HEALTHWEST

FULL BOARD MINUTES

May 29, 2026

8:00 a.m.

376 E. Apple Ave.
Muskegon, MI 49442

CALL TO ORDER

The meeting of the Full Board was called to order by Chair Thomas at 8:01a.m.

ROLL CALL

Members Present: Janet Thomas, Cheryl Natte, Chris McGuigan, John M. Weerstra, Thomas Hardy, Mary Vazquez, Michelle Hazekamp, Janice Hilleary, Tamara Madisson

Members Absent: Charles Nash, Jeff Fortenbacher, Remington Sprague, M.D.

Others Present: Rich Francisco, Holly Brink, Gina Maniaci, Kristi Chittenden, Brandy Carlson, Christy LaDronka, Jennifer Hoeker, Carly Hysell, Melina Barrett, Casey Olson, Helen Dobb, Tasha Kuklewski, Mickey Wallace, Linda Anthony, Lea Streblow, Gary Ridley, Pam Kimble

Guests Present: Commissioner Sims, Matt Farrar

MINUTES

HWB 80-B - It was moved by Mr. Hardy, seconded by Mr. Weerstra, to approve the minutes of the April 17, 2026 Full Board meeting as written.

MOTION CARRIED

COMMITTEE REPORTS

Finance Committee

HWB 76-F - It was moved by Mr. Hardy, seconded by Mr. Weerstra, to approve expenditures for the month of April 2026, in the total amount of $8,511,368.74.

MOTION CARRIED

HWB 77-F - It was moved by Mr. Hardy, seconded by Ms. Thomas, to authorize the submission and acceptance, if awarded, of a grant request in the amount of up to $750,000 to the Michigan Endowment Fund Behavioral Health Fund for the project “Enhancing Behavioral Health Crisis Response & Stabilization in Muskegon County” (grant term anticipated 10/01/2027 – 09/30/2029);and further authorize the Executive Director to execute any required application materials, certifications, and if awarded grant agreements and related documents.

MOTION CARRIED

HWB 78-F - It was moved by Mr. Hardy, seconded by Mr. Weerstra, to authorize the HealthWest Board of Directors to approve the purchase of and / or reimbursement from VitalCore and / or other utilized pharmacies for FY2026.

MOTION CARRIED

HWB 79-F - It was moved by Mr. Hardy, seconded by Mr. Weerstra, to authorize the HealthWest Executive Director to continue contract with Rise ABA effective June 1, 2026, through September 30, 2027, to provide Applied Behavior Analysis Therapy to HealthWest consumers. The funding is within the approved HealthWest Autism Budget of $2,908,811.00.

MOTION CARRIED

ITEMS FOR CONSIDERATION

HWB 81-B – It was moved by Mr. Hardy, seconded by Mr. Weerstra, to approve the continued appointment of Rich Francisco as the Executive Director of HealthWest effective June 5, 2026 to June 4, 2029, and authorizes the HealthWest Board Chair Person, Janet Thomas, to sign the employment agreement.

MOTION CARRIED

OLD BUSINESS

There was no old business.

NEW BUSINESS

There was no new business.

COMMUNICATION

Gary Ridley presented the Strategic Assessment Summary.

DIRECTOR'S COMMENTS

Mr. Francisco, Executive Director, presented his Formal Director's report.

Director's Update

MDHHS Updates:

- **RFP update**. On January 8th, Judge Yates ruled that MDHHS had the legal authority to proceed with procurement but also ruled in favor of the CMHSPs that the RFP released in August 2025 violated Michigan law, which prevents CMHSPs from conducting their required statutory functions. Later, on April 13th, MDHHS requested a hearing to dismiss the case as moot because they had withdrawn the RFP altogether. Judge Yates then had to consider whether to dismiss the case with or without prejudice. The judge finally ruled to dismiss the case without prejudice. The CMHSPs have already filed an appeal of the ruling.

- An update on the **MHF (Mental Health Framework)** initiative. I have updated the board that MDHHS was rolling out a new health benefit called BH-COVER as part of the Mental Health Framework. This gives health plans access to screening individuals in crisis, partial hospitalization, and inpatient screening. This effort effectively privatizes a large segment of services that CMHSPs manage. This change would have introduced complications to crisis services coordination in a system already managed efficiently by CMHSPs. On May 15th, Kristen Morningstar (Specialty Behavioral Health Services Director) issued a delay:
    - "MDHHS will temporarily delay the MHF Coverage Responsibility policy to allow time for system-wide preparation."

- There are still many questions surrounding the “how?” and many stakeholders have pushed back on what this implementation entails. We did receive a memo update on 5/27/2026 stating that, while the delay for MHF remains in place, there is an expectation that assessments will continue, including the use of LOCUS and MichiCANS in determining the level of care for individuals seeking services.

- **CCBHC Caucus Meeting** – 5/27/2026. The group talked about the sustainability of CCBHCs in the state of Michigan. The discussion included the development of a CCBHC data warehouse at CMHA (our association). The CCBHC data warehouse will improve access to data and support advocacy efforts in demonstrating ROI. There is support from MDHHS and other partners to develop this CCBHC database. There is also an effort to centralize TA (Technical Assistance) in a Michigan hub rather than requiring organizations to gather CCBHC information from multiple resources. This effort is funded by the Balmer Group, other funding sources, and the National Council.

LRE Level Updates:

- LRE – A board work session was held on 05/27/2026, and the topic was an educational training on AI (Artificial Intelligence. The goal was to provide an understanding of AI, its use in the current landscape, and how CMHSP partners are using AI. Most CMHSPs have implemented AI to help with documentation in the Electronic Health Record (EHR).

- The LRE Ops group met on 5/20 and discussed several topics, including **the autism framework** proposed by a workgroup composed of CMHSP experts in autism services. All CMHSPs participated in creating a framework for autism service delivery and best practices for the region. This is one area where there is variation in how services are delivered. The group reviewed authorization standards, length-of-stay expectations, and discharge standards to help partners implement this service more consistently.

CMH Level:

- HealthWest continues with various projects:

  - **CSU (Crisis Stabilization Unit)** – A handful of staff along with the project management team and grants team have been busy with coordinating and responding to additional questions from the Michigan Health Endowment fund. We have requested $500,000 in funding to support the development of CSU. This is in addition to the 4M we requested in Congressional Designated Spending for the capital investment for CSU.

  - **Utilization Review:** We are seeing decrease in actual utilization as evidence in our actual expense. HW is at a 6M surplus per the FSR. I am putting together a small work group to review utilization and identify areas where we are seeing the decrease. Actual numbers on the FSR (Financial status reports) are not a final number because of claims lag but we need to understand what is occurring with utilization.

  - **Strategic Plan updates** – Per the presentation from Gary on the strategic plan, we are getting close to the final plan. I would like to give Kudos to his team for coordinating this big lift ensuring we obtained input from all stakeholders, staff, and the Board. Many thanks as well to the different strategic plan committee members for the splendid work put into the strategic plan so far.

AUDIENCE PARTICIPATION

There was no audience participation.

ADJOURNMENT

There being no further business to come before the board, the meeting adjourned at 8:41 a.m.

Respectfully,

Janet Thomas
Board Chair
/hb

PRELIMINARY MINUTES
To be approved at the Full Board Meeting on
June 26, 2026

HealthWest
Muskegon's Behavioral Wellness Connection

TO: **HealthWest Board Members**

FROM: **Janet Thomas, Board Chair, via Rich Francisco, Executive Director**

SUBJECT: **Full Board Meeting**
May 29, 2026
376 E. Apple Ave., Muskegon, MI 49442
https://healthwest.zoom.us/j/94259223301?pwd=1jL64lYh445eFUkwvH4v06Q4ahLLjl.1
Webinar ID: *942 5922 3301* **Passcode: 997543**

AGENDA

1) Call to Order — Action

2) Approval of Agenda — Action

3) Approval of Minutes

   A) Approval of the Full Board Minutes of April 17, 2026 — Action
   (Attachment #1 – pg. 1-4)

4) Public Comment (on an agenda item)

5) Committee Reports

   A) Finance Committee — Action
   (Attachment #2 – pg. 5-7)

6) Items for Consideration

   A) Authorization to Continue Executive Director Appointment — Action
   (Attachment #3 – pg. 8)

7) Old Business

8) New Business

9) Communication

   A) Strategic Assessment Summary Presentation: Gary Ridley — Information
   (Attachment #4 – pg. 9-71)

   B) June Meeting Notice — Information
   (Attachment #5 – pg. 72)

   C) Director's Report — Information
   (Attachment #6 – pg. 73-74)

10) Public Comment

11) Adjournment — Action

/hb

HEALTHWEST

FULL BOARD MINUTES

April 17, 2026

8:00 a.m.

376 E. Apple Ave.
Muskegon, MI 49442

CALL TO ORDER

The meeting of the Full Board was called to order by Chair Thomas at 8:00a.m.

ROLL CALL

Members Present: Janet Thomas, Charles Nash, Chris McGuigan, Jeff Fortenbacher, John M. Weerstra, Thomas Hardy, Remington Sprague, M.D., Mary Vazquez, Michelle Hazekamp, Janice Hilleary, Tamara Madisson

Members Absent: Cheryl Natte

Others Present: Rich Francisco, Holly Brink, Gina Maniaci, Kristi Chittenden, Brandy Carlson, Christy LaDronka, Amber Berndt, Jennifer Hoeker, Carly Hysell, Melina Barrett, Casey Olson, Helen Dobb, Tasha Kuklewski, Brittani Duff, Mickey Wallace, Linda Anthony, Brea Beckley, Suzanne Beckeman, Lea Streblow, Gary Ridley, Pam Kimble

Guests Present: Angie Gasiewski, Derek Miller

MINUTES

HWB 73-B - It was moved by Mr. Hardy, seconded by Ms. Hilleary, to approve the minutes of the March 27, 2026 Full Board meeting as written.

MOTION CARRIED

HWB 74-B - It was moved by Mr. Hardy, seconded by Mr. Weerstra, to approve the minutes of the March 20, 2026 Full Board meeting as written.

MOTION CARRIED

COMMITTEE REPORTS

Program Personnel Committee

HWB 66-P - It was moved by Mr. Weerstra, seconded by Mr. Hardy, to approve the minutes of the February 13, 2026 meeting as written.

MOTION CARRIED

HWB 67-P - It was moved by Mr. Hardy, seconded by Mr. Weerstra, to approve the HealthWest Policy and Procedure for Assisted Outpatient Treatment Resolution, effective April 20, 2026.

MOTION CARRIED

HWB 68-P - It was moved by Mr. Hardy, seconded by Mr. Weerstra, to approve the HealthWest Policy and Procedure for Medication Management effective April 20, 2026.

Recipient Rights Committee

HWB 69-R - It was moved by Mr. Weerstra, seconded by Ms. Hilleary, to approve the minutes of the February 13, 2026 meeting as written. **MOTION CARRIED**

HWB 70-R - It was moved by Mr. Weerstra, seconded by Ms. Natte, to approve the Recipient Rights Reports for February 2026 / March 2026.

MOTION CARRIED

Nominating Committee

HWB 71-N - Motion was amended on the floor - It was moved by Mr. Fortenbacher, seconded by Dr. Sprague, to open ballot voting to the Full Board for their voting.

MOTION CARRIED

HWB 72-N - It was moved by Mr. Fortenbacher, seconded by Dr. Sprague, to authorize the HealthWest Board Chair to make the above Committee appointments, effective April 17, 2026.

MOTION CARRIED

ITEMS FOR CONSIDERATION

HWB 75-B – It was moved by Mr. Hardy, seconded by Dr. Sprague, to approve the expenditures for February 2026 totaling $7,541,599.69.

MOTION CARRIED

Monthly Report from the Chief Finance Officer

Ms. Carlson, Chief Financial Officer, presented the February report, noting an overall cash balance of $9, 550, 307.54 for February 2026.

Finance Update Memorandum

Ms. Carlson, Chief Financial Officer, presented the Finance Update Memorandum for the Board review.

HWB 76-B – It was moved by Dr. Sprague, second by Mr. Hardy, to approve the changes to the HealthWest Consumer Advisory Committee members, effective April 20, 2026.

MOTION CARRIED

OLD BUSINESS

There was no old business.

NEW BUSINESS

There was no new business.

COMMUNICATION

Roslund, Prestage & Company, P.C. presented HealthWest 2025 Financial Statements.

Ms. Jennifer Hoeker, Communications & Operating Coordinator, presented the FY25 Annual Report.

DIRECTOR'S COMMENTS

Mr. Francisco, Executive Director, presented his Formal Director's report.

Director's Update

MDHHS Updates:

- RFP Case hearing April 13th – MDHHS request to dismiss the case as moot.
    - Judge Yates heard the from both sides Region 10 PIHP et al, and CMHSPs – Centra Wellness, et. Al vs. State of Michigan/DTMB
    - MDHHS, through the Attorney General's office, argued that the case should be dismissed as moot, asserting that:
        - The original PIHP RFP has been withdrawn, and
        - There is no active procurement left for the Court to remedy.
    - During the oral argument, the State represented to the Court that MDHHS is developing a new PIHP RFP and further asserted that the challenged conduct will not continue in the same form. Meaning it will be different RFP.
    - Judge Yates did not rule from the bench:
        - No dismissal was granted
        - No finding of mootness was issued
        - No legal conclusions were made regarding any future RFP.
    - Judge Yates opinion from January 8th remains the controlling legal framework that asserts that the RFP
        - Impermissibly restricted CMHSPs from performing stator managed care and administrative functions assigned to them under the Mental Health Code.
        - The RFP failed to ensure CMHSPs had access to Medicaid funding necessary to carry out their statutory duties
    - The April 13th hearing does not replace or weaken the January opinion. MDHHS's claim that it is developing a new RFP:
        - Has no legal effect unless and until such an RFP is issued and reviewed.
        - Does not cure the statutory violations identified by Judge Yates.
        - Even if the case were eventually dismissed as moot, Judge Yates's declaratory findings remain authoritative and would apply to any successor procurement.
    - Judge Yates is taking an additional 7 days to review whether to dismiss the case with or without prejudice and invited the parties to do the same. So next hearing will be on April 20th with ruling the following day.

- MDHHS has released several email correspondences on implementing a new mental health benefit services plan called (BH-COVER) and the goal is for the new benefit to take effect October 1, 2026. This new benefit has been under the initiative of Mental Health Framework. The goal is to identify whether a Medicaid enrollee's mental health services are paid for by the PIHP (Prepaid Inpatient Health Plan) or the Medicaid Health Plan (MHP). The gist of the benefit is that those with BH-COVER and those with higher level needs will go to the PIHP and those not assigned to BH-COVER will be covered by the MHP.

LRE Level Updates:

- The LRE Executive Committee was held on 04/15/2026 to discuss and prepare for the next

LRE full board meeting and discussed several agenda item topics:

- Board work session at the next full board meeting will address the LRE 3-year Strategic plan. The LRE will work with the board members to refresh the goals of the LRE.
- The LRE CEO provided an update on the various lawsuits with MDHHS currently. The 4-PIHP lawsuit related to not signing the contract for FY2025 and the RFP Rebid.
- LRE is also reviewing various policies that need LRE board approval.

➢ The LRE also held the CEO Ops meeting on 04/15/2026. The CEO discussed the following topics:

- February FSR updates from the LRE CFO were presented. HW shows an actual surplus 5.4M which is about 16.3% variance from revenue/expense. OnPoint and West Michigan also showing surplus. HW is also now projecting to have a surplus of about 1.7 M based on LRE Projection.
- LRE continues to work on UM Standard guidelines with the goal of providing partners with standardized way to provide services. For example, the way we provide Autism services could be different from the way our partners in the region do. A UM guideline would help address the variance in authorized services and implement the services more consistently.

CMH Level:

➢ HealthWest continues with various projects:

- SDA – Same Day Access: Christy LaDronka and her team continue to work evaluating and implementing same day access. This not only improves access to services but also follows good practice with CCBHC requirements.
- Various staff from contracts, compliance, and HR have been completing all the requirements and proof submissions for our CMHSP certification in state MiCAL system.
- Gary and his team continue to collaborate with staff at all levels to update the HW Strategic Plan. Reminder: Saturday, April 18th is the board work session for Strategic Planning from 10am to 2pm.

AUDIENCE PARTICIPATION

There was no audience participation.

ADJOURNMENT

There being no further business to come before the board, the meeting adjourned at 8:49 a.m.

Respectfully,

Janet Thomas
Board Chair
/hb

PRELIMINARY MINUTES
To be approved at the Full Board Meeting on
May 29, 2026

HEALTHWEST

FINANCE COMMITTEE REPORT TO THE BOARD

via Janet Thomas, Committee Vice Chair

1. The Finance Committee met on May 15, 2026.

*2. It was recommended, and I move to approve expenditures for the month of April 2026, in the total amount of $8,511,368.74.

*3. It was recommended, and I move to approve the submission and acceptance, if awarded, of a grant request in the amount of up to $750,000 to the Michigan Endowment Fund Behavioral Health Fund for the project “Enhancing Behavioral Health Crisis Response & Stabilization in Muskegon County” (grant term anticipated 10/01/2027 – 09/30/2029) and further authorize the Executive Director to execute any required application materials, certifications, and if awarded grant agreements and related documents.

*4. It was recommended, and I move to approve the HealthWest Board of Directors to approve the purchase of and / or reimbursement from VitalCore and / or other utilized pharmacies for FY2026.

*5. It was recommended, and I move to approve HealthWest Executive Director to continue contract with Rise ABA effective June 1, 2026, through September 30, 2027, to provide Applied Behavior Analysis Therapy to HealthWest consumers. The funding is within the approved HealthWest Autism Budget of $2,908,811.00.

/hb

HEALTHWEST

FINANCE COMMITTEE MEETING MINUTES

May 15, 2026
8:00 a.m.

CALL TO ORDER

The regular meeting of the Finance Committee was called to order by Committee Chair Fortenbacher at 8:01a.m.

ROLL CALL

Committee Members Present:	Jeff Fortenbacher, Janet Thomas, Thomas Hardy, Michelle Hazekamp, John M. Weerstra
Committee Members Absent:	Charles Nash, Remington Sprague, M.D.
Also Present:	Holly Brink, Brandy Carlson, Christy LaDronka, Melina Barrett, Kristi Chittenden, Brian Plumhoff, Linda Anthony, Gary Ridley, Kim Davis, Lea Streblow
Guests Present:	Angela Gasiewski

ITEMS FOR CONSIDERATION

A. *Approval of Expenditures for April 2026*

It was moved by Mr. Hardy, seconded by Mr. Weerstra, to approve expenditures for the month of April 2026, in the total amount of $8,511,368.74.

MOTION CARRIED

B. *Monthly Report from the Chief Financial Officer*

Ms. Carlson, Chief Financial Officer, presented the March report, noting an overall cash balance of $10,191,165.20 as of March 31, 2026.

C. *Finance Update Memorandum*

Ms. Carlson, Chief Financial Officer, presented the Finance Update Memorandum for the Board review.

D. *Authorization to Apply & Accept Grant Funding*

It was moved by Mr. Hardy, seconded by Ms. Thomas, to authorize the submission and acceptance, if awarded, of a grant request in the amount of up to $750,000 to the Michigan Endowment Fund Behavioral Health Fund for the project “Enhancing Behavioral Health Crisis Response & Stabilization in Muskegon County” (grant term anticipated 10/01/2027 – 09/30/2029);and further authorize the Executive Director to execute any required application materials, certifications, and if awarded grant agreements and related documents.

MOTION CARRIED

E. *Authorization to Purchase & Accept Reimbursement from VitalCore Health Strategies, LLC and Various Pharmacies*

It was moved by Mr. Hardy, seconded by Mr. Weerstra, to authorize the HealthWest Board of Directors to approve the purchase of and / or reimbursement from VitalCore and / or other utilized pharmacies for FY2026.

MOTION CARRIED

F. *Authorization to Contract with Rise ABA Center*

It was moved by Mr. Hardy, seconded by Mr. Weerstra, to authorize the HealthWest Executive Director to continue contract with Rise ABA effective June 1, 2026, through September 30, 2027, to provide Applied Behavior Analysis Therapy to HealthWest consumers. The funding is within the approved HealthWest Autism Budget of $2,908,811.00.

MOTION CARRIED

OLD BUSINESS

There was no old business.

NEW BUSINESS

There was no new business.

COMMUNICATIONS

There was no communication.

AUDIENCE PARTICIPATION

There was no audience participation.

ADJOURNMENT

There being no further business to come before the committee, the meeting adjourned at 8:16 a.m.

Respectfully,

Jeff Fortenbacher
Committee Chair

/hb

PRELIMINARY MINUTES
To be approved at the Finance Meeting on
June 12, 2026

REQUEST FOR HEALTHWEST BOARD CONSIDERATION AND AUTHORIZATION

COMMITTEE	BUDGETED	NON-BUDGETED	PARTIALLY BUDGETED
	X		

REQUESTING DIVISION	REQUEST DATE	REQUESTOR SIGNATURE
HealthWest Board	May 29, 2026	Janet Thomas, Chairperson

SUMMARY OF REQUEST (GENERAL DESCRIPTION, FINANCING, OTHER OPERATIONAL IMPACT, POSSIBLE ALTERNATIVES)

As the employment contract for the Executive Director of HealthWest is authorized and approved by the HealthWest Board, approval is requested for the HealthWest Board Chairperson, Janet Thomas, to sign the contract with Rich Francisco, Executive Director of HealthWest, effective June 5, 2026, and terminating June 4, 2029, subject to the early termination provision of this contract.

SUGGESTED MOTION (STATE EXACTLY AS IT SHOULD APPEAR IN THE MINUTES)

The HealthWest Board moves to approve the continued appointment of Rich Francisco as the Executive Director of HealthWest effective June 5, 2026 to June 4, 2029, and authorizes the HealthWest Board Chairperson, Janet Thomas, to sign the employment agreement.

COMMITTEE DATE	COMMITTEE APPROVAL
	_____ Yes _____ No _____ Other
BOARD DATE	**BOARD APPROVAL**
May 29, 2026	_____ Yes _____ No _____ Other

HWB 81-B

HealthWest

Strategic Assessment Summary

Diagnosis • Strategic Implications • Cross-Cutting Themes • Supporting Evidence

May 2026

HealthWest Strategic Assessment Summary | May 2026

Purpose of This Document

This Strategic Assessment Summary establishes the factual foundation of HealthWest's FY2027–2029 strategic planning cycle. It synthesizes findings from 182 staff survey responses, 41 partner survey responses, two staff focus groups, a consumer focus group, regional consumer satisfaction data (LRE FY25 — MHSIP n=384, YSS n=32 for HealthWest), the Board of Directors SWOT and PESTEL exercises, and seven cross-functional workgroup sessions conducted between March and April 2026.

Its central work is the diagnosis — the precise underlying organizational condition that the evidence converges on — together with the strategic implications and cross-cutting themes that follow from it. The 21-issue refined strategic issue set, approved by the Steering Committee, anchors the planning cycle's response. The strategic direction itself will be proposed and adopted at the Steering Committee Pillar Workshop in mid-May.

Data Sources

- Staff Survey: 182 respondents
- Partner Survey: 41 respondents
- Workgroup Domains: 7 independent workgroups, each with two meetings (storyboarding, SWOT + root cause analysis)
- Board of Directors SWOT and PESTEL: April 18, 2026
- Consumer Focus Group: April 8, 2026
- Staff Focus Groups: 2 sessions with the agency's Customer Experience Team, April 2026 — representing administration, nursing, supervision, HR, case management, therapy, and clerical staff serving 6-month engagement terms
- Regional Consumer Satisfaction Data (LRE FY25): MHSIP n=384 HealthWest respondents (1,756 region-wide); YSS n=32 HealthWest respondents
- FY2025 HealthWest Annual Report

Table of Contents

Section 1. The Diagnosis — What the Evidence Is Telling Us

HealthWest enters its FY2027–2029 strategic planning cycle from a position of meaningful organizational strength and genuine consumer trust — and from a position of clear, well-documented organizational challenge that this planning process has surfaced.

This section names the diagnosis: the specific underlying condition that, when addressed, unlocks progress across every other priority. The diagnosis is not a list of problems. It is the single condition that the evidence converges on. It is drawn from independent data sources — staff, partners, consumers, the Board, and seven cross-functional workgroups — that worked without knowledge of each other's findings. Their convergence is the most important finding in this entire document, and it is documented in detail in Section 6 through each workgroup's root cause analysis exercises.

What HealthWest Is Getting Right

The evidence of strength is real and must be named clearly before strategy can build on it.

HealthWest served 7,149 people across Muskegon County in FY2025, managing $106.8 million in public resources responsibly. It earned a $1.06M CCBHC Quality Bonus. It launched a Mental Health Urgent Care, fully implemented the Zero Suicide framework, and launched The HealthWest Way — a cultural transformation initiative that staff recognize as genuine, not performative.

Consumer satisfaction data validates the mission directly: 91.7% of HealthWest consumers would recommend HealthWest to a friend or family member; 92.2% like the services they receive; 87.4% agree that staff believe they can grow, change, and recover. These are not marginal numbers — they reflect deep consumer trust built through individual staff relationships that make a material difference in people's lives.

Partners with eight or more years of relationship with HealthWest — 59% of the 41 partners surveyed — report higher satisfaction and deeper collaboration. Long-term relationship investment pays dividends visible in the data.

The Board, staff, and workgroup members consistently named a culture of learning and growth, forward-thinking leadership on technology and data, passionate and mission-driven staff, and the HealthWest Way's launch as genuine organizational strengths. These are real assets that the strategic plan must protect and amplify.

The Diagnosis

Across every data source — the staff survey, the partner survey, the consumer focus group, regional consumer satisfaction data, the Board SWOT, and seven independent workgroup root cause analyses — the same underlying organizational condition surfaces. These sources worked independently. They used different questions, different methodologies, and different participants. They arrived at the same finding.

THE DIAGNOSIS

HealthWest's internal coordination architecture — the supervisory and leadership development pipeline, the cross-team communication infrastructure, and the cross-departmental governance that allows teams to function as a coherent organization — has not been elevated to the level of strategic investment that the organization's scale, regulatory complexity, and external risk environment now require.

This condition is not a failure of individual competence or effort. The staff are skilled and mission-driven — the data says so clearly. It is a condition of organizational architecture: the structures, workflows, governance, and information flows that connect talented people into coordinated, effective action. The seven independent workgroup root cause analyses, presented in full in Section 6, all terminate at this level. The convergence is the finding.

The Evidence — Seven Independent Sources Converging

Staff Survey (n=182)

- Communication gaps within or across teams — named as the #1 barrier by 55% of staff (100 of 182)
- Confidence in consistent quality across all programs — 5.2 out of 10, the single lowest score in the survey
- Improved communication systems — named as the #1 improvement priority by 64% of staff (116 of 182)
- The gap between team effectiveness (7.6/10) and organizational quality confidence (5.2/10) is itself diagnostic: teams function, but they do not coordinate into a consistent organizational whole

Partner Survey (n=41)

- Communication gaps — named as the #1 collaboration barrier by 49% of partners (20 of 41)
- Turnover and changing contacts — named as the #1 staff challenge by 51% of partners (21 of 41)
- Partners' highest satisfaction comes from individual staff relationships; their greatest frustration is that those relationships do not survive staff transitions — the organization is person-dependent rather than system-dependent

Regional Consumer Satisfaction Data (LRE FY25 — MHSIP/YSS)

- **Region-wide finding:** Across the five-Community Mental Health Service Provider (CMHSP) Lakeshore Regional Entity (LRE) region, crisis respondents scored 25 percentage points lower on the Access domain than respondents established in CSP and TCM programs (61% vs. 86%). This is a regional pattern reported by LRE, not a

HealthWest-specific score, and it reflects an expected experience difference between first-contact crisis service and established long-term programs. Because HealthWest is one of the five CMHSPs contributing to that regional aggregate, the pattern is directly relevant to HealthWest's first-contact system design — a relevance corroborated by the Access and Crisis workgroup's independent root cause analysis (Section 6.2).

- Interaction with provider is the highest regional grievance category — relationship and communication failure at the point of service, region-wide
- Youth social connectedness is the lowest-performing YSS domain region-wide; among HealthWest YSS respondents (n=16 on the social connectedness items), 25% disagree they would have crisis support from family or friends

Consumer Focus Group (HealthWest, April 2026)

- Every consumer cited individual staff relationships as the primary source of benefit and trust — the human connection is what works
- Every consumer named communication failure as the primary barrier — within staff teams, between staff and consumers, between staff and other medical providers
- A Consumer Advisory Committee member explicitly stated: “We've been working on the communications issue for a couple of years now, there's still problems” — naming this as a persistent, unresolved organizational condition
- Staff turnover was named as a direct disruption to consumer care continuity: “I had just signed on to services, been given a case manager and a recovery coach — and then they were gone. I didn't know who to contact.”

Staff Focus Groups (Customer Experience Team, April 2026)

- Two focus groups conducted with members of the agency's Customer Experience Team — staff actively engaged in identifying ways the HealthWest Way could improve the agency, drawn from administration, nursing, supervision, HR, case management, clinician, and clerical functions
- Both groups independently identified the same top-three priority categories: culture, recruitment and retention, and process management
- Both groups independently named communication and collaboration across teams as a foundational issue, cutting across every other priority
- Both groups independently named supervisor buy-in and supervisor capability as a primary mechanism by which culture work succeeds or fails
- The Thursday group identified a recurring pattern between training and follow-through: “a lot of the times we hear that stuff, we're in the trainings, but we don't implement those practices after trainings” — the same closing-the-loop failure named by the Clinical Quality workgroup

Board of Directors Work Session (April 2026)

- “Still siloed thinking” and “siloed focus to solving issues” — both named as weaknesses with votes

- "Communication — brought up by consumers" — the Board named this explicitly, indicating awareness that it has surfaced at the consumer governance level
- "Advocacy at federal and state level" — highest-voted weakness with 6 votes — names the consequence of coordination failure extending to external positioning
- In the PESTEL exercise, when the Board described what happens when MDHHS makes policy changes without stakeholder input, one of the first named consequences was "silo decision making" — placing the silo problem at the intersection of internal organization and external risk

Seven Independent Workgroup Root Cause Analyses

Each of the seven cross-functional workgroups began with a different domain-specific issue and walked it through iterative 'why' questions until reaching a root cause. The full ladders appear in Section 6. The summaries below show where each chain terminated.

- **Workforce and Culture:** supervisory development was named as the explicit root cause; a workgroup member stated directly that the organization 'has not made it a priority from a strategic level.'
- **Access and Crisis Response:** siloed teams operating under decades of layered patches with no cross-team authority to redesign the end-to-end process — 'we're moving, but it's just fragmented.'
- **Clinical Quality and Service Delivery:** managers too aligned with their own departments to see the bigger picture; supervisor alignment failure cascading downward through the org chart.
- **Equity, Compliance, and Risk:** accountability diffused across departments; compliance risk emerges at handoffs where no one owns the transition; staff don't understand the 'why' behind requirements.
- **Community Partnerships:** 'HealthWest staff don't really know about ourselves' — internal coordination failure prevents speaking with one voice externally.
- **Data, Technology, and EHR:** knowledge siloed across IT and program teams; no cross-department governance with authority to own technology decisions end-to-end.
- **Operations, Finance, and Business Sustainability:** no organizational function responsible for coherent cross-department operational standards; the work has never been systematically pruned or redesigned as scope expanded.

Seven groups. Seven different domains. Seven different starting problems. The root cause ladders converge on three architecture-level conditions: insufficient supervisory and leadership development as a strategic investment, communication operating as ad-hoc channels rather than designed infrastructure, and no cross-team governance authority to own end-to-end coordination.

What the Diagnosis Means for Strategy

A precise diagnosis sets the boundary on what kinds of responses can succeed. This one rules out three otherwise-attractive directions.

It cannot be addressed domain by domain. Treating Workforce, Clinical Quality, Compliance, and Technology as separate problems for separate workstream teams is precisely what produced the current condition. Each domain has been optimized independently for years, and the whole has remained fragmented. Continuing in that mode would deepen the diagnosis, not resolve it.

It cannot be addressed through individual performance improvement. Adding training, hiring more staff, or issuing new policies treats an architecture condition as a competence condition. The seven independent root cause analyses consistently identified system-design failures, not effort or skill failures. The organization cannot train its way out of an architecture problem. The Equity workgroup made this explicit: corrective actions are taken, training is delivered, the EHR is configured to force compliance — and repeat audit findings persist anyway.

It cannot be addressed by another initiative bolted on top. The Workforce and Culture group reached a striking conclusion: the reason supervisory development has remained inadequate is not lack of awareness or even lack of resources, but lack of strategic priority. The same dynamic shows up in the Access workgroup's observation that the agency has stacked patches on patches for a decade without ever stepping back to redesign. Adding another initiative without elevating coordination architecture to strategic-investment status would repeat the pattern that produced the diagnosis.

What the diagnosis calls for is an organizational response at the level of the architecture itself — the supervisory and leadership development pipeline, the communication infrastructure, and the cross-departmental governance authority that allow HealthWest to function as a coherent organization rather than as a collection of individually competent departments. The specific shape of that response — the strategic direction that channels all subsequent goal-setting, pillar development, and initiative prioritization — will be proposed and adopted at the Steering Committee's Pillar Workshop.

FUTURE STATE CHARACTERISTICS

If HealthWest successfully addresses this diagnosis, we would expect to see…

1. **Supervisory development treated as a strategic investment, not a training event.** Supervisors across programs and departments have the skills, authority, and organizational support to drive alignment downward and surface problems upward — closing the loop between training and implementation that staff focus groups identified as a persistent failure point.

2. **Communication operating as designed infrastructure, not individual relationships.** Staff, partners, and consumers experience consistent information flow that survives staff transitions — so that a consumer does not lose continuity of care because a

case manager left, and a partner does not lose their primary contact when a Supports Coordinator turns over.

3. **Cross-departmental work governed by a clear, shared authority structure.** Access, crisis, clinical, compliance, and operational processes are redesigned as a whole rather than patched independently within each domain — because the organization has developed a defined governance structure with the standing to own end-to-end coordination.

4. **Consistent organizational quality, not just strong team performance.** The gap between team effectiveness (7.6/10) and confidence in consistent quality across programs (5.2/10) — the largest diagnostic gap in the staff survey — has meaningfully closed. Quality is no longer program-dependent.

5. **HealthWest speaks with one voice externally.** Staff understand HealthWest's services, partnerships, and strategic position well enough to represent the organization coherently — so that community partners experience a coordinated institution rather than a collection of individually competent people who don't know what the other departments do.

The External Risk Environment This Plan Operates Within

Three environmental conditions shape every strategic choice in this cycle. They are not strategic issues HealthWest can directly solve through its own goals; they are conditions HealthWest operates within, and the Steering Committee will treat them as a PESTEL-level environmental assumption that conditions every issue and every pillar in the FY2027–2029 plan:

- **Medicaid funding pressure and threats to the public mental health system.** Medicaid accounts for approximately 91% of total revenue. Federal and state funding volatility was the highest-rated external threat across every workgroup domain SWOT and the Board PESTEL exercise.
- **Privatization risk for Michigan's community-based behavioral health system.** Privatization would shift care from a holistic, community-driven model to a transactional approach, change medical-necessity definitions, and introduce 'any willing provider' dynamics.
- **MDHHS policy volatility.** Policy changes without adequate stakeholder input or transition time create compliance complexity, staff burnout, and — as the Board explicitly named in the PESTEL exercise — silo decision-making inside the organization as a downstream consequence. The organization's coordination infrastructure must be resilient enough to absorb and respond to external policy shifts without fracturing internally.

This assumption is named explicitly in this assessment so that every pillar, goal, and KPI developed in subsequent weeks accounts for it. It is not an additional strategic issue; it is a condition that conditions every issue — and the Environmental Conditions adopted at the Pillar Workshop make this explicit.

The 21 Refined Strategic Issues

Following Steering Committee validation feedback, the validated set of 22 issues elevated by the domain workgroups was refined to 21. The Steering Committee approved the refined set. One issue was merged (Cross-Team Communication & Collaboration absorbed into Relationships, Trust, and Psychological Safety); three issues were reframed with substance preserved (#3 Role Clarity, #12 Systemic Compliance Vulnerabilities, #19 Clarity, Coordination, and Governance of Community Partnerships); the remainder advanced as-is. Full text of all 21 issues appears in Appendix A.

Domain Distribution of the 21 Refined Issues

Domain	Count	Note
Access & Crisis Response	3	All 3 retained (#3 reframed, HR-upstream framing applied)
Clinical Quality & Service Delivery	3	All 3 retained as-is
Data, Technology & EHR	3	All 3 retained as-is
Equity, Compliance & Risk	3	All 3 retained (#12 reframed)
Operations, Finance & Business Sustainability	3	All 3 retained as-is; #15 Facilities confirmed as strategic issue
Workforce & Culture	2	3 → 2; Cross-Team Communication merged into Relationships, Trust, and Psychological Safety
Community Partnerships	4	All 4 retained (#19 reframed); workgroup intent preserved
TOTAL	21	Down from 22 (one merger)

Strategic Guardrail Adopted Alongside Issue #13

The Steering Committee adopted a parallel guardrail companion to Issue #13 (Staff Capacity, Workload, and Effectiveness):

> **Workforce Capacity / Workload / Effectiveness — No-Tradeoff Principle**
>
> HealthWest will not address staff capacity, workload, or effectiveness by trading one of these dimensions for another. Goals and initiatives that affect any of the three must be evaluated against their impact on the other two.

Key Diagnostic Findings at a Glance

Critical external risk: Medicaid accounts for approximately 91% of total revenue. Federal and state funding volatility, public mental health system threats, and privatization risk are now formally named as an environmental assumption conditioning every pillar.

Highest internal gap: Communication gaps — named as the #1 barrier by 55% of staff, the #1 partner obstacle by 49% of partners, and surfaced as a root cause condition in seven independent workgroup analyses.

Regional consumer experience signal — first-contact access: Across the LRE region, crisis respondents scored 25 percentage points lower on access than CSP/TCM respondents (61% vs. 86%). This is regional, not HealthWest-specific data, but the pattern aligns with the Access and Crisis workgroup's independent finding that first-contact system design — not capacity alone — is the limiting factor at HealthWest.

Lowest staff confidence score: Staff confidence in consistent quality across all programs: 5.2 out of 10, is the single lowest score in the staff survey. This is a coordination metric, not a clinical quality metric.

Workforce is the foundation: Retention challenges, supervisory skill gaps, workload strain, and no unified HRIS are systemic constraints on every other organizational priority. The Workforce and Culture root cause analysis named supervisory development specifically as never having been elevated to the strategic-priority level.

Technology is underused: AI and EHR optimization received the highest opportunity votes in multiple workgroup SWOTs and was the Board's fourth-highest strategic priority (7 votes). The Data/Tech/EHR root cause analysis points to the absence of cross-department governance with authority to own technology decisions end-to-end.

Consumer trust is the asset: 91.7% recommendation rate and 92.2% service satisfaction at HealthWest represent a community trust asset built through individual staff relationships — one that coordination failures are eroding from the inside.

Section 1B. Strategic Response — Guiding Policy, Pillars & Environmental Conditions

The Steering Committee Pillar Workshop (May 12, 2026) adopted the following Guiding Strategic Policy, six Strategic Pillars with their associated issues, and three Environmental Conditions. These decisions translate the diagnosis directly into strategic direction and constitute the organizing framework for the FY2027–2029 Strategic Plan.

This policy responds directly to the diagnosis. The convergent finding across all seven independent workgroup root cause analyses — that HealthWest's internal coordination architecture has not been elevated to the level of strategic investment the organization's scale and external risk environment now require — calls for a response at the level of the architecture itself. The Guiding Strategic Policy names that response: build durable organizational capability rather than accumulating isolated fixes.

Guiding Strategic Policy

GUIDING STRATEGIC POLICY

HealthWest will strive to build the human coordination infrastructure — people systems, communication architecture, leadership capability — that allows the organization to deliver consistent, high-quality services in a value-driven environment AND respond to external mandates without organizational fracture. Every strategic investment will be evaluated by whether it builds durable organizational capability that supports our mission, vision and values, not just whether it solves the immediate problem.

Every strategic investment in the FY2027–2029 cycle will be evaluated against one criterion: does it build that capability, or does it merely solve the immediate problem while leaving the architecture untouched?

Strategic Pillars and Issues

The six pillars below organize HealthWest's strategic priorities for the planning period. Each pillar contains the specific strategic issues the organization has committed to address. Note that some issues appear in more than one pillar, reflecting their organization-wide relevance.

Pillar 1 **Clinical Practice Excellence**	**#1** Efficient, Timely Access to Care at First Contact **#2** Internal Coordination & Continuity of Care **#3** Role Clarity, Training, Education Across the Access System **#5** Clinical Skill Strengthening & Consistent Evidence-Based Practice
Pillar 2 **Operational Integrity**	**#4** Clinical Workflow & Documentation Excellence **#5** Clinical Skill Strengthening & Consistent Evidence-Based Practice **#10** Personal Responsibility for Compliance **#11** Shared Responsibility & Cross-Department Accountability **#12** Systemic Compliance Vulnerabilities & Root-Cause Resolution **#14** Internal Cost Structure & Operational Optimization
Pillar 3 **Organizational Culture & Development**	**#6** Cross-Departmental Collaboration to Maximize Staffing Resources **#13** Staff Capacity, Workload, Effectiveness **#14** Internal Cost Structure & Operational Optimization **#16** Relationships, Trust, Psychological Safety **#17** Staff Retention & Workforce Stability
Pillar 4 **Technology Transformation**	**#7** Core IT Operations Resilience & Continuity **#8** Cybersecurity, Data Governance, Risk Management **#9** Making Work Easier Through Automation & Intelligent Tools
Pillar 5 **Community Partnerships**	**#18** Information Flow Between HealthWest and Partners **#19** Clarity, Coordination, Governance of Community Partnerships **#20** Visibility & Awareness of HealthWest Services **#21** Alignment of Partnerships with Community Needs and Gaps
Pillar 6 **Physical Infrastructure Capacity**	**#14** Internal Cost Structure & Operational Optimization **#15** Facilities Capacity & Physical Infrastructure Constraints

Environmental Conditions

The following three conditions are not strategic issues to solve — they are the operating reality every pillar must account for when setting priorities and designing initiatives. They are named here so that no goal, KPI, or initiative is developed without accounting for the environment it must function within.

Condition 1: Medicaid Funding Volatility

Medicaid accounts for approximately 91% of total revenue. Federal and state funding instability is the highest-rated external threat across every workgroup domain SWOT and the Board PESTEL exercise. Every strategic investment must be evaluated for its resilience under funding pressure — not just its effectiveness under stable conditions.

Condition 2: Privatization Pressure

Privatization of Michigan's community-based behavioral health system would shift care from a holistic, community-driven model to a transactional approach — changing medical necessity definitions, introducing any-willing-provider dynamics, and redirecting resources away from safety-net services. HealthWest's strategic direction must strengthen the organization's identity and capability as a community-anchored provider, not merely its operational efficiency.

Condition 3: MDHHS Policy Volatility

Policy changes without adequate stakeholder input or transition time create compliance complexity, staff burnout, and — as the Board explicitly named in the PESTEL exercise — silo decision-making inside the organization as a downstream consequence. The organization's coordination infrastructure must be resilient enough to absorb and respond to external policy shifts without fracturing internally.

Not strategic issues to solve. The operating reality every pillar must account for.

Section 2. How This Assessment Is Organized

Strategic plans frequently fail not because the organization lacked goals or commitment, but because the planning process produced a list of priorities rather than a coherent strategy. Lists of priorities are easy to assemble: each department names what it cares about, the items get aggregated, and the result is announced. What that approach generates is parallel work — each priority pursued by the team that named it, competing for the same time, attention, and resources. When everything is a priority, nothing functions as one.

This planning process is structured to produce something different. The intention is to identify the precise organizational condition the strategy must address, then commit to a coordinated response in which each strategic action reinforces the others rather than competing with them. Three disciplines guide that intention. Each is reflected in a specific phase of the process, and the structure of this document mirrors them.

How to Read This Document

This assessment is organized to lead with conclusions and follow with the evidence that supports them. Readers who want the strategic argument can read Sections 1 through 5 in roughly twenty minutes. Readers who want to verify or interrogate any specific finding will find the supporting evidence in Sections 6 through 12 and Appendix A.

Sections 1–5 — The Strategic Argument

- **Section 1:** The diagnosis itself, the convergent evidence summarized at a glance, the externally-named risk environment, and the 21 refined strategic issues approved by the Steering Committee. Section 1B follows immediately with the Guiding Strategic Policy, Strategic Pillars, and Environmental Conditions adopted at the May 12, 2026 Pillar Workshop.
- **Section 2:** How this assessment is organized — the discipline behind the structure, and how to read the document.
- **Section 3:** Operational profile and current state — the organizational facts the strategy must build on.
- **Section 4:** Strategic implications — what the diagnosis logically implies for any direction the Steering Committee adopts.
- **Section 5:** Cross-cutting themes — five conditions that shape everything HealthWest does, regardless of domain.

Sections 6–12 — The Supporting Evidence

- **Section 6:** Workgroup root cause analysis — seven independent root cause ladders, the empirical core of the diagnosis.
- **Section 7:** Consumer experience data — MHSIP and YSS results, with regional context distinguished from HealthWest-specific findings.
- **Section 8:** External environment — PESTEL analysis grounded in the Board's April 18, 2026 exercise.

- **Section 9:** External environment — Porter's Five Forces adapted for the public-sector behavioral health context.
- **Section 10:** Internal assessment — consolidated SWOT synthesizing all input streams.
- **Section 11:** Domain-by-domain SWOT findings — top-voted strengths, weaknesses, opportunities, and threats from each of the seven workgroups.
- **Section 12:** Voice of staff, partners, and consumers — direct findings from the surveys, focus groups, and interviews.
- **Appendix A:** Refined strategic issue set — the full text of the 21 issues approved by the Steering Committee.

The Three Disciplines Behind This Structure

Discipline 1: Diagnose Before Prescribing

A diagnosis is not a list of problems. It is the specific underlying condition that, if addressed, unlocks progress on the others. A precise diagnosis sets the foundation for everything that follows. A vague or unfocused diagnosis produces vague or unfocused strategy.

Section 1 of this document is the diagnosis, and Section 6 is the empirical foundation that supports it. Together they name the specific organizational condition that independent data sources and seven workgroup root cause analyses converged on: insufficient strategic investment in the supervisory pipeline, communication infrastructure, and cross-departmental governance that allow HealthWest to function as a coherent organization.

This diagnostic phase took seven weeks. It included 14 workgroup sessions with storyboarding, SWOT and root cause analysis, two survey instruments, a consumer focus group, two staff focus groups, regional consumer satisfaction data analysis, and Board SWOT and PESTEL exercises — conducted before any attempt to name the response. The result is a diagnosis grounded in convergent independent evidence rather than facilitator interpretation.

Discipline 2: Choose a Direction — and Choose What Not to Do

After the diagnosis comes the strategic direction: how the organization will respond. A real direction does two things at once. It says yes to a specific approach — channeling action down a particular path — and it says no to other approaches that might also be reasonable but cannot all be pursued simultaneously without producing the coordination failures the diagnosis already documents.

The Steering Committee used this assessment to adopt that direction at the May 12, 2026 Pillar Workshop. The Committee engaged with the diagnosis documented here, surfaced the convergence in the evidence, and determined the organizational logic that governs all subsequent goal-setting, pillar development, and initiative prioritization.

The Guiding Strategic Policy, Strategic Pillars, and Environmental Conditions adopted at the Pillar Workshop are presented in Section 1B of this document, immediately following the diagnosis. They represent the Steering Committee’s considered response to the evidence.

The discipline of saying no is what protects the strategy from collapsing back into a parallel-work list. If all domains receive equal investment, the architecture problem the diagnosis names will not be resolved — because that approach is precisely what produced the architecture problem. The Steering Committee will be asked not only what HealthWest will pursue in this cycle, but what it will explicitly defer or decline.

Discipline 3: Coordinated Action, Not a Catalog of Initiatives

The third element is the coordinated action set, designed in the goal-setting phase of the process — Weeks 10 through 14, after the strategic direction is adopted. Coordinated actions differ from a list of initiatives in one specific way: doing action A changes the conditions under which action B operates, making B more effective. The actions reinforce each other. They are not parallel workstreams competing for the same resources.

A coherence test will be adopted alongside the strategic direction by the Steering Committee. Every goal, KPI, and initiative that workgroups propose must pass two checks: does it build durable organizational capability as defined by the strategic direction, and does it reinforce at least one other pillar rather than running in isolation? Those two checks are what prevent this planning process from producing the well-organized list of departmental priorities that the diagnosis already identifies as the underlying problem.

Why This Sequence Matters

Most strategic plans skip the diagnosis entirely or perform it superficially, jumping immediately to goals and initiatives. When that happens, the goals get organized around the loudest current problems rather than around the underlying condition that produces them — and the result is a plan that treats symptoms while leaving the architecture untouched. Two years later the same problems return.

This planning process spent seven weeks in structured diagnosis before attempting to name the response. The result is empirically dense: when seven independent workgroups, 182 staff, 41 partners, consumers, and the Board all point to the same underlying condition without coordinating their findings, that convergence is analytically meaningful in a way that no single source could be.

That evidential foundation is what makes the strategic decision from the Steering Committee a genuine decision rather than a ratification of staff analysis. The Steering Committee will be asked to look at the convergent evidence and determine for itself what it indicates about where strategic investment must concentrate — and what it must explicitly refrain from pursuing. The strategic direction that emerges from that conversation will be the Committee's, grounded in evidence the staff have surfaced but not pre-decided.

Section 3. Operational Profile and Current State

Mission, Identity, and Values

Organization: HealthWest — Muskegon County's Community Mental Health Services Provider (CMHSP) and Certified Community Behavioral Health Clinic (CCBHC)

Service Territory: Muskegon County, Michigan — with school-based, community-embedded, and co-located services expanding reach across the county

CCBHC Status: HealthWest holds CCBHC designation, enabling enhanced Medicaid reimbursement, quality reporting requirements, and expanded scope of integrated behavioral health practice

Cultural Framework: The HealthWest Way — launched FY2025, inspired by the Disney philosophy. Value statement: “We strive to embrace the Golden Rule when engaging clients, as well as colleagues. We act with integrity, pursue excellence in all we do, and empower one another to grow and succeed.”

FY2025 Service and Financial Snapshot

Total Individuals Served: 7,149 people across Mental Health, IDD, SUD, Corrections, SED, and Autism programs

Total Appointments: 133,434 appointments delivered in FY2025; 6,763 via telehealth

CCBHC Enrollees: 6,485 individuals served under CCBHC designation

Crisis Services: 804 after-hours mobile responses; 17,073 unique Warmline contacts; 1,004 completed ICS interventions

Walk-In Access: 4,161 walk-ins; 2,969 evaluations completed; 94.8% conversion to intake

Integrated Health: 4,735 medical visits; 2,631 dental visits at Integrated Health Center

Total Revenue: $106,782,808

Total Expenses: $106,800,782

Medicaid Revenue Concentration: Approximately 91% of total revenue

CCBHC Quality Bonus: $1,060,490 earned for high-quality services in FY24

Training Investment: 26,317 total training courses completed; average 43 credit hours per staff member

Programs and Service Lines

- Mental Health Services — outpatient therapy, psychiatric evaluation, medication management, ACT team
- Substance Use Disorder (SUD) Treatment — integrated outpatient SUD services, medication-assisted treatment (MAT), recovery coaching, SMART Recovery, residential referrals

- Intellectual and Developmental Disabilities (IDD) — supports coordination, community living supports (CLS), autism services, respite
- Crisis and Urgent Care — Integrated Crisis Services (ICS), Warmline, mobile crisis response, Mental Health Urgent Care, Crisis Residential Unit
- Integrated Health Center — co-located primary care, dental, and behavioral health services
- Corrections — behavioral health services for justice-involved individuals
- Supportive & Ancillary Services — housing support, employment services, veteran services, therapeutic and support groups

Leadership

Executive Director: Rich Francisco

Chief Clinical Officer: Christy LaDronka

Chief Information Officer: Kristi Chittenden

Chief Financial Officer: Brandy Carlson

Medical Director: Dr. Gregory Green

Governance: Board of Directors with active Consumer Advisory Committee embedded in governance and quality improvement processes

FY2025 Notable Achievements

- Launched The HealthWest Way — organization-wide Disney Way training completed for all staff
- Earned $1.06M CCBHC Quality Bonus Payment for FY24 performance
- Improved on-time assessments to 85.6%; reduced average turnaround time to 8.6 days
- Launched Mental Health Urgent Care — rapid access for acute behavioral health needs
- Fully implemented Zero Suicide framework — Suicide Safer Care Pathway, 175+ Caring Contacts sent, lethal means counseling initiated
- Youth teams relocated to NIMS building — improved team co-location and collaboration
- Implemented organizational Risk Management policy with quarterly reviews
- Reduced redundant and outdated policies by 20% through KATA improvement project
- Established a new Project Management Team
- Continued development of dashboards to support data-driven decision-making

Section 4. Strategic Implications

The following implications are not goals. They are the logical outputs of the diagnosis and the convergent root cause analyses, and they should directly shape the strategic direction and coordinated action framework the Steering Committee adopts. They are presented here as implications — directions the evidence points — not as decisions.

Each implication is paired with the refined strategic issue (or issues) it most directly maps to from the 21-issue set approved by the Steering Committee.

1. Communication Must Be Treated as Organizational Infrastructure Investment, Not a Training Initiative

The evidence is too consistent and too cross-domain to address through programs. The Equity workgroup's root cause analysis is explicit: information exists but does not land because no one is responsible for translating organization-level information into team-level meaning. The architecture must be redesigned, not the channels.

Refined issue mapping: Issue #16 (Relationships, Trust, and Psychological Safety — now expanded to include cross-team communication and collaboration following the May 1 merger), Issue #11 (Shared Responsibility & Cross-Department Accountability for Compliance), Issue #18 (Information Flow and Communication Between HealthWest and Partners).

2. Supervisory and Leadership Development Must Be Elevated to a Strategic-Investment Priority

The Workforce and Culture root cause analysis terminated at this exact finding: 'we just have not made it a priority from a strategic level.' The Clinical and Equity ladders independently corroborate it. Adding supervisor training as one initiative among many would repeat the pattern that produced the diagnosis. This requires architectural-level commitment: dedicated capacity, sustained over years, with measurable competency standards — not a program added to an already-saturated workload.

Refined issue mapping: Issue #16 (Relationships, Trust, and Psychological Safety), Issue #5 (Clinical Skill Strengthening & Consistent Evidence-Based Practice), Issue #10 (Personal Responsibility for Compliance, Documentation, and Policy Adherence).

3. Workforce Stability Is a Strategic-Level Investment, Not an HR Program

Every other priority depends on it. The HRIS gap, supervisory development gap, and workload design gap are organizational architecture problems that require organizational-level solutions. The Steering Committee's adoption of the parallel guardrail companion to Issue #13 makes this discipline explicit: capacity, workload, and effectiveness will not be addressed by trading one of them for another.

Refined issue mapping: Issue #13 (Staff Capacity, Workload, and Effectiveness — with no-tradeoff guardrail), Issue #17 (Staff Retention & Workforce Stability), Issue #3 (Role Clarity, Training, and Education — with HR-upstream framing).

4. The Crisis Access Pattern Is a Measurable, Addressable Strategic Target

Across the LRE region, crisis respondents scored 25 percentage points lower on access than CSP/TCM respondents (61% vs. 86%). This is regional, not HealthWest-specific data. However, because HealthWest is one of the five CMHSPs contributing to that aggregate — and because the Access and Crisis workgroup's independent root cause analysis traced HealthWest's first-contact problem to system design, not capacity — the regional pattern is directly relevant. The work calls for system redesign at the first-contact level, not staffing additions alone, and requires authorized cross-team workflow ownership that does not currently exist.

Refined issue mapping: Issue #1 (Efficient, Timely Access to Care at First Contact), Issue #2 (Internal Coordination & Continuity of Care Across Access, Crisis, and Treatment), Issue #3 (Role Clarity, Training, and Education Across the Access System).

5. Technology Investment Evaluated Only for Efficiency Gains Will Underperform

Technology that builds coordination capacity — connecting teams, enabling shared data visibility, reducing manual friction across department boundaries — is the investment that produces compound returns. The Data/Tech/EHR root cause indicates this requires governance authority before it requires more tools.

Refined issue mapping: Issue #7 (Core IT Operations Resilience & Continuity), Issue #8 (Cybersecurity, Data Governance, and Risk Management), Issue #9 (Making Work Easier Through Automation and Intelligent Tools).

6. Compliance Redesign Requires Accountability Architecture, Not More Training

The repeat audit finding pattern is not a knowledge problem. The Equity workgroup's root cause analysis is unambiguous: it is a handoff design problem. The reframing of Issue #12 makes this explicit — the strategic plan must address the systemic vulnerabilities themselves, not only the findings they produce.

Refined issue mapping: Issue #12 (Systemic Compliance Vulnerabilities & Root-Cause Resolution — reframed from 'Repeat Audit Findings' to a system-condition framing), Issue #11 (Shared Responsibility & Cross-Department Accountability for Compliance), Issue #10 (Personal Responsibility).

7. Financial Resilience Requires Deliberate Scenario Planning Now

Medicaid dependency at 91% is a structural condition that cannot be quickly changed, but its risk can be actively managed through reserves, scenario models, and advocacy investment. The Steering Committee's formal designation of Medicaid pressure, public mental health system threats, and privatization risk as a PESTEL-level environmental assumption ensures every pillar will account for this risk explicitly.

Refined issue mapping: Issue #14 (Internal Cost Structure and Operational Optimization), and the named environmental assumption that conditions every pillar.

8. Facilities Are a Strategic Constraint on Growth, Not a Maintenance Concern

The Steering Committee confirmed Issue #15 as a strategic issue rather than reframing it as an operational assumption. The Operations workgroup identified facilities as a hard constraint on growth and program expansion, not a baseline condition. Treating facilities as a strategic issue preserves visibility for the capital-planning conversations that growth-oriented goals will require.

Refined issue mapping: Issue #15 (Facilities Capacity & Physical Infrastructure Constraints).

9. The 91.7% Consumer Recommendation Rate Is a Strategic Asset That Must Be Explicitly Protected

It is built on individual staff relationships, which means workforce instability degrades it directly. Consumer trust and workforce investment are the same investment. Partnership work is the external face of the same dynamic: when partners describe HealthWest, they describe individual staff relationships, and they describe their disruption when those staff move on.

Refined issue mapping: Issue #17 (Staff Retention & Workforce Stability), Issue #16 (Relationships, Trust, and Psychological Safety), Issue #20 (Visibility and Awareness of HealthWest Services in the Community).

10. Partnership Work Requires Governance Before It Requires More Activity

The reframing of Issue #19 to 'Clarity, Coordination, and Governance of Community Partnerships' makes the precondition explicit. The Community Partnerships workgroup's root cause analysis identified internal coordination failure as the upstream cause of external partnership inconsistency: 'HealthWest staff don't really know about ourselves.' Strengthening partnership governance and role clarity is foundational to advancing the other partnership issues.

Refined issue mapping: Issue #19 (Clarity, Coordination, and Governance of Community Partnerships), Issue #18 (Information Flow and Communication Between HealthWest and Partners), Issue #21 (Alignment of Partnerships With Community Needs and Gaps).

11. Choosing What HealthWest Will Not Pursue in This Cycle Is Part of the Strategy, Not Separate From It

The convergent diagnosis indicates that prior attempts to advance multiple parallel priorities are part of what produced the current condition. A strategic direction that does not explicitly defer or decline some otherwise-attractive directions will under-resource the architecture work the diagnosis identifies as primary, and the cycle will recur.

Section 5. Cross-Cutting Themes

Five themes emerged consistently across all data sources — surveys, SWOTs, PESTEL, regional consumer satisfaction data, the consumer focus group, two staff focus groups, and the seven workgroup root cause analyses. These are systemic conditions that shape everything HealthWest does. Any strategy that does not directly address these themes will underdeliver regardless of how well individual domain priorities are executed.

Theme 1: Communication Is Organizational Infrastructure, Not a Soft Issue

Communication gaps were named the #1 staff barrier (55%), the #1 partner obstacle (49%), a root cause of handoff failures in access and crisis, a driver of compliance risk, a source of turnover and disengagement, and a persistent consumer experience concern named by Consumer Advisory Committee members for multiple years. The Equity workgroup root cause analysis articulated the underlying condition precisely: channels exist; the responsibility to translate organization-level information into team-level meaning is not defined. This is not a cultural preference — it is a structural systems condition with measurable clinical, financial, and reputational consequences. The strategic plan must treat communication infrastructure as core organizational investment, not a training initiative. You cannot hold a workshop to fix an architecture problem.

Theme 2: Workforce Is HealthWest's Greatest Asset and Most Significant Risk

Staff are the service. The 91.7% consumer recommendation rate is built entirely on individual staff relationships — as consumers themselves described in the focus group. Retention challenges, supervisory skill gaps, workload strain, psychological safety concerns, and the absence of modern HR infrastructure threaten every other strategic priority. The Workforce and Culture root cause analysis ended at a single, named condition: supervisory development has never been elevated to the strategic-investment level it requires. The HealthWest Way provides the cultural aspirational foundation — the strategic plan must operationalize it through concrete people systems: HRIS, supervisory development as a dedicated program at scale, workload design, and measurement of belonging and morale.

Theme 3: System Design — Not Individual Failures — Drives Most Problems

Workgroups across every domain consistently framed their most significant issues as system-design problems: handoff design in crisis access, accountability diffusion in compliance, information flow structures in partnerships, bureaucratic process in operations, and documentation architecture in clinical quality. The convergent finding from the seven root cause analyses is that no cross-team coordination authority currently owns these architectural conditions. Across the LRE region, the crisis access score gap (61% vs. 86%) is the external confirmation of an internal system design pattern that the Access and Crisis workgroup

independently traced to first-contact workflow design. Training and staffing additions will not resolve these. The systems must be redesigned, and that requires governance authority that the organization does not currently designate.

Theme 4: Technology Is a High-Leverage Underused Capacity Tool

AI, EHR optimization, automation, and cybersecurity governance received the highest opportunity votes in four of seven domain SWOTs and was the Board's fourth-highest strategic priority. Staff describe technology as an opportunity to recover time, reduce administrative burden, and improve data-driven decisions. The Data/Tech/EHR root cause analysis indicates that the prerequisite for capturing those gains is governance authority — a body that can integrate technology decisions with workforce readiness, EHR optimization, and security posture as one coherent program rather than separate concerns. Core IT resilience must be the foundation; automation and AI are the leverage layer above it. The LRE recommendation to improve regional involvement in consumer-led programs also points toward technology as an access enabler for consumer supports.

Theme 5: The External Risk Environment Requires Proactive Organizational Readiness

Medicaid dependency (91% of revenue), workforce shortage in the field, potential privatization, and shifting MDHHS regulatory requirements create a threat environment that is more concentrated and more volatile than in any recent planning period. The Steering Committee has formally designated Medicaid funding pressure, public mental health system threats, and privatization risk as a PESTEL-level environmental assumption that conditions every pillar of the FY2027–2029 plan. The Board's PESTEL exercise identified specific early warning indicators — and named ‘silo decision-making’ as one of the consequences of MDHHS policy changes without stakeholder input, explicitly connecting external disruption to the internal coordination diagnosis. The consumer satisfaction data adds a further dimension: HealthWest's 91.7% recommendation rate is a community trust asset that must be actively protected in a volatile funding environment, because it is both a mission measure and a political asset when advocacy is needed.

Section 6. Workgroup Root Cause Analysis — Seven Independent Ladders

Each of HealthWest's seven cross-functional workgroups conducted a structured root cause analysis on its top-priority issue during its second working session. The method begins with a problem statement and walks it through iterative 'why' questions, with each successive answer pushing past the symptom toward the underlying organizational condition.

The seven groups did not coordinate. They worked in parallel, on different days, with different participants, focused on different domains. Each was asked to start with its own highest-priority issue. Yet the ladders converge. That convergence — documented below from the workgroup conversations and storyboards — is the empirical foundation of the diagnosis presented in Section 1.

Each ladder is presented with its issue statement, the why-steps in the language the workgroup used, and the root cause where the chain terminated. The pattern across all seven appears in the closing subsection.

6.1 Workforce and Culture

Issue Statement (Issue 1, top vote): Trust, communication, and psychological safety are not experienced consistently across the organization, affecting engagement and staff well-being.

Why 1	"Some staff are still stuck in the old culture of not being able to trust supervisors, managers, leaders. And supervisors are not trained well to be supervisors. They're usually promoted from within and they don't have the supervisory skill set they need to give that culture of psychological safety."
Why 2	Why don't we train new supervisors to do their job? "We don't have training. There isn't a training... It's a resource issue. The resources to develop it, sustain a training program, provide all the different areas of training."
Why 3	Why don't we have the resources — people, time, materials? "The workload. It has to be so meaningful, and it has to take thought. It's not something you could sit down in a half an hour, write a training plan, and implement it... it has to be ongoing, it has to be reinforced."
Why 4	Why hasn't the workload been reorganized to make room for it? "Maybe it hasn't been a priority. Clinical resources go to the clients. That's where our time goes. From a leadership standpoint, they look at it as a big thing... not as easy as just saying the words."
ROOT	**"We just have not made it a priority from a strategic level." Supervisory and leadership development has been recognized as essential and named repeatedly across multiple years — yet it has never been elevated to the strategic-investment level it requires.**

Issue Statement (Issue 2, retention/workload): HealthWest experiences challenges retaining staff due to workload pressures, compensation concerns, morale, and perceived support.

Why 1	"We keep adding and adding and adding things, but we never take away things. And a lot of that stuff is government regulations." Productivity pressure is how the agency makes money.
Why 2	Why do we keep adding? Grants require, state requirements, CCBHC has separate requirements from Medicaid — "you're dealing with two different funding sources on top of the private insurance. It's just very complicated funding source requirements. But I don't think we've looked at how that trickles down to our staff and their workload."
Why 3	Are we asking staff to do things not actually required? "Do we have systems in place that have just been there forever and we don't do anything with that data or that information? Do we have spreadsheets sitting out there that nobody's using anymore?"
Why 4	Why does the work fall to staff who are already at capacity? "We have that inner drive, like it needs to be done, I got this... So maybe the strength, the passion of our staff is also a weakness."
Why 5	Why aren't there other people on the team with the same credentials able to assist? Teams not staffed for the actual scope of work. Mission-driven staff absorb gaps that compound until burnout.
ROOT	**No organizational mechanism prunes or redesigns the work as scope expands; team structure is sized to historical assumptions rather than current scope. The architecture of how work is designed, distributed, and pruned has not been owned at the organizational level.**

6.2 Access and Crisis Response

Issue Statement: People seeking crisis or urgent behavioral health support are not consistently able to begin appropriate care at first contact, resulting in delays, repeated handoffs, and inefficient use of access and crisis resources.

Why 1	"The system's too clunky right now... Too many steps to ask about things, or there's too much siloed... we don't have enough staff that can do the same thing."
Why 2	Why so many steps? Billing, CCBHC, CARF, and other accreditations — "there's so many things that we have to hit" — each forcing extra steps without integrated design.
Why 3	"Everybody's working towards the same goal, but we're not necessarily moving at the same speed... I think that's why we have a million dashboards. We just have a lot of different systems, but the right hand's not talking to the left hand." "It's like we're like a Lego piece — we're moving, but it's just fragmented."

Why 4	Why is the agency built this way? “There’s process problems, personnel problems, or policy problems, and oftentimes they interplay.” Layers of CCBHC, COVID, and political-change pivots stayed in place: “how much of what is being done is because 10 years ago, we had to do it this way, and then we had to keep tweaking, tweaking, tweaking, tweaking, tweaking — instead of eliminating.”
Why 5	Why a patchwork rather than redesign? “Time. We have to be scrappy to get things done. By the time we re-evaluate, it’s already been way too long. So you may as well just slap a band-aid on there.” Each team is so specialized that no one has authority across the whole.
ROOT	**“It’s not necessarily a person problem, it’s a system problem.” No cross-team authority owns the end-to-end first-contact-to-care process. A decade of patches has produced a workflow that nobody designed and nobody can redesign without authorization that does not currently exist.**

6.3 Clinical Quality and Service Delivery

Issue Statement: Clinical workflows, documentation requirements, and utilization management expectations are not consistently aligned, creating inefficiencies that reduce available provider time and complicate service delivery.

Why 1	Overlapping demands from CCBHC and MDHHS; “sometimes necessary duplication, but other times unnecessary duplication... expectations aren’t clear, which contributes to either duplication or it not getting done at all.”
Why 2	Why is there a lack of clarity around who does what? “There’s overlap on who could do what... it can get passed off thinking the next person’s going to pick it up.” Positions rolled out without sufficient role definition.
Why 3	Why is it structured with all this overlap? Clinical reasons make some handoffs appropriate, but the structure breeds resentment and “a lack of seeing ourselves as all one team... in service around the individual in the middle.”
Why 4	Why are we still struggling after the HealthWest Way, leadership training, team-building, prior cultural initiatives? “We’re really good at identifying what needs to improve, but we’re not good at closing the loop.”
Why 5	Why does it always go away? Competing priorities consume the day; staff have no clear order-of-operations rule for which thing to drop.
ROOT	**“Our management is not aligned, which is leading to why our supervisors aren’t aligned... We still have managers that are too aligned with their own departments that they forget the bigger picture.” Departmental optimization at the cost of organizational coherence — a misalignment that originates at the management layer and cascades downward.**

6.4 Equity, Compliance, and Risk

Issue Statement A (Personal Responsibility): Inconsistent individual accountability for following policies, procedures, and documentation standards contributes to compliance risk and quality variation.

Why 1	Culture ("if I see my coworker not doing something, why should I have to do it?"); "a lack of being held accountable by people whose job it is to hold people accountable."
Why 2	Why don't we hold people accountable? Fear of turnover ("if I hold them accountable, they'll leave for an easier job"); the difficulty of difficult conversations; lack of top-down modeling — "it's usually expected on a bottom-up level... versus being modeled top-down."
Why 3	Confidence issue at the supervisor level: "A lot of people get promoted into positions or they start new positions and their confidence level is low and so they don't necessarily take accountability for what they need to know in order to do their job the most effective and efficient way." "Very different skills you need to be a supervisor."
Why 4	Why is communication a barrier despite multiple channels? "Everybody receives and gives information differently... I think about how many different ways we communicate information, and there's still a handful of people that didn't get the information." Newsletter exists but supervisors aren't expected to translate it into team meetings; information arrives but does not land.
ROOT	**Communication is not architected. Channels exist; the responsibility to translate organization-level information into team-level meaning is not defined. Combined with the supervisor-development gap, accountability fails not because individuals are uncommitted but because the system does not equip supervisors to hold it.**

Issue Statement B (Shared Responsibility / Repeat Audit Findings): Compliance risks persist because accountability for required tasks is diffused across departments, leading to workflow gaps and repeated audit findings.

Why 1	Why diffuse responsibility? "We probably work in a system that's too complex to have one person be responsible for most of our processes from beginning to end." Tasks have to be spread out.
Why 2	Why no consistency despite spreading the work? "Interpretation" differs across people; "there are parts of that process that we don't own, and so it's hard to put the accountability and the ownership in somebody else's hands." Standards diverge: "There's no consistency among the standards of what's in a BPS, how much information's in there."

Why 3	Why do gaps persist when we change the form, change the EHR, change the PowerPoint? “We try changes to the EHR to make the document force it to have to be met. And then people still find a way for it not to be met.”
Why 4	Why can’t we set clear expectations? “We’re trying to interpret and get answers from MDHHS and we’re not getting the answers. So we’re making the best possible interpretation we can and moving that forward.” Staff don’t understand the why behind requirements: “It was a lack of true understanding about the implications about what I’m doing with these documents.”
ROOT	**Compliance failure originates at handoffs no one owns, compounded by an absence of shared understanding of why the work matters. Each department executes its segment correctly; the transitions between them have no architect, no owner, and no shared language. Repeat audit findings are the visible result of a structural condition.**

6.5 Community Partnerships

Issue Statement: Information sharing and communication between HealthWest and community partners is inconsistent, reducing alignment, responsiveness, and effective coordination.

Why 1	“We are so specialized in each group. I might know one thing, [colleague] knows another, but we’re not transferring that information to everyone... We’re too siloed by teams.”
Why 2	Why does it persist? Constant regulatory change; multiple inconsistent channels (Teams, email, text, phone); “we’re already working on communicating that within ourselves and aren’t communicating those changes to our partners when that happens.”
Why 3	Why does it still happen if everyone agrees it’s a problem? Different communication styles across supervisors; some relay information, others don’t. “It’s almost like you’re playing telephone, and the message kind of changes. By the time it gets to the frontline workers, it’s changed a little bit.”
Why 4	Why despite having a communications manager and community relations team? “People have to share. If I get something, I share it... But everyone has to do that.” Information stops at supervisor levels; no defined expectation about when or how to push it down or out.
ROOT	**“What I’m really hearing is that HealthWest staff don’t really know about ourselves. So how in the heck are we supposed to tell other people about it?” External communication failure is a downstream symptom of internal coordination failure. The agency cannot speak with one voice externally because it does not coordinate one internally.**

6.6 Data, Technology, and EHR

Issue Statement: Core IT operations face resilience and continuity risks that threaten system reliability, regulatory compliance, and the organization's ability to sustain day-to-day clinical and operational work.

Why 1	The IT landscape has expanded roughly fivefold in a decade — "only had 4–5 key systems 10 years ago, have 25 key systems now." "Things change every year, must reevaluate and prioritize wants/needs." Staff using multiple devices and programs (iPhones, computers, varied platforms) compounds the surface area to maintain.
Why 2	Why can't the team keep up? Staff capacity — "even if had funding supports, still need to have adequate number of staff to support projects." Vendor-driven change is outside the team's control: "vendors that sell the software update product whenever — always moving and changing, usually for the better, but then they change the licensing." The VMWare example was named directly — cost skyrocketed, ownership changed mid-fiscal year, software had to be replaced under pressure. "We have no control over that change."
Why 3	Do all the systems we're using play well together? "Not all the way through from one product to another: sometimes there are gaps between, then we must manually enter or create processes that didn't exist to transfer for analysis." When the group was asked whether those gaps pose a burden on capacity, the answer was direct: yes — the time spent addressing those gaps is time that would otherwise meet staffing requirements for project work.
Why 4	IT operations are vital, so why has the agency not prioritized this? The group's answer pointed to a budget transparency problem rather than a funding-availability problem. "If we say we need the money, it comes up" — meaning resources can appear when needs are named, but the proactive scoping conversation does not happen. "Nice to haves aren't prioritized because we worry about funding." The team has "a standard, but don't truly know what IT budget is — haven't gotten 'real' budget from finance." Project costs are submitted as wish lists: "We come up with list of what we need and submit, then if no one says no we assume it is a yes." Other teams run IT-dependent projects without notifying IT in advance, and vendor licensing timelines do not align with the fiscal year, making it impossible to prepare for cost increases.
Why 5	Why has this transparency gap persisted? "Most of the time no one is telling us no" — but no one is telling the team yes either, with a clear scope. The conversation has been framed as "what can we get for the dollar" rather than "this is what we need." The group named the reframe directly: "If you knew what exactly was needed and what they can spend — instead of saying what can we get for the dollar vs this is what we need?" The current shape produces decisions by default rather than by strategic conversation.

ROOT	**No cross-departmental governance authority exists to align IT scope, budget transparency, vendor contract timing, project pipeline visibility, and staff capacity into a single coherent technology strategy. The team executes capably within its silo, but the conditions that determine whether that execution can succeed — what counts as a real budget, which projects across the agency will require IT support, when licensing renewals will hit — are not coordinated at the organizational level. The result is reactive operation under constant external change, with manual workarounds absorbing the capacity that should go to the resilience and modernization work the agency needs.**

6.7 Operations, Finance, and Business Sustainability

Issue Statement: Current staffing levels, workload expectations, and role design limit staff effectiveness and sustainability, reducing the organization's ability to operate efficiently, support quality services, and meet growing operational and service demands.

Why 1	MDHHS paperwork, two parallel customer-service systems on the clinical side, GAP regulations on the finance side — “it takes up a lot more staff time.” Scope of practice and documentation has expanded since most staff were hired.
Why 2	Why hasn’t the structure adapted? Some constraints are external (the school day, post-COVID telehealth shifting talent to private practice with limited licenses). Internal structure has not been redesigned to absorb the change.
Why 3	Why can’t we compete? Benefits used to be better. Younger workforce values flexibility/time over pay/pension. “They value how much time will you give me off, how flexible will you be... AOD requirements are painful for them.”
Why 4	Why haven’t we modernized? “County policies.” Union negotiations bind benefit structures. Becoming an authority would absorb risk. “The alternative might not be a great alternative, but it’s not insurmountable.”
ROOT	**Per the workgroup’s Top 3 rationale: “Constraints on effectiveness persist even when formal productivity or capacity limits are not reached.” No organizational function owns the alignment of workforce design — roles, scope, benefits, schedule structure — to community/staff needs as those shift. Each department adapts what it can within its silo; no one is responsible for the whole.**

Convergence — What the Seven Ladders Share

Each of the seven root cause ladders began with a different domain-specific issue and walked through iterations of ‘why.’ Each terminated at one of three architecture-level conditions. The numbering below reflects the frequency with which each condition was named at the bottom of a chain.

1. No defined cross-team coordination authority
Six of the seven workgroup ladders bottom out at this condition. Access names it as the absence of cross-team authority to redesign the end-to-end first-contact process. Clinical names it as manager misalignment cascading downward. Equity names it as accountability diffusion at handoffs no one owns. Community names it as the inability to speak externally with one voice because no one coordinates the internal voice. Data names it as the absence of cross-department technology governance. Operations names it as the absence of any function responsible for coherent cross-department standards. The starting issues differ; the bottom of the chain is the same shape.

2. Communication operating as ad-hoc channels rather than designed infrastructure
All seven ladders reference this. Equity describes information that exists but does not land. Community describes telephone-game distortion through the supervisor layer. Workforce describes communication as one of three named symptoms in the founding issue statement. Operations and Clinical describe the same dynamic. The shared finding: the channels exist, but the organization has never defined whose job it is to translate organization-level information into team-level meaning, or to coordinate which channel carries what.

3. Supervisory and leadership development never elevated to strategic priority
Workforce names this as the explicit root cause of its top issue: “we just have not made it a priority from a strategic level.” Clinical names manager misalignment as its terminal cause. Equity names confidence and skill at the supervisor layer as a why-step. Access names the absence of authority across teams — a leadership-architecture condition. The pattern: HealthWest has invested in clinical work, in cultural framing (the HealthWest Way), and in technology, but has not invested at strategic-investment scale in the human coordination capability that connects them.

What This Convergence Means

Seven groups working independently, on different problems, on different days, with different participants, arrived at three architecture-level conditions. The convergence is not a facilitator interpretation of the data — it is the data. A diagnosis of this specificity, supported by independent evidence at this density, narrows the strategic decision to a small set of viable directions. The Steering Committee’s task is to choose among those, and equally to name what HealthWest will explicitly not pursue in this cycle so the chosen direction has the resources it requires to actually succeed.

Section 7. Consumer Experience Data — MHSIP and YSS Results

About This Data

The Michigan Department of Health and Human Services mandates an annual customer satisfaction survey for all CMHSP consumers. The Lakeshore Regional Entity (LRE) administers this survey across all five regional CMHSPs. For FY2025, the Mental Health Statistics Improvement Program (MHSIP) was used for adults and the Youth Services Survey (YSS) for children and families. This is standardized, validated survey data allowing benchmarking against state and national norms when published.

Reading Note: Regional vs. HealthWest-Specific Data

This section reports two kinds of figures. HealthWest-specific scores reflect responses from HealthWest consumers only (MHSIP n=384, YSS n=32 for HealthWest). Regional figures — typically reported as LRE aggregates or as comparisons across the five regional CMHSPs— reflect a much larger sample (1,756 region-wide MHSIP respondents in FY25) and include the other four CMHSPs. Where a finding is regional, the report names it as such; HealthWest is one of the five contributing CMHSPs.

This distinction matters most for the crisis-versus-established-clients access comparison: that is regional LRE data, not a HealthWest-specific score.

MHSIP Respondents (Adult, HealthWest only): 384 completed surveys

YSS Respondents (Youth, HealthWest only): 32 completed surveys

CCBHC Module Respondents (HealthWest only): 273 completed surveys

Survey Scale — MHSIP: 1 (strongly agree) to 5 (strongly disagree) — lower numbers are more positive

Survey Scale — YSS: 1 (strongly disagree) to 5 (strongly agree) — higher numbers are more positive

Overall Quality and Satisfaction — HealthWest Strengths

HealthWest's overall consumer satisfaction performance is strong, particularly on quality and relationship dimensions. These are genuine organizational strengths that strategy must protect and build upon.

I like the services I receive here: 63.6% strongly agree, 28.6% agree — 92.2% positive

If I had other choices, I would still get services from this agency: 53.0% strongly agree, 32.6% agree — 85.6% positive

I would recommend this agency to a friend or family member: 56.0% strongly agree, 35.7% agree — 91.7% positive

Staff believed that I can grow, change, and recover: 59.0% strongly agree, 28.4% agree — 87.4% positive

I felt comfortable asking questions about my treatment and medication: 59.5% strongly agree, 32.3% agree — 91.8% positive

I was given information about my rights: 57.1% strongly agree, 35.4% agree — 92.5% positive

I felt free to complain: 51.1% strongly agree, 35.1% agree — 86.2% positive

Access and Availability — HealthWest Scores

HSAG Overall — MHSIP Access Scores (HealthWest, n=384)

I would recommend this agency to a friend or family member: 4.39 average

The location of services was convenient: 4.37 average

Staff were willing to see me as often as I felt it was necessary: 4.44 average

Staff returned my calls within 24 hours: 4.27 average

Services were available at times that were good for me: 4.36 average

I was able to get all the services I thought I needed: 4.29 average

I was able to see a psychiatrist when I wanted to: 4.23 average

CCBHC Module — Access Scores (HealthWest, n=273)

The location of services was convenient: 4.41 average

Staff were willing to see me as often as I felt it was necessary: 4.49 average

Staff returned my calls within 24 hours: 4.31 average

Services were available at times that were good for me: 4.38 average

I was able to get all the services I thought I needed: 4.32 average

I was able to see a psychiatrist when I wanted to: 4.27 average

Critical Finding — Regional Crisis-vs-Established Access Gap

Across the five-CMHSP LRE region in FY25, crisis respondents scored significantly lower on the Access domain (61%) compared to respondents established in CSP and TCM programs (86%). This is regional data reported by LRE — it compares two service-type cohorts across the entire region, not two HealthWest-specific cohorts. LRE notes the pattern is common across regions: established CSP/TCM clients have built relationships,

regular medication management, and integrated care coordination; first-contact crisis clients have not. Some experience difference is expected.

The pattern is nonetheless directly relevant to HealthWest for two reasons. First, HealthWest is one of the five CMHSPs contributing to the regional aggregate, so the regional pattern reflects HealthWest's first-contact experience as part of the same population dynamic. Second, the Access and Crisis workgroup's independent root cause analysis (Section 6.2) identified first-contact system design — not staffing capacity — as the root cause of access friction at HealthWest. The internal diagnosis and the regional external pattern point in the same direction: the work calls for first-contact workflow redesign with cross-team workflow ownership, not staffing additions alone.

Treating the regional figure as a HealthWest-specific score would misstate the data. Treating the underlying first-contact design challenge as something other than a strategic priority would understate it.

Outcomes — MHSIP

MHSIP Outcomes — HSAG Overall (HealthWest, n=384)

I deal more effectively with daily problems: 4.16 average

I am better able to control my life: 4.20 average

I am better able to deal with crisis: 4.14 average

I am getting along better with my family: 4.16 average

I do better in social situations: 4.03 average

I do better in school and/or work: 4.17 average

My housing situation has improved: 4.03 average

CCBHC Module — Outcomes (HealthWest, n=273)

I deal more effectively with daily problems: 4.24 average

I am better able to control my life: 4.27 average

I am better able to deal with crisis: 4.25 average

I am getting along better with my family: 4.23 average

I do better in social situations: 4.13 average

I do better in school and/or work: 4.26 average

My housing situation has improved: 4.07 average

CCBHC Functioning Scores (HealthWest, n=258–262)

My symptoms are not bothering me as much: 42.2% strongly agree, 29.1% agree — 71.3% positive

I do things that are more meaningful to me: 45.8% strongly agree, 29.2% agree — 75.0% positive

I am better able to take care of my needs: 44.4% strongly agree, 34.5% agree — 78.9% positive

I am better able to handle things when they go wrong: 42.4% strongly agree, 35.5% agree — 77.9% positive

I am better able to do things that I want to do: 43.4% strongly agree, 36.0% agree — 79.4% positive

YSS Youth Results (HealthWest, n=32)

Outcomes

I am satisfied with the services my child received: 4.18 average

My child is better at handling daily life: 3.58 average

My child gets along better with family members: 3.65 average

My child gets along better with friends: 3.77 average

My child is doing better in school and/or work: 3.38 average

My child is better able to cope when things go wrong: 3.19 average

I am satisfied with our family life right now: 3.38 average

Access

The services my child and/or family received were right for us: 3.93 average

The location of services was convenient for us: 4.32 average

Services were available at times that were convenient for us: 4.25 average

My family got the help we wanted for my child: 3.71 average

My family got as much help as we needed for my child: 3.68 average

Staff respected my family's religious/spiritual beliefs: 4.54 average

CCBHC Social Connectedness — YSS (HealthWest, n=16)

Social Connectedness is the lowest-performing domain in the YSS region-wide and is flagged by LRE as a regional improvement priority. The HealthWest-specific responses below are consistent with that regional pattern.

I know people who will listen and understand me when I need to talk: 50.0% strongly agree, 43.8% agree, 6.3% undecided

I have people I am comfortable talking with about my child's problems: 62.5% strongly agree, 31.3% agree, 6.3% disagree

In a crisis, I would have the support I need from family or friends: 31.3% strongly agree, 37.5% agree, 6.3% undecided, 18.8% disagree, 6.3% strongly disagree

I have people with whom I can do enjoyable things: 37.5% strongly agree, 62.5% agree

The 'in a crisis, I would have support from family or friends' item shows 25.1% disagree or strongly disagree among HealthWest YSS respondents — the highest negative response of any social connectedness item. This indicates meaningful social isolation risk among youth in HealthWest services and aligns with the regional LRE-flagged improvement priority.

LRE Regional Improvement Priorities

The LRE FY25 Customer Satisfaction Survey identified these specific improvement priorities applicable to HealthWest as one of the five regional CCBHCs:

- YSS Social Connectedness: 'I know people who will listen and understand me when I need to talk' — flagged as lowest scoring for youth region-wide
- All populations: Involvement in consumer-led programs (support groups, drop-in centers, crisis phone line) — lower-scoring across all respondent groups region-wide
- Men: Scored lower on 'I am better able to deal with crisis' — gender-specific outcome gap region-wide
- Grievance focus areas (region-wide): Access and availability; quality of care; interaction with the provider or plan (highest grievance category region-wide)

Section 8. External Environment — PESTEL Analysis

The Board of Directors conducted a structured PESTEL exercise on April 18, 2026, analyzing the external environment through three scenario lenses: (1) Medicaid funding cuts, (2) privatization of Michigan's behavioral health system, and (3) MDHHS policy changes without stakeholder input. The following synthesizes those findings into a PESTEL framework with strategic implications.

Named Environmental Assumption (Approved May 1, 2026)

Medicaid funding pressure, threats to the public mental health system, and privatization risk have been formally designated by the Steering Committee as a PESTEL-level environmental assumption that conditions every issue and every pillar in the FY2027–2029 plan. They are not added as a 22nd strategic issue because they are conditions HealthWest operates within rather than problems HealthWest can directly solve. They are surfaced explicitly throughout this assessment, and the Environmental Conditions adopted at the Pillar Workshop confirm that pillar-level framing fully accounts for them.

Political — Risk Level: CRITICAL

- Federal funding priorities shifting — CCBHC funding, Medicaid, and other funds at risk
- State balanced budget pressures creating downstream MDHHS constraint
- Medicaid work requirements under federal consideration
- MDHHS policy changes without stakeholder input — Board identified as Scenario 3
- Privatization pressure on Michigan’s community-based CMH system — Board Scenario 2
- Federal policy changes (HR1 cited explicitly by Board)
- Less local input in silo decision-making at state level

Strategic implication: Protect CCBHC status, build advocacy capacity, develop policy monitoring and rapid-response capability

Economic — Risk Level: CRITICAL

- Medicaid redetermination impacting enrollment — potential revenue reduction
- Cost of services increasing faster than revenue growth (flagged in Operations SWOT)
- Direct Care Worker (DCW) wage pressures creating provider partner instability
- High inflation raising operational costs — IT equipment, facilities, benefits
- Qualified clinical applicant pool shrinking; increasing recruitment costs
- Capitation-to-FFS shift risk if privatization occurs — revenue model disruption

Strategic implication: Develop financial scenario models, build reserves, identify cost optimization levers, monitor enrollment weekly

Social — Risk Level: HIGH

- Housing instability directly increasing caseload acuity and crisis demand
- Growing unhoused population creating complex service needs
- Community needs outpacing organizational capacity — cited by 51% of staff
- Older workforce with increasing healthcare and retirement costs
- Medicaid work requirements creating access barriers for working-age adults
- Stigma limiting help-seeking and community understanding of behavioral health
- Generational expectations of younger workers differ from current culture

Strategic implication: Expand crisis continuum, deepen housing partnerships, build community education capacity

Technological — Risk Level: HIGH

- AI tools for clinical documentation and administrative efficiency emerging rapidly
- Smart technology scheduling portals reducing access barriers
- EHR optimization opportunities not yet fully realized
- Cybersecurity threats growing faster and more sophisticated — highest-voted threat in Data SWOT (6 votes)
- Increased costs for IT equipment, software licensing, and cloud services
- Data governance and interoperability gaps limiting cross-system care coordination

Strategic implication: Prioritize AI/automation investment, build IT resilience foundation, address cybersecurity governance

Environmental / System Conditions — Risk Level: HIGH

- Privatization would shift care from holistic, community-driven model to transactional approach
- Under privatization: more admin costs, ‘any willing provider’ dynamics, change in medical necessity definitions
- CCBHC and standard Medicaid service variances creating operational confusion and extra work
- Prevention services disappearing — reducing upstream impact and future demand management
- More uninsured individuals as Medicaid eligibility tightens
- Increase in lawsuits and recipient rights challenges if service quality deteriorates

Strategic implication: Maintain CCBHC excellence, protect prevention investments, build public-facing quality narrative

Legal / Regulatory — Risk Level: MEDIUM

- Expanding compliance mandate requirements consuming staff capacity
- Conflicting CCBHC and standard MDHHS standards creating compliance complexity

- 'Freedom to Work Act' provisions — limited staff knowledge creating equity risk
- Contracts with managed care organizations if privatization advances
- Increased administrative burden for billing, prior authorizations, and documentation under potential privatization

Strategic implication: Strengthen compliance infrastructure, invest in policy literacy, monitor legislative changes

Board-Identified Early Warning Indicators

Medicaid Funding Cuts — Watch For

- Rising Medicaid no-show rates or consumers communicating about Medicaid end dates
- Increased acuity and more severe symptom presentations at intake
- Emergency department utilization increases; inpatient utilization growth
- Shelter attendance and homelessness indicators rising in Muskegon County
- Law enforcement involvement with behavioral health consumers increasing
- Food pantry utilization, indigent care costs, overdose rates, and retail fraud as population stress indicators

Privatization — Watch For

- Reduction in room for contract negotiations with MDHHS
- Less community input into service design and policy direction
- Cash flow disruptions; changes in prior authorization and clean claim rates
- Enrollment shifts; administrative burden metrics increasing
- Separation of residential, physical, and mental health service contracting

MDHHS Policy Changes Without Input — Watch For

- Staff turnover spikes and burnout indicators following policy announcements
- System changes announced without adequate transition time
- Decrease in staff trust scores and engagement signals
- 'Silo decision making' — the Board explicitly named this as a downstream consequence, connecting external policy disruption to the internal coordination diagnosis

Section 9. External Environment — Porter's Five Forces

While HealthWest operates as a public safety-net provider rather than a traditional for-profit competitor, Porter's Five Forces framework illuminates the competitive and structural dynamics shaping its strategic position. This analysis is adapted for the behavioral health public-sector context.

Threat of New Entrants / Substitutes — Intensity: MODERATE, Rising

Private behavioral health practices, telehealth platforms, and managed care organizations could absorb mild-to-moderate need clients if privatization advances, potentially reducing CCBHC enrollment volume. ‘Any willing provider’ models under privatization would enable lower-cost entrants with lower regulatory burden. However, HealthWest’s safety-net mandate, CCBHC designation, and specialized services (ACT, IDD, SED, crisis) create structural barriers for competitors serving complex needs.

Bargaining Power of Buyers — Funders/MDHHS/PIHPs — Intensity: HIGH

MDHHS and the PIHP structure give state-level buyers significant pricing and service-definition power. Medicaid rules, CCBHC performance standards, and capitation structures are set externally. Under privatization, health plan medical loss ratio requirements could further limit service-level flexibility. The Board explicitly identified this as a critical risk: ‘less room for negotiations; less input from community.’

Bargaining Power of Suppliers — Workforce and Vendors — Intensity: HIGH

Qualified behavioral health clinicians are in limited supply nationally and regionally. HealthWest competes against private practice (better pay, lower complexity), hospitals, and telehealth firms for talent. Credentialed staff carry significant bargaining leverage. IT vendor power is rising — EHR vendors can decline feature requests; equipment and licensing costs are increasing. DCW wage pressures in the provider partner network compound systemic fragility.

Threat of Substitute Services — Intensity: MODERATE

Emergency departments, law enforcement crisis response, and informal community supports serve as substitutes when HealthWest services are inaccessible or delayed. Telehealth-only behavioral health providers compete for mild-moderate need clients with insurance. Prevention service reductions increase future crisis demand but reduce upstream engagement touchpoints.

Competitive Rivalry — Intensity: LOW–MODERATE

As a CMHSP with a geographic service mandate, HealthWest does not face traditional market competition for its core population. Competition intensifies in specific areas: recruiting licensed clinicians; attracting school-based service contracts; positioning for CCBHC quality bonuses; and retaining contracted provider partners who face ongoing financial pressure.

Porter's Summary Insight

HealthWest's strongest competitive position comes from its mission lock-in (safety-net mandate), CCBHC designation, long-standing community trust, and breadth of integrated services. Its greatest structural vulnerabilities are funding buyer concentration (MDHHS/Medicaid) and workforce supplier scarcity. Strategy must protect the differentiated, community-based model while aggressively building financial resilience and workforce pipeline to reduce these structural dependencies.

Section 10. Internal Assessment — Consolidated SWOT

The following consolidated SWOT synthesizes findings from seven workgroup domain SWOTs, a Board of Directors SWOT exercise, staff and partner surveys, the consumer focus group, and the FY25 regional consumer satisfaction data. Items reflect the most frequently cited and highest-voted themes across all inputs.

Strengths

- Mission-driven, passionate staff — highest-voted strength across 5 of 7 domain SWOTs
- 92%+ HealthWest consumer recommendation rate and service satisfaction — genuine competitive differentiator
- The HealthWest Way — cultural framework launched; genuine effort recognized by staff (6 votes in Workforce SWOT)
- CCBHC designation enabling enhanced reimbursement, quality bonus, and expanded scope
- Crisis services strength — Warmline, Urgent Care, ICS, mobile response cited in Clinical Quality SWOT (4 votes)
- Improving culture of safety, trust, and listening — feedback mechanisms valued by staff
- Leadership forward-thinking on technology and data — building dashboards, preparing for AI
- Strong data and analytics team; desire to do good work cited in Data/Tech SWOT (6 votes)
- Culture of learning and growth — highest Operations/Finance strength (7 votes)
- Retention and development supports — tuition, PSLF, stipends, internship program valued
- Admin departments communicate and work well together — Equity/Compliance SWOT (5 votes)
- Long-standing community relationships — 59% of partners with HealthWest 8+ years
- CCBHC Quality Bonus earned — $1.06M for FY24; evidence of measurable clinical excellence
- Staff believed I can grow, change, and recover: 87.4% positive HealthWest consumer rating

Weaknesses

- Supervisory skill sets underdeveloped for leadership roles — Workforce SWOT (6 votes); named as the explicit root cause of Workforce Issue 1 in root cause analysis
- Communication failures across teams — top barrier in every domain; staff survey: 55%; surfaced as a root cause condition in seven independent workgroup analyses
- ‘Old culture’ norms persisting — favoritism, fear-based decision-making
- Too many inconsistent requirements across departments — Operations SWOT (7 votes)

- Bureaucracy slowing decision-making and responsiveness — Operations SWOT (6 votes)
- Too many steps to access services — systemic friction at every entry point — Access SWOT (7 votes)
- Siloed service delivery — teams not moving as one — Clinical Quality SWOT (4 votes); root-cause finding in 5 of 7 workgroups
- Out of compliance / repeat audit findings — Equity/Compliance SWOT (6 votes); Equity root cause analysis traced to handoff ownership gaps; refined Issue #12 reframes this as systemic vulnerabilities and root-cause resolution
- No unified HRIS — reliance on spreadsheets slowing hiring and workforce decisions
- EHR limitations and manual data entry creating errors and staff burden
- Regional crisis access pattern (LRE FY25): crisis respondents region-wide score 25 points lower on access than CSP/TCM respondents (61% vs. 86%) — the Access workgroup's independent root cause analysis identifies first-contact system design as the underlying condition at HealthWest
- Youth social connectedness is the lowest-performing YSS domain region-wide; among HealthWest YSS respondents, 25% disagree they would have crisis support from family or friends
- Staff confidence in consistent quality across programs: 5.2/10 — lowest staff survey score
- Interaction with provider is the highest regional grievance category
- Poor follow-through on commitments — cited in Community Partnership and Data SWOTs

Opportunities

- AI adoption for clinical documentation, compliance auditing, and administrative efficiency — highest-voted opportunity in multiple SWOTs
- CSU (Crisis Stabilization Unit) development — highest-voted opportunity in Access/Crisis SWOT (6 votes)
- Cross-department collaboration — highest single issue vote in Workforce and Culture SWOT (6 votes)
- Unified HRIS implementation — strong interest to modernize HR infrastructure
- Consumer-led program expansion — LRE-identified regional improvement target; directly connected to social connectedness gap
- Closing the regional crisis access pattern — measurable, CCBHC-relevant improvement target with first-contact redesign as the lever
- Expanded community partnerships and remote intake access points (schools, police depts, jails)
- Grants and external funding for IT, workforce development, and service innovation
- Improved integrated care — whole-person model deeper integration across MH and SUD

- Data-sharing and interoperability advances enabling more seamless care coordination

Threats

- Medicaid funding cuts and federal/state political climate — highest-voted threat in 6 of 7 domain SWOTs; now formally named as an environmental assumption conditioning every pillar
- Cybersecurity threats growing faster and smarter — Data SWOT (6 votes)
- Workforce shortages and lack of qualified applicants regionally — Workforce SWOT (3 votes)
- Privatization of Michigan behavioral health system — Board Scenario 2; part of the named environmental assumption
- Cost of services exceeding revenue growth — financial sustainability risk
- State and federal regulatory changes without adequate transition support
- Housing instability and unhoused population growth increasing caseload acuity
- Loss of community partners due to provider funding constraints and rate inadequacy
- Youth school and work outcome gaps — ‘my child is doing better in school and/or work’ scores 3.38 on YSS at HealthWest, below positive threshold
- Men scoring lower on crisis coping outcomes region-wide — LRE-flagged regional equity finding
- Regional grievance concentration in access, quality, and provider interaction categories

Section 11. Domain-by-Domain SWOT Findings

Each of HealthWest's seven cross-functional workgroups conducted a structured SWOT analysis. Dot votes indicate participant emphasis. The following presents each domain's highest-voted items.

Workforce and Culture

Strengths

- Genuine, visible effort to improve organizational culture — follow-through recognized by staff (6 votes)
- Passionate, mission-driven staff committed to the work (5 votes)
- Active listening mechanisms — hot seats, comment boxes, surveys
- Retention and development supports — PSLF, HRSA loan forgiveness, tuition reimbursement, stipends

Weaknesses

- Supervisory skill sets not adequately developed for leadership — promoted without sufficient training (6 votes)
- Communication among and between teams — persistent, multi-layer problem (5 votes)
- ‘Old culture’ norms persisting — favoritism, tenure-based status, ‘good ole boys’ mentality (3 votes)
- No unified HRIS — reliance on spreadsheets slowing hiring, creating data gaps

Opportunities

- Cross-collaboration — single highest individual issue vote (6 votes)
- HRIS implementation — modernize hiring, onboarding, and workforce planning
- External training, conferences, and formalized leadership development pipelines

Threats

- Political environment and government funding uncertainty — most-voted threat (6 votes)
- Regional workforce shortage and lack of qualified behavioral health applicants (3 votes)
- Rising cost of health coverage and benefits threatening retention

Access and Crisis Response

Strengths

- Staff that genuinely cares and goes above and beyond — highest-voted strength (8 votes)
- Beginning to improve inter-departmental communication and collaboration (6 votes)
- Creativity in problem-solving; person-centered care prioritizing consumer needs

Weaknesses

- Too many steps required to access one thing — core system design failure (7 votes)
- Lack of communication across and between teams (3 votes)

- Unclear role definition — ‘who does what’ confusion internally and externally

Opportunities

- CSU (Crisis Stabilization Unit) development — highest-voted opportunity (6 votes)
- Expanded community partnerships to build trust and improve crisis response (5 votes)
- SUD detox capacity expansion (3 votes); more intake access points in community (2 votes)

Threats

- Funding constraints (5 votes) and provider/staffing shortages (5 votes) — tied as highest threats
- ‘Old thinking — we’ve always done it this way’ creating organizational resistance (3 votes)

Clinical Quality and Service Delivery

Strengths

- Crisis services — Warmline, Urgent Care, CRU — cited as top strength (4 votes)
- Improving culture and communication; use of data and analytics (3 votes)
- Caring and compassionate clinical staff

Weaknesses

- Siloed teams — working toward same goal but not moving as one (4 votes)
- Streamlining paperwork and workflows needed (3 votes)
- Admin requirements making staff task-oriented over clinically minded (2 votes)

Opportunities

- Maximize use of AI for clinical documentation and decision support (3 votes)
- Improved integrated care — whole-person model (3 votes)
- Funding Crisis Continuum through community collaboration — CSU

Threats

- Political climate and impact on funding — most-voted threat (4 votes)
- Housing instability directly increasing caseloads and service complexity (3 votes)
- Unable to remain competitive on clinician pay — talent flight to private practice (2 votes)

Equity, Compliance and Risk

Strengths

- Administrative departments communicate and work well together (5 votes)
- Technology and process change tools available; education-focused culture (2 votes)

Weaknesses

- Out of compliance — repeat audit findings persist despite corrective actions (6 votes); refined Issue #12 reframes this as systemic vulnerabilities and root-cause resolution
- No cross-departmental database for research and information storage (5 votes)

- Cross-disciplinary communication and understanding gaps (3 votes)

Opportunities

- AI for auditing, compliance monitoring, and risk identification — highest-voted opportunity (7 votes)
- Creative and continual training — including external partners in HealthWest Way training (6 votes)

Threats

- Funding loss — most-voted threat (6 votes)
- Inconsistent and unclear direction from MDHHS and LRE creating compliance ambiguity (4 votes)

Community Partnerships

Strengths

- Data gathering capability to support additional needs identification and funding applications (3 votes)
- Drive to be a valuable community resource; building out locations in schools and youth settings (2 votes)

Weaknesses

- Services not well-known in the community despite HealthWest name recognition (3 votes)
- Poor follow-through on commitments (3 votes)
- Lines of communication not always clear; some partners see HealthWest as a barrier (2 votes)

Opportunities

- Collaboration with other community organizations — highest-voted opportunity (4 votes)
- Data growth to share and gather community needs — tied highest (4 votes)

Threats

- Funding — most-voted threat by significant margin (6 votes)
- Government and political environment (5 votes)

Data, Technology and EHR

Strengths

- Staff knowledge and skill — tied for highest-voted strength (6 votes)
- Desire to do good work — tied highest (6 votes)
- Leadership forward-thinking, preparing for future technology investments (3 votes)

Weaknesses

- Not following through — most-voted weakness (5 votes)
- EHR limitations — unable to develop internally; vendor can refuse requests (3 votes)

- Knowledge silos — different teams hold parts of responsibilities without coordinating (2 votes)

Opportunities

- AI use — highest-voted opportunity (6 votes)
- Grants and external funding for IT and technology initiatives (5 votes)

Threats

- Cybersecurity threats growing smarter and faster — highest-voted threat (6 votes)
- State and federal regulations and funding changes impacting IT investment (5 votes)

Operations, Finance and Business Sustainability

Strengths

- Culture of learning and growth — highest-voted strength (7 votes)
- People and staff resilience (3 votes)

Weaknesses

- Too many requirements that are inconsistent across departments — highest-voted weakness (7 votes)
- Bureaucracy slowing responsiveness and decision-making (6 votes)

Opportunities

- Technology advancements to improve efficiency — highest-voted opportunity (5 votes)
- Process improvement skills and KATA model as internal change infrastructure (4 votes)

Threats

- Medicaid changes — highest-voted threat (6 votes)
- Funding availability and state/federal law changes (5 votes)
- Cost of service exceeding revenue growth; qualified clinical applicant pool shrinking (2 votes)

Section 12. Voice of Staff, Partners, and Consumers

Staff Survey — Quantitative Findings (n=182)

Organizational Performance Ratings (0–10 scale)

Team Effectiveness: 7.6/10

HealthWest Way Treatment Frequency: 7.1/10

Morale on Team: 6.9/10

Ease of Data Access: 6.9/10

Operational Efficiency: 6.7/10

Ease of Service Access (staff-rated): 6.1/10

Confidence in Consistent Quality Across All Programs: 5.2/10 — lowest score in survey

Top Barriers to Effective Work

Communication gaps within or across teams: 100 of 182 staff (55%) — single highest-ranked barrier

High workload or competing priorities: 80 staff (44%)

Inefficient or unclear workflows: 67 staff (37%)

Staffing shortages or vacancies: 62 staff (34%)

Top Improvement Priorities

Improved communication systems: 116 of 182 staff (64%) — single highest-ranked improvement priority

Streamlined workflows: 114 staff (63%)

Staff training and development: 71 staff (39%)

Data-driven decision-making: 48 staff (26%)

New or additional service offerings: 47 staff (26%)

Top Stress Factors

High workload/caseload: 109 of 182 staff (60%)

Staffing shortages or turnover: 82 staff (45%)

Communication gaps or lack of timely information: 73 staff (40%)

Frequent changes in expectations, policies, or priorities: 64 staff (35%)

Inefficient or unclear workflows: 56 staff (31%)

Top External Pressures

Regulatory/compliance requirements: 100 of 182 staff (55%)

Community needs outpacing capacity: 93 staff (51%)

Workforce shortages in the field: 82 staff (45%)

Funding constraints: 59 staff (32%)

Staff Focus Groups — Customer Experience Team (April 2026)

Two focus groups were conducted with members of the agency's Customer Experience Team — staff serving rotating six-month terms with explicit responsibility to identify ways the HealthWest Way can improve agency performance. Participants were drawn from administration, nursing, supervision, HR, case management, clinician, and clerical functions, providing a deliberate cross-section of agency roles. The Monday and Thursday cohorts met separately and independently produced the same top-priority themes: culture, recruitment and retention, and process management — with communication and supervisor capability surfacing as cross-cutting conditions on every other priority.

On Communication and Collaboration Across Teams

"Communication between teams must improve." — Staff Focus Group, Monday cohort

"The ever-changing program referral guidelines evolve continuously to meet client needs, but is not communicated out." — Staff Focus Group, Monday cohort

On Supervisor Capability and Modeling the HealthWest Way

"No one taught you when you became a new supervisor how to implement this at a meeting or how to talk about it at a meeting." — Staff Focus Group, Monday cohort

"With the lack of modeling or the lack of education or support given to new supervisors on how to do this, why has that not been addressed by the agency at this point?" — Staff Focus Group, Monday cohort

"We need our supervisors to buy in." — Staff Focus Group, Monday cohort

On Training and Follow-Through

"Actually do what you're trained to do based on the trainings instead of going to the training and ignoring it." — Staff Focus Group, Thursday cohort

On Workload and Defining the Safety Net

"You hear it even from leadership, we are the safety net of the community... meaning we've got to catch everything, do everything. And do we have to? Maybe we better well define what that safety net is." — Staff Focus Group, Thursday cohort

"So, it's like, yes, we feel like I might be doing too much, but guess what? We're the best at doing too much." — Staff Focus Group, Thursday cohort

"You don't have to come into a role and then feel like you're being thrown a bunch of things and you weren't aware of it." — Staff Focus Group, Thursday cohort

On Retention and Industry Context

"People leave and one of the things they say in their exit is that my training was not, I didn't feel prepared for the work." — Staff Focus Group, Thursday cohort

Convergence With the Diagnosis

The two focus groups produced findings that converge directly with the seven workgroup root cause analyses, the staff survey, the partner survey, the consumer focus group, and the Board SWOT. The Monday cohort's discussion of supervisor buy-in for the HealthWest Way arrived at the same root cause as the Workforce and Culture workgroup: supervisory development has not been resourced or modeled at the agency level. The Thursday cohort's discussion of workload arrived at the same root cause as the Operations and Workforce workgroups: no organizational function owns the work of pruning, redefining, and prioritizing scope as community pressure expands. That a pair of independently-convened focus groups, on different days, drawn from a deliberate cross-section of agency functions, surfaced the same architecture-level findings as the rest of the planning process is itself part of the convergent evidence supporting the diagnosis in Section 1.

Partner Survey — Key Findings (n=41)

Partners represented hospitals, contracted MH/SUD/IDD providers, schools, AFC/residential providers, law enforcement, and public health agencies. 59% have partnered with HealthWest for 8 or more years.

Performance Ratings

Overall Partnership Strength: 6.9/10 average

Coordination Consistency: 6.9/10 average

Timeliness of Access: 6.8/10 average

Crisis Coordination Effectiveness: 7.1/10 average

Administrative Efficiency: 7.1/10 average

Top Challenges

Top Collaboration Barrier: Communication gaps — named by 20 of 41 partners (49%)

Top Coordination Challenge: Turnover and changing contacts — named by 21 of 41 partners (51%)

Top Operational Barrier: Lack of clarity on processes — named by 13 of 41 partners (32%)

Representative Partner Quotes

"Turnover for Supports Coordinators affects the clients we support tremendously. We never know who to contact and neither do they. The new Support Coordinators are not trained on what their role is." — Contracted Provider, Partner Survey 2026

"Inconsistencies across multiple counties. If someone moves, it's terrible. We have had more success with other counties. When isn't everyone in our region operating in the same way, and why is there such a communication breakdown across counties?" — Community Partner, Partner Survey 2026

"There is a shared desire to be a positive support to our community and a desire to see improved outcomes. Our collaboration needs stronger communication and coordination." — School-Based Partner, Partner Survey 2026

"More communication and collaboration on meeting community needs — working together, not against each other." — Community Partner, Partner Survey 2026

Board of Directors — Strategic Priority Ranking

1 (tied). Protect community-based holistic care model from privatization: 9 votes

1 (tied). Strengthen strategic partnerships and community alignment: 9 votes

3. Build policy influence and state-level advocacy capacity: 8 votes

4. Leverage technology and AI to improve efficiency: 7 votes

5. Stabilize and sustain the workforce: 6 votes

6. Expand and optimize crisis and urgent care services: 3 votes

Consumer Focus Group — Key Findings (April 8, 2026)

The following quotes are taken directly from the focus group transcript and verified against the source document.

How Consumers Described Services

"I feel accomplished. From knowing where I was at to where I'm at now — that sense of accomplishment." — Consumer 2

"I feel great. My treatment is doing good. I feel focused." — Consumer 3

What Helped Most

"Everybody that I have come across … has always taken time with me." — Consumer 3

"The employees have accepted me. The training I've received since January 2018 on the board and now with my internship has helped me grow as a person and helped me help others." — Consumer 5

What They Would Change

"Number one, the communication. The separation of the communication. My team don't communicate. They just push it forward. What could you change? Try to have the staff members communicate." — Consumer 3

"Communication would really be beneficial. It almost seems like you have to pry to get to those services." — Consumer 2

“The employee turnover has been a real problem. I had just signed on to services, been given a case manager and a recovery coach — and then they were gone. I didn’t know who to contact.” — Consumer 2

“Communication. Even though on the board we’ve been working on the communications issue for a couple of years now, there’s still problems. The biggest thing is not just communication between staff and client — it’s staff and staff.” — Consumer 5 (Consumer Advisory Committee member)

Facilitator Meeting Closing Summary

“There’s been a whole bunch of different ways of communication that’s come up — whether it’s staff not communicating together, staff not communicating with you, staff not communicating with other medical professionals. Communication seems like a big thing on the negative side. On the positive side, many of you talked about the positive relationships you’ve built with people here, and how important that was.”

Appendix A. Refined Strategic Issue Set — 21 Issues

This appendix presents the full text of the 21 refined strategic issues approved by the Steering Committee. The validated set contained 22 issues; the refined set contains 21. One merger and three reframes are documented in the change notes below each issue. Substance was preserved in every case.

Issues marked [REFRAMED] include sharpened or expanded language; [RENUMBERED] indicates sequence change only with no substantive edit. Source: original workgroup-authored statements and rationales, refined per Steering Committee validation feedback.

Two Items Resolved by Executive Decision

Issue #15 (Facilities Capacity & Physical Infrastructure Constraints) was retained as a strategic issue rather than reframed as an operational assumption. The Operations workgroup identified facilities as a hard constraint on growth; reframing as an assumption would remove visibility for capital planning.

Medicaid funding pressure, public mental health system threats, and privatization risk are treated as a PESTEL-level environmental assumption that conditions every issue and pillar, surfaced explicitly in the Strategic Assessment Summary narrative and addressed through the Environmental Conditions adopted at the Pillar Workshop. Not added as a 22nd issue.

Access & Crisis Response

Issue #1 — Efficient, Timely Access to Care at First Contact

Domain: Access & Crisis Response

Issue Statement: People seeking crisis or urgent behavioral health support are not consistently able to begin appropriate care at first contact, resulting in delays, repeated handoffs, and inefficient use of access and crisis resources.

Change from validated set: *No change. 12 of 14 reviewers approved as-is.*

Issue #2 — Internal Coordination & Continuity of Care Across Access, Crisis, and Treatment

Domain: Access & Crisis Response

Issue Statement: Care coordination across Access, crisis response, and treatment teams is inconsistent, creating handoff gaps, duplicated work, and disruptions in continuity of care.

Change from validated set: *No change. 11 of 14 reviewers approved as-is.*

Issue #3 — Role Clarity, Training, and Education Across the Access System [REFRAMED]

Domain: Access & Crisis Response

Issue Statement: Inconsistent role clarity, training, and education — both internally and across community and emergency partners — leads to inappropriate service use, delayed responses, and inefficiencies across the access and crisis system. This issue addresses standardization at the point of hire and onboarding (job descriptions, postings, expectations) as well as ongoing role definition for staff and external partners.

Change from validated set: *Reframed. 6 of 14 reviewers flagged this for merge or refinement; 1 voted not to advance. Sharpened to (a) explicitly include HR-upstream framing per recommendation that role clarity and training begin at job description, posting, and hiring, and (b) clarify the internal/external scope. Substantive issue preserved.*

Clinical Quality & Service Delivery

Issue #4 — Clinical Workflow & Documentation Excellence

Domain: Clinical Quality & Service Delivery

Issue Statement: Clinical workflows, documentation requirements, and utilization management expectations are not consistently aligned across programs, creating inefficiencies that reduce available provider time, complicate service delivery, and limit the organization's ability to deliver timely, high-quality care.

Change from validated set: *No change. 13 of 14 reviewers approved as-is.*

Issue #5 — Clinical Skill Strengthening & Consistent Evidence-Based Practice

Domain: Clinical Quality & Service Delivery

Issue Statement: Clinical skill development and evidence-based practice implementation are not consistently supported across programs, leading to variation in care quality, staff confidence, and fidelity to evidence-based models.

Change from validated set: *No change. 11 of 14 reviewers approved as-is.*

Issue #6 — Cross-Departmental Collaboration to Maximize Staff Resources

Domain: Clinical Quality & Service Delivery

Issue Statement: Staff capacity is not being fully leveraged across departments due to limited cross-department collaboration, flexible deployment, and shared resource models, reducing the organization's ability to respond efficiently to demand and increasing strain during periods of staffing constraint.

Change from validated set: *No change. 10 of 14 reviewers approved as-is. Reviewers noted thematic adjacency to Workforce & Culture cross-team communication; cross-domain linkage will be addressed at the pillar level rather than through merger.*

Data, Technology & EHR

Issue #7 — Core IT Operations Resilience & Continuity

Domain: Data, Technology & EHR

Issue Statement: Core IT operations face resilience and continuity risks that threaten system reliability, regulatory compliance, and the organization's ability to sustain day-to-day clinical and operational work.

Change from validated set: *No change. 12 of 14 reviewers approved as-is.*

Issue #8 — Cybersecurity, Data Governance, and Risk Management

Domain: Data, Technology & EHR

Issue Statement: Evolving cybersecurity threats and unclear data governance responsibilities increase organizational risk while complicating secure, appropriate access to systems and information.

Change from validated set: *No change. 13 of 14 reviewers approved as-is.*

Issue #9 — Making Work Easier Through Automation and Intelligent Tools

Domain: Data, Technology & EHR

Issue Statement: Current technology systems and utilization thereof do not sufficiently reduce manual effort or cognitive load, limiting staff productivity and diminishing the return on existing and future technology investments.

Change from validated set: *No change. 13 of 14 reviewers approved as-is.*

Equity, Compliance & Risk

Issue #10 — Personal Responsibility for Compliance, Documentation, and Policy Adherence

Domain: Equity, Compliance & Risk

Issue Statement: Inconsistent individual accountability for following policies, procedures, and documentation standards increases compliance risk, contributes to quality variation, and weakens the organization's ability to sustain audit readiness and equitable practice across programs.

Change from validated set: *No change. 11 of 14 reviewers approved as-is.*

Issue #11 — Shared Responsibility & Cross-Department Accountability for Compliance

Domain: Equity, Compliance & Risk

Issue Statement: Compliance and quality risks persist because responsibility for required tasks and oversight is diffused across departments, resulting in workflow gaps at handoffs, unclear ownership, and increased risk of errors and repeat audit findings.

Change from validated set: *No change. 9 of 14 reviewers approved as-is.*

Issue #12 — Systemic Compliance Vulnerabilities & Root-Cause Resolution [REFRAMED]

Domain: Equity, Compliance & Risk

Issue Statement: The organization continues to experience repeat audit findings, indicating that underlying compliance vulnerabilities are not being fully resolved at root cause despite corrective actions and training. Sustained improvement requires addressing the systemic conditions that allow findings to recur, not only the findings themselves.

Change from validated set: *Reframed. 6 of 14 reviewers flagged this for merge or refinement. Title and statement refined to shift framing from 'repeat audit findings' (an outcome) to systemic vulnerabilities and root-cause resolution (a system condition). Substantive issue preserved.*

Operations, Finance & Business Sustainability

Issue #13 — Staff Capacity, Workload, and Effectiveness

Domain: Operations, Finance & Business Sustainability

Issue Statement: Current staffing levels, workload expectations, and role design limit staff effectiveness and sustainability, reducing the organization's ability to operate efficiently, support quality services, and meet growing operational and service demands.

Change from validated set: *No change to issue statement. 12 of 14 reviewers approved as-is. Steering Committee adopted parallel guardrail ('HealthWest will not address staff capacity, workload, or effectiveness by trading one of these dimensions for another') per recommendation; the issue is retained as written and the guardrail is adopted alongside it.*

Companion Guardrail to Issue #13

HealthWest will not address staff capacity, workload, or effectiveness by trading one of these dimensions for another. Goals and initiatives that affect any of the three must be evaluated against their impact on the other two.

Issue #14 — Internal Cost Structure and Operational Optimization

Domain: Operations, Finance & Business Sustainability

Issue Statement: Internal cost structures and operational processes are not consistently aligned with revenue growth and service priorities, creating inefficiencies and increasing long-term sustainability risk.

Change from validated set: *No change. 12 of 14 reviewers approved as-is.*

Issue #15 — Facilities Capacity & Physical Infrastructure Constraints

Domain: Operations, Finance & Business Sustainability

Issue Statement: Current facilities and physical infrastructure limit program growth, staff capacity, and the organization's ability to respond effectively to community demand, creating a structural constraint on future service expansion.

Change from validated set: *No change to issue statement. 13 of 14 reviewers approved as-is. Executive decision: reviewer proposal to reframe Issue #15 as an operational assumption was considered and declined. The Operations workgroup identified facilities as a hard constraint on growth, not a maintenance concern; reframing as an assumption would remove visibility for capital planning. Issue retained as a strategic issue.*

Workforce & Culture

Issue #16 — Relationships, Trust, and Psychological Safety [REFRAMED]

Domain: Workforce & Culture

Issue Statement: Trust, communication, and psychological safety are not experienced consistently across the organization, limiting staff engagement, openness, and well-being, and reducing the organization's ability to sustain a healthy, high-performing workforce. This issue now also encompasses the cross-team communication and collaboration concerns previously elevated as a separate issue.

Change from validated set: *Reframed to absorb merged Issue #18 (Cross-Team Communication & Collaboration). Original substance preserved; scope expanded to include cross-team communication and collaboration as integral to a healthy workplace culture. 8 of 14 reviewers flagged the prior cross-team communication issue for merge — the only issue with a majority signal for consolidation.*

Issue #17 — Staff Retention & Workforce Stability

Domain: Workforce & Culture

Issue Statement: HealthWest experiences ongoing challenges with staff retention and workforce stability driven by workload pressures, morale, compensation concerns, and perceived organizational support, creating strain on remaining staff and disrupting service continuity.

Change from validated set: *No change. 12 of 14 reviewers approved as-is.*

Community Partnerships

Issue #18 — Information Flow and Communication Between HealthWest and Partners [RENUMBERED]

Domain: Community Partnerships

Issue Statement: Information sharing and communication between HealthWest and community partners is inconsistent, reducing alignment, responsiveness, and effective coordination of services.

Change from validated set: *Renumbered from #19 (no substantive change). 10 of 14 reviewers approved as-is.*

Issue #19 — Clarity, Coordination, and Governance of Community Partnerships [REFRAMED]

Domain: Community Partnerships

Issue Statement: Community partnerships are not consistently coordinated, clearly defined, or governed, resulting in fragmented collaboration, duplicated efforts, unclear ownership, and missed opportunities to improve outcomes. Strengthening partnership governance and role clarity is foundational to advancing other partnership work.

Change from validated set: *Renumbered from #20 and reframed. 6 of 14 reviewers flagged for merge or refinement. Title and statement sharpened to make partnership governance and ownership explicit. Issues retained as separate to preserve workgroup intent that 4 issues advance from this domain.*

Issue #20 — Visibility and Awareness of HealthWest Services in the Community [RENUMBERED]

Domain: Community Partnerships

Issue Statement: Limited visibility and understanding of HealthWest's services among community partners and the public reduces effective referrals, collaboration, and appropriate use of services.

Change from validated set: *Renumbered from #21 (no substantive change). 11 of 14 reviewers approved as-is.*

Issue #21 — Alignment of Partnerships With Community Needs and Gaps [RENUMBERED]

Domain: Community Partnerships

Issue Statement: Community partnerships are not consistently aligned with the most significant unmet needs and service gaps, limiting their overall impact on community outcomes.

Change from validated set: *Renumbered from #22 (no substantive change). 9 of 14 reviewers approved as-is.*

Merged Issue — Documented for Transparency

Cross-Team Communication & Collaboration (former #18) [MERGED into #16]

Status: Merged into Issue #16 (Relationships, Trust, and Psychological Safety).

Change from validated set: *8 of 14 reviewers flagged for merge — the only issue with a majority signal for consolidation. Multiple reviewers identified relationships/trust and cross-team communication as a single underlying culture issue. Substance preserved within the expanded culture issue.*

Principles That Guided Refinement

Three principles guided every refinement from the validated set to the approved set:

- **Domain ownership:** Each issue remains in the domain that elevated it. No issue was relocated across domains.

- **Substance preservation:** Reframes sharpen language but do not change the underlying concern. Workgroup rationales for each elevated issue continue to apply.
- **Workgroup count integrity:** The Community Partnerships workgroup intentionally elevated 4 issues (per their Top Issues memo, due to a tie). That count was preserved despite reviewer overlap concerns.

HealthWest Behavioral Health — Strategic Assessment Summary — FY2027–2029 Planning Cycle
May 2026 — Prepared by the Strategic Planning Facilitation Team

May 29, 2026

MEETING NOTICE JUNE 2026

The HealthWest Board will meet in the following sessions during the month of June 2026. Please remember we must have a quorum in person for these meetings. If you participate remotely, your vote will not count. If you have any questions, please let me know.

Program Personnel Committee	Friday, June 5, 2026
Recipient Rights Committee	Friday, June 5, 2026
Finance Committee	Friday, June 12, 2026
Full Board Meeting	Friday, June 26, 2026

The administrative office will contact you via email to remind you of these meetings.

The complete schedule of committee and board meetings for 2026 can be found online at https://healthwest.net/board-agendas-minutes-2026/

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cc: HealthWest Board Members

MEMORANDUM

Date: 05/29/2026

To: HealthWest Board of Directors

CC: Mark Eisenbarth, Muskegon County Administrator
Matt Farrar, Muskegon County Deputy Administrator
Angie Gasiewski, Muskegon County Finance Director

From: Rich Francisco, Executive Director

Subject: **Director's Update**

MDHHS Updates:

- **RFP update**. On January 8th, Judge Yates ruled that MDHHS had the legal authority to proceed with procurement but also ruled in favor of the CMHSPs that the RFP released in August 2025 violated Michigan law, which prevents CMHSPs from conducting their required statutory functions. Later, on April 13th, MDHHS requested a hearing to dismiss the case as moot because they had withdrawn the RFP altogether. Judge Yates then had to consider whether to dismiss the case with or without prejudice. The judge finally ruled to dismiss the case without prejudice. The CMHSPs have already filed an appeal of the ruling.

- An update on the **MHF (Mental Health Framework)** initiative. I have updated the board that MDHHS was rolling out a new health benefit called BH-COVER as part of the Mental Health Framework. This gives health plans access to screening individuals in crisis, partial hospitalization, and inpatient screening. This effort effectively privatizes a large segment of services that CMHSPs manage. This change would have introduced complications to crisis services coordination in a system already managed efficiently by CMHSPs. On May 15th, Kristen Morningstar (Specialty Behavioral Health Services Director) issued a delay:

    - "MDHHS will temporarily delay the MHF Coverage Responsibility policy to allow time for system-wide preparation."

    - There are still many questions surrounding the "how?" and many stakeholders have pushed back on what this implementation entails. We did receive a memo update on 5/27/2026 stating that, while the delay for MHF remains in place, there is an expectation that assessments will continue, including the use of LOCUS and MichiCANS in determining the level of care for individuals seeking services.

- **CCBHC Caucus Meeting** – 5/27/2026. The group talked about the sustainability of CCBHCs in the state of Michigan. The discussion included the development of a CCBHC data warehouse at CMHA (our association). The CCBHC data warehouse will improve access to data and support advocacy efforts in demonstrating ROI. There is support from MDHHS and

other partners to develop this CCBHC database. There is also an effort to centralize TA (Technical Assistance) in a Michigan hub rather than requiring organizations to gather CCBHC information from multiple resources. This effort is funded by the Balmer Group, other funding sources, and the National Council.

LRE Level Updates:

- LRE – A board work session was held on 05/27/2026, and the topic was an educational training on AI (Artificial Intelligence. The goal was to provide an understanding of AI, its use in the current landscape, and how CMHSP partners are using AI. Most CMHSPs have implemented AI to help with documentation in the Electronic Health Record (EHR).

- The LRE Ops group met on 5/20 and discussed several topics, including **the autism framework** proposed by a workgroup composed of CMHSP experts in autism services. All CMHSPs participated in creating a framework for autism service delivery and best practices for the region. This is one area where there is variation in how services are delivered. The group reviewed authorization standards, length-of-stay expectations, and discharge standards to help partners implement this service more consistently.

CMH Level:

- HealthWest continues with various projects:

    - **CSU (Crisis Stabilization Unit)** – A handful of staff along with the project management team and grants team have been busy with coordinating and responding to additional questions from the Michigan Health Endowment fund. We have requested $500,000 in funding to support the development of CSU. This is in addition to the 4M we requested in Congressional Designated Spending for the capital investment for CSU.

    - **Utilization Review:** We are seeing decrease in actual utilization as evidence in our actual expense. HW is at a 6M surplus per the FSR. I am putting together a small work group to review utilization and identify areas where we are seeing the decrease. Actual numbers on the FSR (Financial status reports) are not a final number because of claims lag but we need to understand what is occurring with utilization.

    - **Strategic Plan updates** – Per the presentation from Gary on the strategic plan, we are getting close to the final plan. I would like to give Kudos to his team for coordinating this big lift ensuring we obtained input from all stakeholders, staff, and the Board. Many thanks as well to the different strategic plan committee members for the splendid work put into the strategic plan so far.