitment and retention. |
| Continued discussion for use of specialty needs plans. |
| Community resistance/pushback with things like: harm reduction; Diversity, Equity, Inclusion (DEI) efforts; Medication Assisted Treatment (MAT); etc. |
| Reduced Block Grant revenue |
| Administrative Workloads increasing – more so regarding clinical documentation/paperwork requirements. |
| Value Based Purchasing arrangements lack consideration for willingness/stages of change for beneficiaries and level of recidivism. |

Please see Appendix E for a complete list of all noted threats.

## STRATEGIC GOALS:

Reminder that Strategic Goals are board approved. Strategic Objectives are management developed prerogatives about which the board advises.

The following represents the proposed MSHN Strategic Priorities, Strategic Goals, Tasks/Activities, and Responsible Leads and Champions for Fiscal Years 2024 and 2025.

## BETTER HEALTH

| | | | | | |
|---|---|---|---|---|---|
| MSHN will improve its population health and integrated care activities. | | | | Deputy Director (DD) | |
| | 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 (DUCM) | MSHN will explore the use of geographic information systems in order to better understand neighborhood-level characteristics and areas of need. | Deputy Director | 11/01/23 |
| | | | MSHN will work with its partner CMHSPs to develop a standardized process for collecting and sharing data related to social determinants of health including the use of SDOH z-codes on service encounters. | Director of Utilization and Care Management/ CIO | 12/01/23 |
| | | | MSHN will explore opportunities to address existing transportation barriers for SUD and behavioral health services including policy recommendations and advocacy with MDHHS for non-emergency behavioral health transportation. | Director of Utilization and Care Management | 06/30/24 |
| | | | MSHN will identify specific strategies to improve SDOH within the population served. | Director of Utilization and Care Management | 03/01/24 |
| 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. | | | | Deputy Director | |
| | MSHN will work with regional CMHSPs, other PIHPs, and MDHHS, to improve access to specialty behavioral health services for children and youth involved in the child welfare system | Chief Behavioral Health Officer (CBHO) | MSHN will engage with MDHHS and regional partners to clarify issues related to service delivery to children/youth and families, especially those involved with the Child Welfare System. | Deputy Director | 10/01/23 |
| | | | Examine wrap-around services for children exposed to trauma; support for children's navigators with children/youth and families with complex care needs, especially those in the child welfare system. | Chief Behavioral Heath Officer | 01/01/24 |
| | | | MSHN will engage with MDHHS and regional partners to improve access to behavioral health services for children/youth, especially those involved with the Child Welfare System. | Deputy Director | 10/01/23 |
| | | | MSHN will develop standardized reporting process for children/youth involved in the Child Welfare System. | Chief Information Officer | 12/01/23 |
| | | | MSHN will review key data point and develop key performance indicators to track improvements in outcomes for children/youth involved in the child welfare system. | Chief Behavioral Heath Officer | 02/01/24 |
| | MSHN will expand availability and implementation of opioid health homes, SUD health homes, behavioral health homes, certified community behavioral health clinics, and other integrated health programming. | Deputy Director | MSHN will report on quality measures related to all health homes and other integrated health programming, working with HH's to improve performance where needed. | Director of Utilization and Care Management | 10/01/23 |
| | | | MSHN will develop a selection process to ensure consistent application and acceptance of new health home partners (OHH and BHH) | Director of Utilization and Care Management | 10/01/23 |
| | | | MSHN will assess readiness for implementation of SUD Health Homes in the region. | Deputy Director | 12/01/24 |
| | | | MSHN will work with its partner CMHSPs to assess readiness for implementation of Certified Community Behavioral Health Clinics (CCBHC) | Director of Utilization and Care Management | 08/01/24 |
| | | | MSHN will develop an annual review process to monitor behavioral health homes within the region ensuring they meet all the requirements identified by the MDHHS and SAMHSA. | Director of Utilization and Care Management | 03/01/24 |
| | | | MSHN will develop an action plan based on the results of the readiness assessment of SUD Health Homes in the region; to include policy guidance, application and selection of SUD Health Home provider. | Director of Utilization and Care Management | 03/01/24 |
| | | | MSHN will select a SUD Health Home provider in region to begin services in FY25 | Director of Utilization and Care Management | 08/01/24 |
| | MSHN will identify regional strategies for the prevention and treatment of substance use disorders, community recovery, and harm reduction to reduce overdose death, including identifying and addressing health disparities in this area. | Chief Clinical Officer | MSHN will monitor its Provider Network to ensure Evidence Based Practices are included in substance use disorder prevention, treatment and recovery programs as part of the site review process. | Director, SUD Operations | 09/30/25 |
| | | | MSHN prevention team will work with community partners to increase access to substance use disorder services/resources for older adults (55+). | Prevention Lead | 09/30/25 |
| | | | MSHN will support access to harm reduction supplies and programs like Narcan, fentanyl test strips, and syringe service programs including but not limited to Narcan vending machines. | Treatment Specialist, Lead for Harm Reduction | 09/30/25 |
| | | | MSHN will work to increase access to re-entry services and will work with contracted providers to expand access to services within incarcerated settings. | Director, SUD Operations | 09/30/25 |
| | | | MSHN will work on increasing awareness and reducing health disparities rooted in both systemic barriers to access and quality care and community attitudes and stigma that creates mistrust of SUD services, best practices like Medication-Assisted Treatment and Harm reduction. | Chief Clinical Officer | 09/30/25 |
| MSHN will lead local and statewide key initiatives, including complex care management, population health, and physical health integration at the point of service so that health equity and health outcomes are improved for all beneficiaries. | | | | Deputy Director | |
| | MSHN will support care coordination and complex care management for all consumers within the region with a focus on achieving health equity for underserved or traditionally marginalized populations. | Deputy Director | MSHN will develop a risk stratification to support care coordination and complex care management (CCM) based on identified health equity analysis. | Deputy Director | 12/01/23 |
| | | | MSHN will develop care plans and a process to document follow up to support care coordination and complex care management based on identified health equity analysis. | Director of Utilization and Care Management | 03/01/24 |
| | | | MSHN will develop key performance metrics to monitor CCM. | Deputy Director | 06/01/24 |
| | | | MSHN will develop initiatives to address key performance metrics related to health equity within the region | Director of Utilization and Care Management | 10/01/24 |
| | 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. | Director of Utilization and Care Management / Chief Information Officer | 10/01/24 |
| | | | MSHN will pursue e-consent management opportunities to improve care coordination between behavioral health, physical health, and SUD systems of care. | Director of Utilization and Care Management / Chief Information Officer | 10/01/24 |

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## BETTER CARE

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| MSHN will improve access to services and supports across the region. | | | | Deputy Director | |
| | 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 (CBHO) | MSHN will review and address need for increasing access to children's services, including acute care. | HCBS Administrator (Youth) | 01/01/24 |
| | | | MSHN will participate in PRTF discussions through MDHHS planning workgroup as appropriate. | CBHO | 01/01/24 |
| | | | MSHN will review and determine capacity needs for ABA services and work with region and providers. | HCBS Administrator (Youth) | 10/01/23 |
| | | | MSHN will develop tracking system for Total Number of enrollees who have asked for a service but who weren't able to be served from 10/1/2022 - current (NAA Report) | Utilization Administrator/Customer Service Manager | 10/01/23 |
| | 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 will review, report, and increase use of *CRM/OPEN Beds* | CBHO/DUCM | 10/01/24 |
| | | | MSHN will open the regionally-operated crisis residential unit, develop monitoring system, and quality reviews. | CBHO | 10/01/23 |
| | | | MSHN will monitor mobile crisis response (intensive crisis stabilization services) activities, and suggest process and outcomes metrics. | CBHO/HCBS Administrator (Youth) | 01/01/24 |
| | | | MSHN will work with MDHHS to implement relevant process and outcomes measures for MiCAL. | CBHO | 12/01/23 |
| | | | 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. | Treatment & Recovery Specialist | 09/30/25 |
| | | | 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. | DUCM | 10/01/25 |
| | | | MSHN will work with MDHHS to implement PRTF and ICTS in the region. | CBHO/HCBS Administrator (Adult) | 10/01/24 |
| | | | Address Inpatient Access issues and emergency department boarding. | CBHO | 10/01/23 |
| | | | MSHN will identify opportunities and implement enhanced care coordination initiatives for individuals with complex care needs. | CBHO/DUCM | 12/01/23 |
| | 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. | Director of Care and Utilization Management | 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 Navigator (VN) | 04/01/24 |
| | | | 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 Navigator (VN) | 04/01/24 |
| | | | MSHN will work with its CMHSP partners to increase access to veteran navigators and veteran peer specialists in their communities. | Veteran Navigator (VN) | 12/31/24 |
| MSHN will enhance regional quality and compliance. | | | | Deputy Director | |
| | MSHN will provide leadership on improving the consistency and implementation of person-centered planning, self-determination, conflict free access and planning, and independent facilitation in the region. | Chief Compliance and Quality Officer/Chief Behavioral Health Officer | PCP toolkit/training resource will be reviewed on a quarterly basis and updated as needed. | Chief Compliance and Quality Officer | 10/01/24 |
| | | | MSHN will provide templates, formats and/or guidelines as identified through semi-annual review by CLC and QIC. | Chief Compliance and Quality Officer | 10/01/24 |
| | | | MSHN will identify a plan to address the strengthening of safeguards for conflict free access and planning, as appropriate. | CBHO | 10/01/24 |
| | | | MSHN will work to achieve compliance with the identified conflict free access and planning model required by MDHHS. | CBHO | 09/30/25 |
| | 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). | CBHO | 10/01/23 |
| | | | MSHN will identify the group most appropriate to address system reform objectives (including what, who, by when, related metrics (if any). | CBHO | 11/01/23 |
| | | | MSHN will work with its partners to establish a workplan to address system reform objectives (including what, who, by when, related metrics (if any). | CBHO | 01/01/24 |
| | | | Promote and expand mental health first aid training and other intervention practices to strengthen regional crisis response. | CBHO | 10/01/24 |
| | Expand penetration rates in specialty populations (in particular, older adults, adolescents, and in communities experiencing health disparities and inequity). | Chief Behavioral Health Officer | MSHN will establish baseline penetration rate for its specialty populations including utilization rates of SUD and BH services. | DUCM | 10/01/24 |
| | | | MSHN will identify strategies to address increasing penetration rates for adolescents and older adults (including what, who, by when, related metrics (if any)). | DUCM | 10/01/24 |
| | | | 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. | CCO | 09/30/25 |
| | | | MSHN will review and identify gaps in provision of wraparound, SEDW, and CWP services to eligible youth and increase enrollment and capacity for addressing complex care needs. | HCBS Administrator (Youth) | 10/01/24 |
| | MSHN will conduct an analysis of its SUD Access System and recommend improvements as appropriate. | Director of Utilization & Care Management | MSHN will conduct a feasibility analysis for centralizing some or all SUD Service Access, with a focus on reducing redundancy and improving the experience of the person served. | UM Administrator | 04/01/24 |
| | | | MSHN will conduct an equity/outcome analysis for funding provided for 24/7/365 SUD Access to regional partners and propose adjustments, if warranted, based on that analysis. | Director of Utilization & Care Management/CFO | 04/01/24 |
| | | | MSHN will ensure the SUD provider system has a similar level of funding for performing similar SUD Access functions as those provided by CMHSP Participants. | Director of Utilization & Care Management/CFO | 04/01/24 |
| | With its regional partners and other stakeholders, MSHN will evaluate opportunities and feasibility for increasing housing opportunities for individuals with various housing support needs and develop or fund options (if feasible) consistent with the Home and Community-Based Services final rule. | Chief Behavioral Health Officer | MSHN will research feasibility/allowability to establish and/or work with providers to increase specialized housing options within the region. | CFO / Provider Network Committee | 10/01/24 |
| | | | MSHN will review and utilize the Network Adequacy Assessment for addressing the identification of housing support needs in the region. | CBHO | 10/01/24 |
| | | | MSHN will work with PIHP partners across the state to establish a strategy to increase the availability of HCBS compliant settings. | HCBS Administrator (Adult) | 10/01/24 |
| | MSHN will have well established compliance processes that are recurring, consistent and measurable and aimed at preventing, detecting, and deterring fraud, waste and abuse. | Chief Compliance and Quality Officer | 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. | MEV Auditor/Chief Compliance and Quality Officer | 10/01/24 |
| | | | 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 | 06/01/24 |
| | | | 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 | 06/01/24 |
| | | | Complete a compliance risk assessment for MSHN. | Chief Compliance and Quality Officer | 12/01/23 |

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## BETTER VALUE

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| Public Resources are used efficiently and effectively. | | | | Chief Financial Officer | |
| | MSHN will maximize funding to participating organizations in regional integrated health initiatives (CCBHC, OHH, BHH, SUD-HH) | Chief Financial Officer | MSHN will ensure MDHHS mandated rates are provided to Integrated Health Partners in addition to monitoring fiscal impacts and risk to the region as a whole | Chief Financial Officer | 01/01/24 |
| | | | MSHN will ensure sufficient internal capacity to carry out integrated health initiatives. | Chief Executive Officer | 09/30/25 |
| | | | MSHN will take steps to ensure it has funds available to cover disallowances by MDHHS of health home participation so that recoveries from providers are avoided. | Chief Executive Officer; Chief Financial Officer | 06/01/24 |
| | 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 | 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 | Ongoing |
| | | | MSHN's Fiscal Officers will ensure MDHHS feedback regarding State changes are addressed and corrected in a timely manner. | Chief Financial Officer | Ongoing |
| 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 | 10/01/23 |
| | | | MSHN will assess long-term planning and readiness for accreditation. | Deputy Director | 10/01/24 |
| | 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 | Ongoing |
| | | | MSHN and its Regional Finance Council will monitor budget trends to evaluate cost-effectiveness. | Chief Financial Officer | Ongoing |
| | 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; Deputy Director | Ongoing |
| | | | 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. | Deputy Director; Chief Financial Officer | 10/01/25 |
| | MSHN will explore opportunities to develop and/or partner with other PIHPs, other organizations, CMHSP Participants, SUD Providers to integrate public behavioral health services into any proposed Dual Special Needs Plan (D-SNP) or other Special Needs Plans that may evolve, including proposed Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNP) | Chief Executive Officer | MSHN will monitor the development of Special Needs Plans by MDHHS and initiate internal planning when warranted | Chief Executive Officer | 10/01/25 |
| | | | MSHN will monitor the developments associated with the Medicaid Health Plan rebid and initiate internal planning when warranted. | Chief Executive Officer | 10/01/25 |
| | | | MSHN will monitor developments associated with Conflict Free Access and Planning and initiate internal planning when warranted. | Chief Executive Officer | 01/01/25 |
| | Ensure coordination with counties and the State regarding opioid settlement funds to prevent duplication and ensure effective/efficient use of resources. | Chief Clinical Officer | MSHN will collaborate with external partners like MDHHS, MAC, the Opioid Advisory Commission and the Opioid Task Force's Racial Equity Workgroup to inform application and utilization of opioid settlement funds in the region. | Chief Clinical Officer | 09/30/25 |
| | | | MSHN will work with all of the PIHPs' regional SUD Directors on staying informed and, where possible, on implementation of opioid settlement funding initiatives around the state. | Chief Clinical Officer | 09/30/25 |
| | | | MSHN will work with regional partners who are recipients of opioid settlement dollars to ensure application of evidence-based best practices. | Director of SUD Operations | 09/30/25 |
| | MSHN will review Medicaid, contractual, and PIHP requirements on its network and will reduce redundancy and administrative burden and/or non-value-added requirements on the CMHSP and SUD provider systems wherever appropriate. | Deputy Director | Consider reducing number of MEV reviews/year and or expanding reviews from two-year cycle to three (or more) year cycle. | Compliance Administrator | 10/01/23 |
| | | | Review monitoring tools to improve efficiencies and reduce duplication. | Compliance Administrator | 10/01/24 |
| | | | Implement and use of CRM for organizational credentialing and individual credentialing; reducing MSHN paperwork required of provider | Compliance Administrator | 01/01/24 |
| | | | Review and revise where allowable the site review schedule to reduce burden on the provider network. | Compliance Administrator | 10/01/24 |
| | | | Analyze new methods to monitor provider compliance and performance placing less burden on the provider network. | Compliance Administrator | 06/01/24 |
| | 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. | Deputy Director; Chief Financial Officer | 06/01/25 |
| | | | 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.<br>BOARD INPUT: conduct board development on value based purchasing | Deputy Director; Chief Financial Officer | 09/30/25 |
| | | | MSHN will secure the use of Consultants and Subject Matter Experts to strengthen VBP strategies. | Deputy Director; Chief Financial Officer | 09/30/25 |
| | 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 | 10/01/24 |
| | | | 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 | 10/01/24 |
| | | | Identify if there are similar reports that could be combined, discontinued, etc. and any needed additional reports. | Chief Information Officer | 10/01/24 |
| | | | Identify a centralized place to store plan of correction that is easily accessible by MSHN staff. | Chief Compliance and Quality Officer | 06/01/24 |
| | | | Review use of management systems to increase efficiency with completing required functions. | Quality Manager/Compliance Administrator | 10/01/24 |
| | | | 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. | Quality Manager | 10/01/24 |

## BETTER PROVIDER SYSTEMS

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| 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 | |
| | Ensure MSHN's network is adequate to meet consumer demand. | Deputy Director | Address recommendations from the Annual Network Adequacy Assessment (NAA) FY21 and the FY22 Addendum | Deputy Director | 09/30/23 |
| | | | Conduct Geomapping analysis including focus areas as identified by MDHHS | Deputy Director | 10/30/23 |
| | | | Revise and update NAA FY23 based on MDHHS template | Deputy Director | 12/01/23 |
| | | | Develop recommendations to increase provider capacity to address gaps | Deputy Director | 03/01/24 |
| | | | Work with CMHSPs to increase regional crisis services continuum providers | Deputy Director | 04/01/24 |
| | 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. | Director of SUD Operations | 03/01/24 |
| | | | Review quarterly/annual QAPI summary results and develop performance incentives based on low performing areas. | Deputy Director | 03/01/24 |
| | | | MSHN will conduct an assessment of Certified Clinical Supervisor (CCS) capacity within the region for licensed SUD treatment programs. | UM Administrator | 03/01/24 |
| | | | MSHN will request feedback through the SUD Providers to develop a workplan to increase CCS capacity and competency within the region. | UM Administrator | 06/01/24 |
| | | | MSHN will identify and share with the region any best practices associated with improving beneficiary's access to necessary services and supports. | CBHO | 01/01/24 |
| | | | MSHN will survey the provider network for cultural competence that could improve penetration and engagement in populations that are historically underserved. | Chief Clinical Officer | 09/30/25 |
| | MSHN will advocate for public policies that promote an adequately compensated, safe, effective and well-trained workforce. | Chief Executive Officer | Continue advocacy around conflict free access and planning consistent with MSHN Board adopted resolution | CBHO, Deputy Director, Chief Executive Officer | 01/01/25 |
| | | | Advocate for long-term funding and other supports to reduce turnover, improve retention and ability to attract new workers into the regional workforce. | Chief Financial Officer; Chief Executive Officer | 09/30/26 |
| | | | Continue advocacy and effort to improve MDHNS workforce support initiatives, including administrative effort reductions, compensation, and other incentives, especially focused on the SUD workforce. | Chief Executive Officer | 09/30/2026. |
| | MSHN will actively engage MDHHS and other stakeholders in planning efforts relating to conflict free access and planning so that least disruptive models that work best in the region and for the region's beneficiaries are advocated for. | Chief Behavioral Health Officer | Once a model for conflict free access and planning is adopted by MDHHS, MSHN will develop and submit an implementation plan to MDHHS. | CBHO | 10/01/24 |
| | | | MSHN will effectively utilize the appropriate regional councils and committees to implement the adopted conflict free access and planning model. | CBHO | 09/30/25 |
| | | | Board will develop a resolution opposing current models (as of 05/2023) for Conflict Free Access and Planning while supporting strengthening of existing procedural safeguards with CFAP. | CEO | 05/31/23 |
| | Increase community connections through coalitions, prevention and community events to motivate, connect, and encourage engagement of providers and beneficiaries (on an in-person basis). | Chief Clinical Officer | MSHN will continue supporting community coalitions with funding for county-specific SUD prevention and recovery activities as deemed appropriate by the coalitions based on community need(s). | Prevention Specialist Lead | 09/30/24 |
| | | | MSHN will engage in community level town hall/focus group activities to ensure input is received from communities across the region on perceived and real barriers to access and to care. | Chief Clinical Officer | 09/30/24 |
| | | | MSHN will continue to hold regional (NW, South and East) ROSC meetings to encourage connections and engagement in prevention and recovery activities. | Treatment & Recovery Specialist | 09/30/25 |
| | Provider systems are fragile and stressed due to the magnitude and frequency of change. Invest in improving change management systems at MSHN and across the region. | Deputy Director | Review provider communication systems to ensure effective and valuable | Deputy Director | 08/01/24 |
| | | | Research change management system applications for use in areas such as contracts, policies, MDHHS guidance, etc. | Chief Information Officer | 08/01/24 |
| | | | Conduct analysis of feasibility, use of and return on investment related to a change management system | Deputy Director | 12/01/24 |
| | 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 any newly proposed system redesign, changes with conflict free case management, etc. | Deputy Director | 06/01/24 |
| | | | MSHN will monitor increased provider participation in health homes to ensure sufficient internal capacity for all departments (quality, IT, clinical, finance, etc.) | Deputy Director | 06/01/24 |

| BETTER EQUITY | | | | | |
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| 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 Utilization and Care Management | |
| | MSHN will increase access to health services for historically marginalized groups and implement actions intended to reduce/eliminate disparities in service access and engagement | Director of Utilization and Care Management | MSHN will monitor key performance indicator data related to service access and engagement to identify where disparities exist | Director of Utilization and Care Management/Quality Manager | 10/01/24 |
| | | | MSHN will obtain input from the affected populations around barriers to engaging in treatment and effective outreach strategies. | Director of Utilization and Care Management/CCO | 10/01/24 |
| | MSHN will develop and implement initiatives around outreach and engagement to underserved individuals & communities. | Chief Clinical Officer | MSHN will apply lessons learned from the FY23 Spring Lecture series, networking with local and national experts, and consultation with community stakeholders to develop strategies to improve engagement in targeted communities. | Chief Clinical Officer | 01/31/24 |
| | | | MSHN will work with community-level leaders, influencers and stakeholders to create townhall focus groups to inform efforts in reducing stigma and improving engagement in underserved communities. | Chief Clinical Officer | 01/31/24 |
| | | | MSHN will facilitate community outreach efforts and will provide linkages between community leaders and Learning Collaborative pilot members, so action planning is informed by community input and engagement. | Chief Clinical Officer | 12/31/23 |
| | MSHN will utilize population health data to identify and reduce health outcome 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 Utilization and Care Management/CIO | 12/31/23 |
| | | | 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. | Director of Utilization and Care Management/CIO | 12/31/23 |
| | | | MSHN will use predictive modeling and/or risk stratifications to identify at-risk groups and individuals in order to offer targeted prevention and intervention. | Integrated Health Coordinators | 10/01/24 |
| | MSHN will ensure there is a process to operationalize and implement diversity, equity, and inclusion within MSHN's regional infrastructure in all aspects of organizational responsibility and operations. | Chief Clinical Officer | MSHN will use lessons learned from Equity Upstream Learning Collaborative to generalize action steps to reduce health disparities in persons served by MSHN's provider networks. | Chief Clinical Officer | 09/30/25 |
| | | | MSHN will utilize its internal IDEA workgroup as well as its REACH external workgroup to inform policies, operations and system improvement. | Chief Clinical Officer | 09/30/24 |
| | | | MSHN's internal workgroup of employees (IDEA) and external workgroup of persons with lived experiences (REACH) are empowered to make broad recommendations for improvement in MSHN operations, policies and processes, and will be utilized to ensure effective and inclusive internal and external processes for improving diversity, equity, inclusion, and accessibility. | Chief Clinical Officer | 09/30/25 |

This concludes the MSHN Strategic Plan for FY 2024/2025.

The following pages include supplemental information that may be of interest to some readers.

# Appendix A: Complete List of All Key Assumptions

**This appendix lists all input received in the strategic planning process and does not necessarily reflect the views of Mid-State Health Network Pre-Paid Inpatient Health Plan**

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| MDHHS Priority: Children in Foster Care is a focus of MDHHS; depth of understanding roles and responsibilities and needs vary across the region and across the public behavioral health system. |
| MDHHS Priority: Continued effort to improve Access to services. |
| MDHHS Priority: Expansion of Certified Community Behavioral Health Clinics (CCBHCs) and Behavioral/Opioid/Substance Use Disorder Health Homes. |
| MDHHS Priority: Expanding MDHHS oversight of PIHP managed care operations will add administrative burdens (and cost) and may complicate regional operations and delegation arrangements. |
| Medicaid Health Plan rebid may have significant impacts on public behavioral health services. |
| Conflict Free Access and Planning will likely have significant impacts on MSHN, Participating CMHSPs and providers across the region and the state and may require PIHPs to centralize certain managed care functions that are currently delegated. |
| Continued review of Specialty Needs Plans (SNPs) legislative and executive branch. |
| There will be major, but unknown, changes in the public behavioral health system. We should be drivers of those changes and not passive. |
| Politicization of health equity issues will result in pushback from some stakeholders. |
| Workforce shortages will continue to be a critical issue. Staffing shortages may cause reductions in services or closures of provider organizations (especially in the SUD provider network). |
| Some form of direct care worker wage supports will continue and/or increase. |
| Access to local/community psychiatric inpatient care and state hospital care will continue to be a challenge and will continue to pressure demand for crisis residential and crisis stabilization services. |
| Psychiatric Residential Treatment Facilities are likely to be approved by Centers for Medicare & Medicaid Services (CMS) for Michigan. |
| Child and Adolescent Needs and Strengths (CANS) assessment tool will be required statewide in FY24-25. There will also be significant effort at implementing a replacement for the Supports Intensity Scale (SIS). |
| There will likely be increased pressures to use value-based arrangements, including incentives for achieving certain person-centered outcomes. |
| Medicaid Enrollment will likely decline causing decreased revenue impacts. |
| MDHHS to continue to increase monitoring and oversight (CMS requirements) without thoughtful implementation leading to duplication of reporting/monitoring and inconsistencies with what is reported statewide. |
| Delegated Managed Care reviewing is a good way to monitor compliance. |
| Our system as we know it is on the brink of change. |
| Our public behavioral health system is motivated to do the right thing. |
| The State knows better than the PIHPs on what the system needs to be better. |
| Higher emphasis on timely access to services. |
| Need to advocate for a reduced administrative burden. |
| New Conflict-Free Access and Planning (CFAP) requirements from MDHHS are likely to result in significant changes to the way CMHSPs currently operate and may require PIHPs to centralize certain managed care functions that are currently delegated. |
| Higher emphasis on timely access to services. |
| Lack of availability of services and providers for those who are stepping down services - such as leaving hospitalization – this affects conflict free requirements as well. |
| Clients are struggling and the system is not providing the overall support needed. |
| Look at credentials being required for services – this limits those who are available for support in an environment lacking provider capacity. |

| Appendix A: Complete List of All Key Assumptions |
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| **This appendix lists all input received in the strategic planning process and does not necessarily reflect the views of Mid-State Health Network Pre-Paid Inpatient Health Plan** |
| In addition to psychiatric inpatient care, access to residential / specialized residential care is limited, especially for persons with greater behavioral needs and/or medical acuity. |
| CCBHC Integration – opportunities for further expansion. |
| The ending of the Public Health Emergency will impact Medicaid enrollment. |
| MDHHS Comprehensive Quality Strategy will impact the PIHPs through standardization of Medicaid Programs in Michigan. |
| The CMHSP system will continue to face pressure to address placement solutions for children. |
| Money that the legislature has allotted to the education system to provide mental health services has diluted CMHSPs ability to provide treatment and has also resulted in CMHSP staffing loss/migration to the schools. |
| Less focus on medical necessity is putting pressure on the CMHSP system to provide care to those individuals who do not meet medical necessity. |
| Home and Community Based Services (HCBS) Rule and Licensing and Regulatory Affairs (LARA) continue to be in opposition in many areas, creating conflict in policy implementation. |

# Appendix B: Complete List of All Noted Strengths

**This appendix lists all input received in the strategic planning process and does not necessarily reflect the views of Mid-State Health Network Pre-Paid Inpatient Health Plan**

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| Focus on doing the right thing(s) for consumers is central to all MSHN and CMHSP Participant operations. The region is a strong advocate for consumers. |
| MSHN provides excellent support, resources, and technical assistance to our SUD provider network, as evidenced by affirming feedback from many providers who contract with multiple PIHPs. |
| Great employee retention rate; onboarding process and HR policies/procedures are well-defined |
| Transparency in operations (both internal and with provider network); many opportunities for employees and stakeholders to provide input into processes that directly affect them. |
| MSHN is viewed as a strong leader in the State for many different initiatives and areas of expertise. Strong collaboration with MDHHS. |
| Dedicated, committed, high-performing, and efficient staff. |
| High level of cohesion and collaboration with and among regional CMHSP participants and MSHN. |
| Financial strength of the organization and financial leadership at the PIHP level. MSHN and CMHSPs are committed to the fiscal health of the region and holding one another accountable. |
| MSHN anticipates and prepares for changes in the system. |
| Good diversity of thought influenced by diverse backgrounds. |
| Strong and effective regional Board of Directors |
| Strong and effective regional councils and committees |
| Longevity at MSHN of subject matter experts helps organizational progress and development. |
| Organizational adaptability maximizes efficiency and functionality (e.g., restructuring to include administrator role). |
| Regional provider oversight is strong and directly applied. |
| Innovation is a key value and MSHN's staff are committed to developing innovative ways of service delivery with SUD providers. |
| Strong customer service system involving different roles/departments. |
| Customer Service: Our Providers are our priority. MSHN staff accommodates the providers in many ways. |
| Timeliness/Turnaround: The execution of tasks given at a state level are fast and executed properly. |
| The Value of MSHN employees: MSHN provides a very inclusive environment for staff. |
| Financially strong |
| MSHN's staff are committed to developing innovative ways of service delivery with SUD providers. |
| MSHN and CMHSPs are committed to the fiscal health of the region and holding one another accountable. |
| MSHN has a great reputation with MDHHS in various areas. |
| MSHN makes the network and consumers aware of what is happening in the political climate. |
| Delegation Model allows CMHSPs to provide services to meet their local needs while being in compliance with established standards. |
| Soliciting feedback from CMHSPs |
| Providing information, good communication, communicating changes, and involving CMHSP staff in changes. |
| Access to content experts for assistance. |
| Project management and meeting required timelines. |
| MSHN holds the CMHSPs accountable for ensuring CMHSPs are compliant with contract requirements/changes. |
| MSHN staff are sensitive to the struggles of service(s) delivery experienced by the CMHSPs. |
| MSHN staff are approachable and are available to answer questions. |
| Providing high-quality care to those we serve. |
| Access for persons served to communicate with CMHSP leaders. |
| Our consistent Information Technology (IT) group collaboration. |
| Ability to identify opportunities and threats as they come up. |
| We have the right people getting together on a regular basis, getting to know each other so when difficult discussions are needed, we are familiar with each others tendencies. |
| Ability to read data and glean interpretations correctly and to redirect when it is interpreted incorrectly. |

| Appendix B: Complete List of All Noted Strengths |
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| **This appendix lists all input received in the strategic planning process and does not necessarily reflect the views of Mid-State Health Network Pre-Paid Inpatient Health Plan** |
| Mutual respect between MSHN and CMHSP staff. |
| MSHN responsiveness to CMHSP (and CMHSP responsiveness to MSHN) and turnaround time is excellent. |

| Appendix C: Complete List of All Noted Weaknesses |
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| **This appendix lists all input received in the strategic planning process and does not necessarily reflect the views of Mid-State Health Network Pre-Paid Inpatient Health Plan** |
| Decentralized access for SUD services has led to individuals receiving wrong services/incorrect level of care. Provider feedback that access process is duplicative and inefficient. |
| Lengthy process for needed changes to be decided and implemented. |
| No local funds at PIHP level. |
| Departments can become siloed creating communication and collaboration issues. |
| Large number of performance measures being implemented and monitored that are not outcome focused but rather focused on process and compliance. |
| Lack of standardization and centralization among the region's providers. |
| Implementation of new standards is not always coordinated among all the involved staff/departments leading to inefficiencies and at times duplication of work/efforts. |
| Lack of diversity in MSHN staff and in MSHN's provider networks. |
| Interdepartmental communication is sometimes problematic and complicated leading to some providers "answer shopping." |
| Effect of Conflict Free Access and Planning on systems of care-CMHSP and SUD. |
| MSHN Phone System is ineffective for warm transfers of consumer calls and needs replacement. |
| MDHHS issues rules, regulations, etc., and MSHN limited to overseeing/enforcing these, i.e., can't make "it" happen without a policy requirement. |
| As a top PIHP in the state, MSHN addresses initiatives thoroughly and the State looks to MSHN to assist in multiple arenas and on many initiatives. While this is great, it could lead to increased staff burnout/apathy due to involvement on multiple fronts. |
| Regional provider oversight is strong and directly applied-this is a positive, but it is rumored that some Applied Behavior Analysis (ABA) providers don't want to contract with CMHSPs in the MSHN region because of this. |
| Interdepartmental communication: This includes departments making decisions without all departments affected being notified. Some providers are aware of this because they attempt to pin one staff member against another with the assumption that they are not aware of the issue. |
| Communication regarding changes in processes. |
| Communication overall. |
| Lack of availability of services and providers for beneficiaries who are stepping down level of care such as leaving hospitals, etc. |
| Credentials/Qualifications required limit staff availability. |
| Need for stronger advocacy |
| Responsibility gets delegated to the CMHSP level – this can be challenging when CMHSPs are trying to reduce administrative staff/costs – this can be a burden for staff- challenging to available resources. |
| Requirements for compliance with standards has become too much of a focus – requirements and oversight continue to grow and takes away from focus on service provision. |
| MSHN could take over some of the standard reports versus CMHSPs completing – such as the data for grievance and appeals. |
| Look at reports/data that are reviewed through councils/committees – are these required- is there a benefit to the reports. |
| It can take a long time to come to a final decision. |
| Slow process |
| Over review of opinions |
| Desire to receive 95% agreement or to be perfect. |
| Multiple individuals are in new IT roles across our region. |
| The different councils within MSHN do not always seem to be on the same page. This applies to the need for common definitions and nomenclature between departments. |
| Finalization; report of project and results interpretation need to be published. |
| The Customer Service process for MDHHS when concerns come to them. |
| The lack of advocacy for CMHSP from MSHN. |

| Appendix C: Complete List of All Noted Weaknesses |
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| **This appendix lists all input received in the strategic planning process and does not necessarily reflect the views of Mid-State Health Network Pre-Paid Inpatient Health Plan** |
| CMHSPs can feel like they are doing things wrong. |
| Workforce shortages |

| Appendix D: Complete List of All Noted Opportunities |
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| **This appendix lists all input received in the strategic planning process and does not necessarily reflect the views of Mid-State Health Network Pre-Paid Inpatient Health Plan** |
| While also a threat, Conflict-Free Access and Planning requirements may present many opportunities to improve our services and their management. This will also have redesign implications for SUD access. |
| Better marketing/messaging strategies about the success and strength of the public mental health system (particularly PIHPs) to combat prevalent narratives in mainstream media – be proactive; not just reactive. |
| Education for public and provider systems about roles/responsibilities of PIHP vs Medicaid Health Plans; most Medicaid enrollees, stakeholders, and general public don't understand the role of the PIHP and specialization. |
| Opioid Settlement Funds present many opportunities to improve and expand services for residents of the state struggling with opioid addiction. |
| Continued expansion of integrated health initiatives (BHH, CCBHC, OHH, SUD Health Homes, etc.). Expansion in both sites and number of individuals enrolled. |
| MSHN should explore more Value Based Purchasing (VBP) opportunities that incentivize improving outcomes and/or quality of care. |
| A regionally operated crisis continuum (crisis residential, crisis stabilization, psychiatric residential treatment facilities, etc.) can be value added for the region. |
| PIHP-level, regional recruitment efforts to address workforce shortages across the region. |
| Propose new initiatives and partnerships to address state priorities with children services, foster care, crisis services, and other areas where need is acute. |
| Focus on underprivileged communities. |
| Consistent, ongoing plan for SUD services in rural communities. |
| Ensure coordination with counties and state regarding opioid settlement funds. |
| Develop SUD County plans that are replicable for other counties to implement. |
| Review Medicaid requirements and PIHP requirements to reduce, where possible, nonvalue added functions. |
| Consider obtaining accreditation to align with national measures better. |
| Develop/utilize evidence-based quality management strategies to proactively identify/address risk areas (Failure Mode Effect Analysis, Impact Analysis, etc.). |
| Evaluate functions that would lead to greater efficiencies if centralized. |
| Evaluate monitoring and oversight processes for the provider network (quality versus compliance based, effectiveness of plans of correction, etc.). |
| Advocacy and outreach to schools and other community providers to enhance collaboration and coordination of services. |
| Use MSHN's great reputation and standing to push for change (many areas). Strategize to maximize opportunity for success. Pilot successful Value Based Purchasing options in conjunction with MDHHS to use statewide. |
| Work with MDHHS as the primary representative for PIHPs and CMHSPs contract matters. |
| Expand OHH programs to generate additional local revenue for MSHN. |
| Changes in legislators can be an opportunity to reach out for advocacy and assistance to improve provider networks that are struggling to keep people. |
| Form new and strong relationships with decisions makers in Lansing. |
| Greater Advocacy |
| Social media campaign to highlight the good work happening through CMHSPs and how much better than what the health plans would provide. |

| Appendix D: Complete List of All Noted Opportunities |
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| **This appendix lists all input received in the strategic planning process and does not necessarily reflect the views of Mid-State Health Network Pre-Paid Inpatient Health Plan** |
| Look at deemed status – this could lead to reduced monitoring and oversight for services/programs who are accredited and found in compliance. |
| Better coordination with schools, law enforcement and veterans. |
| The State's push for Health Homes. |
| Look at MSHNs site review process and increased managed care oversight by MDHHS. |
| Consider regional health care benefit purchasing group (HR; employee benefits). |
| Consideration of developing housing for individuals living with Autism, especially those who require care and supports from aging parents or other caregivers. |
| Improve communication and collaboration with MDHHS on new initiatives. |
| Changes in legislators can be an opportunity to reach out for advocacy and assistance to improve provider networks that are struggling to keep people. |
| Evaluate and improve the system for monitoring regional performance by evaluating current measures, including process/outcomes to ensure relevance. |
| Have available all regional performance measures in one location to view and identify regional process improvements. |
| Utilize Quality Improvement Council (QIC) as a centralized monitoring body for regional performance. |
| QIC to focus on areas that require improvement. |
| Develop a consolidated process/venue for PIHPs to collaborate on system issues, best practice, recommendations to MDHHS etc. |
| Increased communication from the work groups-purpose and progress. |
| Improve the internal monitoring process by evaluating for effectiveness, eliminating redundancies with other processes, incorporating aspects of quality and conformance versus compliance. |
| Explore opportunities for Electronic Medical Records (EMR) data sharing specific to SUD screenings and access; additionally, American Society of Addiction Medicine (ASAM) training opportunities for CMHSP Access Staff. |
| MSHN facilitate opportunities to strengthen relationships between SUD treatment providers and the local CMHSPs. |

| Appendix E: Complete List of All Noted Threats |
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| **This appendix lists all input received in the strategic planning process and does not necessarily reflect the views of Mid-State Health Network Pre-Paid Inpatient Health Plan** |
| New/Ongoing legislative proposals to integrate behavioral health and physical health. System redesign and ever-changing political environment. |
| Health plan rebid may cause significant public behavioral health systems changes. |
| Conflict Free Access and Planning models could fundamentally change how the public mental health system operates, can increase complexity for beneficiaries, and alter regional dynamics and arrangements. |
| End of COVID-19 Medicaid continuous enrollment could negatively affect financial resources. |
| Statewide behavioral health workforce shortages continue to stretch all provider systems (SUDSP and CMHSP) to breaking point despite best efforts toward recruitment and retention. |
| Continued discussion for use of specialty needs plans. |
| Community resistance/pushback with things like harm reduction, DEI efforts, MAT, etc. |
| Reduced Block Grant revenue |
| Administrative Workloads increasing – more so regarding clinical documentation/paperwork requirements. |
| Value Based Purchasing arrangements lack consideration for willingness/stages of change for beneficiaries and level of recidivism. |
| Lack of communication/coordination/collaboration from MDHHS, LARA, Michigan Certification Board for Addiction Professionals (MCBAP), Michigan Association of Recovery Residences (MARR). |
| Lack of Medicare providers for SUD services. |
| Change in state leadership-need to build or rebuild relationships further complicated by confusing state reorganization. |
| System redesign and ever-changing political environment. |
| Future sustainability of current grant funded programming. |
| Influence of "high profile situations" (like parent who posted on YouTube about system access) and the impressions given to and thought by the general public. Also related-media influence. |
| Continued effect of staffing shortage. |
| Sustainability of grant funded programming. |
| Legislators focused on transferring Medicaid dollars for special populations to Medicaid health plans. |
| The distance created by the pandemic between CMHSPs, and individuals served, local communities, and community providers. |
| Increased regulatory scrutiny focused on CMHSP business practices and not considering if the mandates improve the lives of individuals served. |
| MDHHS departments not having consistent messaging to the behavioral health system. |
| Continuity of care for individuals – need to retain qualified individuals. |
| Lack of individuals who know how to write grants. |
| Education at the local level with new changes. |
| The State's attempts to move to a market-based model represents a threat to everyone in our system, not just IT. |
| Conflict Free Case management |
| Lack of consistency and guidance from the State and direct contradiction between technical guidelines/advisory and the federal compliance departmentation. |
| Lack of adequate CCBHC funding. |
| Lack of interdepartmental communication at the state level. |
| Variances of behavioral health specialty population compared to other health plans, etc. Not being considered when identifying standard expectations. |
| Medicaid redetermination process |
| Perception of public mental health services versus commercial - private systems. |
| MDHHS is making decisions that have no actual positive outcome for our consumers and are just administrative burdens that don't even meet the contractual obligation to CMS, in particular the Section 1915(i) of the Social Security Act-State Plan Amendment roll out. |

| Appendix E: Complete List of All Noted Threats |
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| **This appendix lists all input received in the strategic planning process and does not necessarily reflect the views of Mid-State Health Network Pre-Paid Inpatient Health Plan** |
| MDHHS has different standards for different programs-Definition of "amount" i.e., Autism and Self Determination. |