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Strategic Plan

September 2026

Acknowledgements

Every part of this plan traces back to someone who was willing to describe their own experience, honestly and in their own words. This page is a thank-you to them.

Seven staff workgroups gave months to seven separate problems, each one working from firsthand experience of what the work actually requires. None of them set out to find the same answer. All seven did anyway.

Staff focus group members and survey respondents spoke plainly about what an ordinary day looks like, without anyone editing it first.

The Consumer Advisory Committee brought their lived experience of care to the table and described what it looks like from the receiving end, an account only they could give.

External providers and community partners spoke just as candidly about what the relationship looks like from outside HealthWest, including where communication breaks down and where it holds. That is a view of the agency HealthWest cannot generate on its own.

Board members gave a full day to examining the agency from two directions at once: what was working inside it, and what was pressing on it from outside. Both readings are in this plan.

A steering committee and the Community Relations team held five months of that input. Every account arrived separately. They are the ones who made it a plan.

To everyone who gave their time, their honesty, and their own account of this agency's work: thank you. This plan belongs to the people of HealthWest. What is written here is what we heard. It is now up to us to show we listened.

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The Plan in One Page

CONDITION

HealthWest does good work. It does not yet do it the same way everywhere.

- Authority to fix a problem crossing two departments sits only at the top.
- Information moves through whoever happens to know whom rather than through anything designed.
- The supervisors who hold the work together have never been developed as a strategic priority.

STRATEGY

Build the coordination infrastructure the organization does not currently have, meaning the people systems, the way information moves, and the supervisors who hold the work together.

TEST

Does this leave the organization more capable than it found it, or does it only solve the problem in front of us?

ARCHITECTURE

FOUNDATION Makes consistent work possible. It does not produce it.

STRUCTURE How work moves, and where the definition of that work lives.

CAPABILITY The people who do the work and the supervisors who lead them.

DELIVERY Where the work meets a person.

PILLARS

- | | |
|--|------------------------------------|
| 1 Clinical Practice Excellence | 4 Technology Transformation |
| 2 Operational Integrity | 5 Community Partnerships |
| 3 Organizational Culture and Development | 6 Physical Infrastructure Capacity |

10 goals | 28 initiatives | 24 measures, four for each pillar

EVIDENCE

Three of the twenty-four measures cannot move unless the organization has actually become coordinated.

- Staff confidence in the quality of service on teams other than their own
- Rate of rework or returned documentation at defined handoff points
- Planned versus unplanned discharge, with progress against the person's own service plan goals

Staff perception, agency process, consumer outcome: three views of one claim, each able to fail differently.

FY2030 POSITION

HealthWest has the organizational freedom to choose its strategic path rather than absorb decisions made for it.

HealthWest FY2027-2029 Strategic Plan

You do not walk into HealthWest and simply get handed a treatment plan.

Someone sits with you and takes a history. What is happening at home. Whether you are working. What your body is doing. What your mind is doing. Only then does a diagnosis get named, and only then does a plan get built, tailored to you and to the goals you are working toward. Therapy, medication, a peer who has been where you are, help finding an apartment. Each one working in concert with the others. And nowhere in that plan is the promise that the condition disappears. What the plan offers is a life you can direct, in a community you belong to, with the condition still present but no longer in charge.

This is that kind of plan, built in that order.

The pressures HealthWest works under are not likely to be resolved by FY2030, and this plan does not pretend otherwise. What it builds is an organization with the durable capability to meet what arrives, and the standing to choose its response rather than absorb it. Staff, partners, consumers, and seven workgroups starting from unrelated problems all arrived at the same finding, which is one condition in three parts: authority to fix a problem crossing two departments sits only at the top, information moves through whoever happens to know whom rather than through anything designed, and the supervisors who hold the work together have never been developed as a strategic priority.

What follows is the response. Build the coordination infrastructure the organization does not currently have, meaning the people systems, the way information moves, and the supervisors who hold the work together. Every commitment here had to pass one test: does it leave the organization more capable than it found it, or does it only solve the problem in front of us.

What passed is ten goals across six pillars, weighted rather than spread, because effort spread evenly across three years produces ten disconnected improvements and the same organizational problem. What did not pass is also named: no new recurring cost for unfunded expansion, staffing growth, or new service capacity until unit cost is aligned with reimbursement and the General Fund position is stabilized. That is not a decision to do less. HealthWest is authorized and staffed to deliver service that currently goes undelivered, and the reason it goes undelivered is the condition named in this plan.

The growth this plan pursues is the kind that has already been paid for.

The Condition

HealthWest does good work. It does not yet do it the same way everywhere.

That finding did not come from one place. A staff survey, a partner survey, a consumer focus group, regional satisfaction data, two staff focus groups, a board work session, and seven staff workgroups each started from a different problem. None of them were looking for this conclusion. All seven arrived at it anyway.

SEVEN STARTING PROBLEMS

ONE CONDITION, IN THREE PARTS

Access & Crisis

Teams under decades of layered fixes, moving but fragmented

Technology

Knowledge trapped between the data team and program teams

Operations

Work never pruned or redesigned as the agency's scope expanded

Community Partnerships

Staff who don't know their own organization well enough to speak with one voice

Compliance

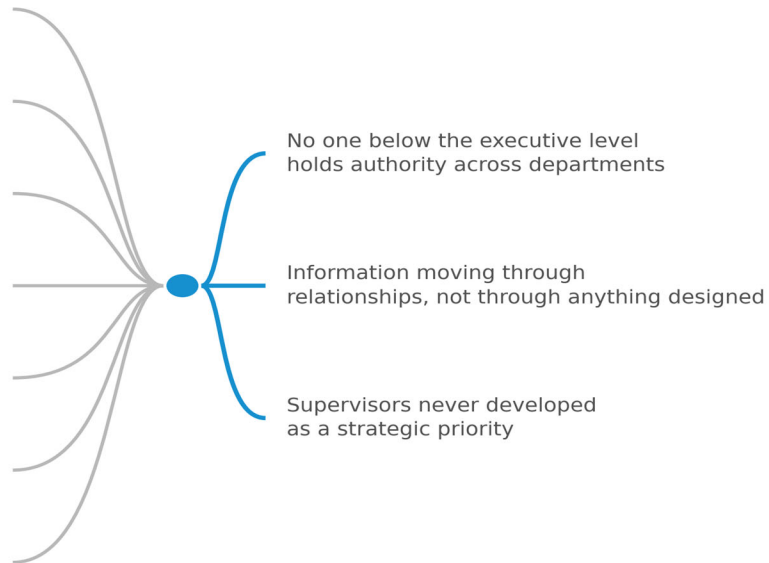
Risk collecting at handoffs nobody owns the transition for

Clinical Quality

Confidence in quality holding across every program, lowest score in the staff survey

Workforce & Culture

Staff leaving under workload, compensation, and thin support



The finding has three parts. No one below the executive level holds the authority to fix a problem that crosses two departments. Information moves through whoever happens to know whom, not through anything designed. And the supervisors who hold the work together have never been developed as a strategic priority.

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.

These are not failures of effort or skill. Every workgroup that traced its problem back far enough landed at the same level. That is how the organization is put together, not how hard anyone is working.

What it looks like from outside

A member of the consumer advisory committee started services and was assigned a case manager and a recovery coach. He had met neither of them. By the time he reached either one, both had left the agency, and nobody had told him. He did not know who to call next. While he was working that out, the court was told he was not participating in his treatment, and he was jailed for it. He was not refusing to engage. He was trying to reach an organization that had no way to tell him what happened next.

That is the condition, at full cost, to one person.

It shows up in smaller ways constantly. Partners report that their best experiences with HealthWest come from individual staff members, and their worst frustration is that those relationships end when the staff member leaves. The organization works through people rather than through anything that outlasts them. A board member noted that the communication problem has been worked on for a couple of years and is still there. This is not a recent slip. It is a durable condition, and durable conditions do not resolve on their own.

What it looks like from inside

Ask staff how well their own team performs and they rate it highly. Ask how confident they are that quality holds across every program in the agency and the score drops to the lowest point anywhere in the staff survey. That gap between the two answers is the largest one the assessment found.

The gap does not mean quality is bad elsewhere. It means staff cannot vouch for work they cannot see, and there is no shared standard they could judge it against if they could. They do not know what they would be looking for.

The workgroups said the same thing in different words. Access described teams working under decades of layered fixes with no cross-team authority to redesign the whole path. The current path is moving but fragmented. Technology described knowledge trapped between the data team and the program teams, with nobody able to make a decision that binds both. Operations described work that has never been pruned or redesigned as the agency's scope expanded. Compliance described risk collecting at handoffs, in the space between two departments where nobody owns the transition. Community partnerships put it most bluntly: staff do not really know their own organization, which is why HealthWest cannot speak to the community with one voice.

Seven groups. Seven starting points. One answer.

The board reached it independently, too. Siloed thinking was named as a weakness in their work session. When asked what happens when the state changes policy without warning, one of the first things board members named was that decisions get made in silos. The internal condition and the external risk landed in the same sentence before anyone had connected them on paper.

Why the obvious responses do not work

Fixing it department by department is what produced it. Every area of the agency has been improved on its own for years. Many improvements worked, but what accumulated is a set of good solutions that do not always fit together.

Training and hiring treat it as a competence problem. It is not one. The people are skilled and the effort is there. What is missing is the structure that connects the effort.

Adding one more initiative beside the existing structure repeats the pattern. Coordination has to be built as the thing the organization runs on, not as another project running alongside everything else.

The condition demands that its parts be built together, as one connected system, because they succeed or fail together.

What the Planning Process Showed

Before any of this was written, seven staff workgroups spent roughly five months doing the diagnostic work the plan rests on. Those sessions were coordination of the designed kind: people from different departments, a defined method, and a structure that held from one meeting to the next rather than depending on who happened to be in the room.

This plan commits the organization to building exactly that, at scale. It has already been run once at small scale inside the organization, so what happened when it ran can be known rather than assumed.

Participants were surveyed at the close. Nearly all of them reported that the sessions pushed discussion past first answers, and that points raised in earlier meetings carried into later ones. That second finding worked inside each group, not between them: each group opened its first meeting by mapping its own problem, working blind to where the process would lead, and its later analysis was tested against that early map. The diagnosis rests on convergence, seven groups starting from unrelated problems and arriving at the same condition, and convergence is only meaningful if each group actually reached it on its own.

Nearly all participants also said they expected this process to produce a plan worth following. They were forecasting a document none of them had read, so this is not evidence about the sessions themselves. However, it is the only evidence in this plan of whether the work has standing with the people who did it, before implementation asks anything of anyone.

The Strategy

Every commitment in this plan had to pass one test.

THE STRATEGIC POLICY

HealthWest will 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.

The first sentence names what the organization is building. Infrastructure here does not mean buildings and it does not mean software. It means the people systems, the way information moves, and the supervisors who hold the work together. Every program depends on these things, and none of them belong to any single department. That is exactly why none of them have ever been any one person's job.

It also names what the building is for: consistent service, and the ability to absorb whatever arrives from Lansing or Washington as one organization rather than as separate departments each handling its own piece.

The second sentence is the one that costs something. Nearly everything HealthWest could do is worth doing, and an organization that weighs each request on its own merits ends up doing a little of all of it. The test asks a harder question: does this leave the organization more capable than it found it, or does it only solve the problem in front of us? Both are legitimate reasons to act. Only one is a reason to spend three years on something.

This is a test, not a statement of values.

THE GOVERNING TEST

Does this leave the organization more capable than it found it, or does it only solve the problem in front of us?

Stated plainly: HealthWest is building the connections between its departments and the people who lead the work, so that good care happens everywhere instead of in pockets.

The Environment

Three conditions set the boundary of what HealthWest can do, and none of them are inside the agency's control: Medicaid funding volatility, privatization pressure, and instability in state policy. This plan does not solve these conditions. They are the weather HealthWest operates in, and they are the reason the plan is built the way it is.

An organization meets conditions like these one of two ways. It absorbs whatever arrives and adjusts afterward, learning the terms once someone else has already set them. Or it is coherent enough to have something to say when the terms change, and steady enough to act on what it decides. The difference between those two organizations is not how hard the conditions press. It is what each one built before the pressure came.

That is why an environmental lens belongs in a plan about internal coordination. Every condition below reaches HealthWest through the same seams this plan is working on, and the agency's freedom to choose its own response depends on whether those seams hold.

How the Plan Is Built

The work is already good, and it is confirmed as good from the outside. Consumers recommend the agency and report satisfaction at high rates, and most affirm that people can grow, change, and recover. The state's quality measures reward the work: HealthWest regularly earns CCBHC Quality Bonus Payments, and its depression remission results rank among the best of the state's CCBHCs.

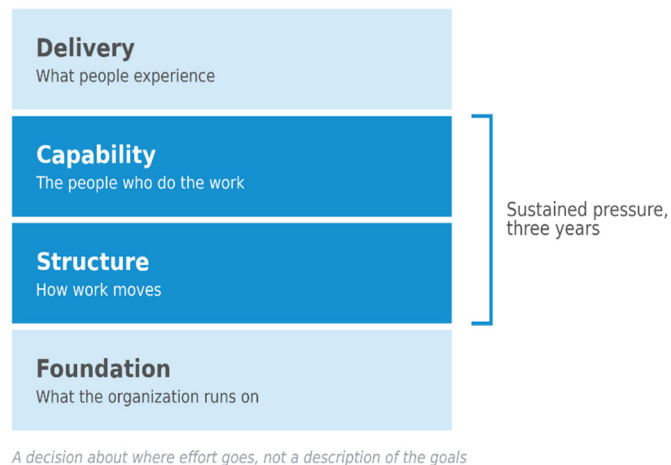
What is uneven is not the ability. It is the reproduction of it.

Over years, teams built their own solutions to problems nobody had solved centrally, and many of those solutions worked. What accumulated is a patchwork. Staff feel the friction daily where those patches meet. Those are the agency's seams. That daily friction is not separate from the systemic problem. It is the systemic problem showing up at a desk.

Three years is not enough time to do everything equally. Spreading effort evenly across ten goals would produce ten disconnected improvements and the same organizational problem HealthWest currently faces.

So the goals are sorted into four layers, by what each one holds up. **Foundation** is what the organization runs on: its money, its buildings, its technology and data. **Structure** is how work moves between departments and where the rules for that work live. **Capability** is the people who do the work and the supervisors who lead them. **Delivery** is what consumers and the community actually experience.

Effort is not distributed evenly across those four. It concentrates in Structure and Capability. Foundation and Delivery are real work too, and neither is left alone, but the middle is where this plan applies sustained pressure for three years. That is a decision, not a description of the goals.



How the plan is organized

What follows is organized two ways at once.

Everything starts at the test. Every commitment in this plan had to pass it, and nothing appears here that did not.

What passed is sorted by subject into six pillars: Clinical Practice Excellence, Operational Integrity, Organizational Culture and Development, Technology Transformation, Community Partnerships, and Physical Infrastructure Capacity. Under each pillar are the goals, which are what the organization commits to. Under each goal are the initiatives, which are the work that delivers the commitment. An initiative carries the number of the goal it serves, so 6.1 is the first piece of work under the sixth goal.

The layers cut across all of it. A pillar tells a reader what a goal is about. A layer tells them what it holds up, and what holds it up in turn. The same ten goals answer both questions, and neither answer ranks them.

PART ONE

Goals by Pillar

How this plan will be measured

Twenty-four measures, four for each pillar.

They draw on information HealthWest already produces. Several require reaching that information at a detail and a rhythm the current reporting was never built for. Building that reach is part of the technology and data governance work identified in this plan.

The measures state direction rather than targets. Several have never been tracked as a trend, and setting a number before there is a baseline would commit the organization to the number instead of the direction. Targets get set early in the plan review cycle, against what the baseline shows.

The plan does not carry measures for individual goals or initiatives. That work is more fluid and belongs with the teams doing it, close enough to see what is actually happening and adjust as conditions change. It is tracked and watched, but it does not need to sit in a three-year plan at that level of detail.

Three of the twenty-four measures are the ones the plan is really asking to be judged on, because all three of them cannot move unless the organization has actually become coordinated. They are named at the end of this part, once the commitments they test have been read.

1

PILLAR 1

Clinical Practice Excellence

Make care reachable, make it reflect what the person came for, and hold it to one standard wherever they receive it.

GOALS

1	Reliable Access and Crisis Continuum	DELIVERY	3 initiatives
2	Workforce Training for Demonstrated Proficiency	CAPABILITY	2 initiatives

PILLAR MEASURES

ACCESS	EXPERIENCE	OUTCOMES	CONSISTENCY
--------	------------	----------	-------------

A person's experience of HealthWest should not depend on which door they came through, or which team picked them up.

1

GOAL

Reliable Access and Crisis Continuum

DELIVERY

What consumers and referral partners meet at the point of contact and through the crisis system.

- 1.1 The end-to-end pathway from first contact to first service.** A documented path from first contact through team placement to first treatment contact, with a way to schedule that first service. *A referral is not the same as beginning treatment, and today's handoff from the front door to an active team varies. Until the path is defined, there is nothing to measure and nothing to improve.*
- 1.2 Access and crisis continuity.** Same-day triage plus the follow-through that keeps people engaged after a crisis, a hospitalization, a warmline call, or a missed appointment, treating mobile crisis, crisis residential, and walk-in urgent care as one connected set of routes. *People fall out of contact at transitions. Where the routes are unclear or unavailable, the emergency department becomes the default entry point, and this is the most expensive path for the person and for the county.*
- 1.3 A defined community-based service delivery model.** A cross-departmental model that makes community-based delivery an expected, measured part of care throughout a person's time with HealthWest, not only at intake. *Meeting people where they are is expected of every team, but no team sets what it means, so each reads it differently and none of them measure it consistently.*

2

GOAL

Workforce Training That Produces Demonstrated Proficiency

CAPABILITY

Whether staff can apply the standards the organization sets, not only complete the training about them.

2.1 A competency framework that links learning to demonstrated application. Role-based learning connected to evidence that the skill shows up in the work, across clinical, compliance, and technology skills, with required federal and state trainings reinforced through supervision rather than rebuilt as separate modules. *Training completion is tracked. Whether the training changed anything is not. A staff member can finish a module and never apply it, and nothing in the current system would show that.*

2.2 Clinical performance and supervision tied to consumer outcomes. Evaluations and clinical supervision that examine caseload service data, progress against a person's own plan goals, and discharge outcomes, so coaching is grounded in what consumers actually experience. *A clinician can receive a strong evaluation in a period when no one on their caseload progressed toward a goal, because outcomes are not part of the conversation. Supervisors cannot coach to outcomes they never see.*

How this pillar is measured

ACCESS

Time from a person's first contact to their first service, trended over time.

Whether the door opens.

EXPERIENCE

Consumer-reported experience of the services they receive, tracked at defined points after admission.

What the care is like once it does.

OUTCOMES

Planned versus unplanned discharge, with progress against the person's own service plan goals, and the rate of escalation to higher levels of care including length of stay.

Whether the work moved the thing the person came for, rather than whether the episode closed tidily.

CONSISTENCY

Staff-reported confidence in the quality of service delivery on teams other than their own, tracked over time.

Whether staff can vouch for the standard beyond what they can see directly. This is the one thing the other three measures cannot detect.

Together they reach the center of what this pillar has to produce. What they do not track is the fidelity of any individual clinical model, which belongs to the teams running them.

2

PILLAR 2

Operational Integrity

Make work come out the same regardless of who performs it or which department it crosses.

GOALS

3	A Coordinated Operating Model	STRUCTURE	4 initiatives
4	A Single Authoritative Source of Truth	STRUCTURE	2 initiatives
5	Simplified and Automated Operational Processes	STRUCTURE	2 initiatives
6	Sustainable Financial Stewardship	FOUNDATION	3 initiatives

PILLAR MEASURES

DOCUMENTED
PROCESSHANDOFF
REWORKAUDIT
CORRECTIONBILLING
INTEGRITY

This is the pillar where the condition is most directly addressed, because it is where the rules for how work moves get written down and given an owner. Four goals sit here, and they make one argument: define the work, put it in one findable place, connect the standard to daily practice, and manage the money that carries all of it.

3

GOAL

A Coordinated Operating Model with Defined Roles and Accountable Handoffs

STRUCTURE

How work moves across the organization: roles, handoffs, and shared accountability.

3.1 Mapped and owned cross-departmental workflows. Documented workflow maps across finance, human resources, facilities, and clinical work, with the connection between one team's process and the next made explicit and given an owner, including consumer coverage enrollment and renewal, which crosses access, clinical, and finance and currently belongs to no one. *Different departments run different processes for the same task. This creates gaps.*

Coverage renewal shows the cost directly: more frequent redetermination means more chances for coverage to lapse, and every lapse potentially turns billable service into General Fund cost.

3.2 Standardized handoffs and internal referral. A shared definition of what a warm handoff is, how internal referrals and transitions work, and who does what during a transfer, including the step down from crisis and the return from hospital. *A term like warm handoff means different things on different teams, and transfers stall on unclear steps. This is where consumers most often fall through.*

3.3 Standardized role and scope definitions. Plain-language statements of what a role actually does on a given team, beyond the shared job description, in place from the job posting onward. *The same job description covers very different work depending on the team, so staff and new hires begin without a clear picture of their own scope. Unclear scope creates friction at every handoff.*

3.4 Closed-loop tracking for corrective actions and incidents. One process that follows a finding or an incident from identification to documented resolution, with a named owner and a timeline, covering audit corrective actions and required incident follow-ups. *Findings are identified and assigned, and follow-through varies, so the same issue often reappears at the next audit. A closed loop is what turns correction into something that holds.*

4

GOAL

A Single Authoritative Source of Truth for Policies, Workflows, and Standards

STRUCTURE

One maintained home for the guidance staff rely on, so the operating model can be found and kept current.

4.1 A single authoritative source of truth. One maintained home for policies, workflows, procedures, and compliance guidance, with named ownership, a review cycle, and search that works. *Guidance currently lives in email, chat threads, shared drives, and memory. Staff cannot reliably find current direction, and different teams end up applying different versions of it.*

4.2 Documentation standards connected to practice. Shared documentation standards for clinical programs, carried into daily work through training and supervision, including the golden thread from assessment to plan to service to note, and the consumer's own account of whether the service is meeting their goals. *The standard exists on paper and is applied unevenly, which drives both compliance findings and billing errors. The same inconsistency affects the person: where the record asks for the consumer's experience and that goes uncompleted, the agency has documented the service without any record of whether it worked.*

5

GOAL

Simplified and Automated Operational Processes

STRUCTURE

How manual burden comes down, once the work is defined and documented.

5.1 Standardized and automated core administrative processes. Standardized core processes such as purchase requests and targeted automation of high-volume manual work once the underlying process is understood and owned. *Automating a process nobody has defined only reproduces the problem faster and makes it harder to change. Standardize first, then automate, and the time saved goes back to the work that serves people.*

5.2 Billing, documentation, and payer integrity checkpoints. Checkpoints connecting service documentation to billing accuracy, including a named owner for monitoring changes to the Medicaid code chart, verification that services are billed to the funding stream that carries them, and verification of consumer coverage status including upcoming renewal dates and lapsed coverage. *Changes to the code chart are published outside the agency, and whether they reach the people whose documentation has to change depends on chance. That is how a change gets found in an audit or a clawback instead of in advance. Billing to the wrong stream carries a second, easy-to-miss cost: it forgoes surplus in the stream that generates it, loads cost onto the stream that does not cover its own delivery, and overstates cost per unit in a way that weakens the agency's own case on rate adequacy.*

6

GOAL

Sustainable Financial Stewardship

FOUNDATION

6.1 A financial stewardship decision framework. Criteria for evaluating major resource decisions against strategic priorities, deliberate management of the General Fund by priority rather than by whoever raises a need first, and modeling that quantifies what the General Fund absorbs and what will be asked of it. It separates the cost of service not delivered from the cost the rate does not cover, treats coverage loss as its own driver, and holds reserve building as a live objective. *Without written criteria, money follows whoever asks rather than strategy. This is why the billing integrity work, the provider network decisions, and the crisis continuum's scope all depend on what this framework establishes first. The General Fund is the only meaningfully flexible money the agency holds, and separating rate shortfall from delivery shortfall matters because a model reporting only cost per unit blames both on the same cause, which does not survive scrutiny. Cost control is not only protective; it is one of the few ways the agency generates flexible money at all.*

6.2 A structured pathway for high-complexity needs. A defined cross-departmental route for people whose needs cross psychiatric, medical, financial, and support lines, with a full review and cost-offset analysis rather than fragmented individual effort. *These situations are handled inconsistently today and consume disproportionate staff time and cost. A defined pathway gives the same response regardless of which staff member encounters the situation.*

6.3 Provider network structure and stability. Deliberate development of the network, including expanded Designated Collaborating Organization relationships for services within CCBHC scope, early monitoring of provider financial health, and contract rate support where flexible funds allow. *Two exposures, two responses. For services within CCBHC scope, bringing providers inside HealthWest's own structure improves clinical integration and reduces reliance on arrangements the agency does not control. HealthWest answers for these services whether or not it delivers them. For residential and other traditional services, that option does not exist; provider viability depends on wage-pressured rates the agency does not set, and provider failure there disrupts placement for people with the highest support needs. That instability shows up in the relationship before it shows up in the financials, which is why monitoring it has to be a relationship, not a report.*

How this pillar is measured

DOCUMENTED PROCESS Share of key cross-departmental processes documented, owned, and actively used. Whether the standard exists and is used.	HANDOFF REWORK Rate of rework or returned documentation at defined handoff points. Whether it survives contact between departments.
AUDIT CORRECTION Repeat audit findings year over year, trending toward zero, with corrective actions carrying a named owner and a documented resolution. Whether correction holds across a year rather than closing a single citation.	BILLING INTEGRITY Billing integrity: claim error rate at first submission, service documentation completed within required timeframes, and services billed to the funding stream that carries them, verified rather than assumed. Whether it holds where the consequence is financial.

The first two measures are read against each other, because that is where this pillar is most exposed: if documentation climbs while rework holds flat, the standard exists on paper and is doing nothing. Four goals sit under this pillar, and the measures track whether the work comes out the same, not the speed of any individual process, which belongs to the teams redesigning them.

3

PILLAR 3

Organizational Culture and Development

Make supervisors capable of holding a standard, and make staff stay long enough to meet it.

GOALS

7

Durable Leadership and Change Architecture

CAPABILITY

3 initiatives

PILLAR MEASURES

TURNOVER

TRAINING
COMPLETION

SUPERVISION
AND ROLE
CLARITY

TIME TO FILL
VACANCIES

This is the layer that never stays built, because it lives in people rather than in documents, and it is the one the diagnosis named most directly.

7

GOAL

Durable Leadership and Change Architecture

CAPABILITY

How supervisors are developed, and how change reaches the people it affects.

7.1 A structured supervisory and management development system. Defined supervisory and management competencies with an ongoing development system behind them, connecting the development efforts that already exist rather than replacing them, and holding managers accountable for developing the supervisors who report to them. This includes tracking training completion by unit and by role, not only by agency average, so gaps in the development system itself become visible. *Supervisory quality varies, and staff confidence in their supervisor drives both retention and performance. Development has never been treated as an ongoing investment, and this is the clearest case of work that cannot be finished: a supervisor developed this year does not stay developed when they leave, and a new cohort arrives every year needing the same thing.*

7.2 Belonging and culture health monitoring. An ongoing read on belonging and culture through the structured supervision conversation, so leadership sees early signals without adding another survey. *Culture and belonging move before turnover does. Today that signal reaches leadership only when a supervisor happens to mention it to someone who acts on it, which means it arrives for some teams and not others. Carrying it through the supervision conversation makes it a route instead of a mention.*

7.3 Recruitment and workforce pipeline. An intentional pipeline that extends the internship and training-partnership model already producing hires across clinical and health professional roles, including master's level clinical, nursing, and medical assistant positions, with targeting driven by

service delivery capacity rather than vacancy on an organizational chart. Prescriber recruitment is handled separately, including exploring residency and training partnerships, and includes reducing the dependence of specific programs on individual clinicians. *HealthWest has already shown it can build a working pipeline. That capability is currently aimed at filling empty seats rather than the roles that actually limit what the agency can deliver. Prescriber capacity is the sharpest of those limits: smaller supply, longer timeline, and some services currently rest on a single prescriber in a way that caps what can be sustained.*

How this pillar is measured

TURNOVER

Turnover at the agency level and by supervisor and department, distinguishing expected from concerning turnover.

Whether people stay.

TRAINING COMPLETION

Required training completion, tracked on time separately from eventual completion, for supervisory staff separately from the staff they oversee, read by unit rather than by agency average, against what was scheduled.

Whether the organization's own standards reach the people accountable for them.

SUPERVISION AND ROLE CLARITY

Staff experience of supervision and role clarity: confidence in supervisor, psychological safety and trust in leadership, and understanding of what is expected in the role, including new hires at defined points after start.

Whether the development is landing where it is felt.

TIME TO FILL

Time to fill by role category, with direct care and prescriber roles tracked separately.

Whether the organization can replace what it loses.

What is not tracked here is whether an individual supervisor is effective. That is a supervisory relationship, not a strategic indicator.

4

PILLAR 4

Technology Transformation

Make tools governed, trustworthy, and usable.

GOALS

8

Reliable Technology and Data Governance

FOUNDATION

3 initiatives

PILLAR MEASURES

TOOL
GOVERNANCEREPORTING
COVERAGEIN-YEAR
VISIBILITYSTAFF
PROFICIENCY

The authority to decide across departments on technology is not missing. What is missing is a defined and promoted process for how a technology question gets raised, routed, and answered, so teams solve their own problems with their own tools and never encounter the path. Systems accumulate rather than get chosen, and the data everything else is measured with cannot be fully trusted.

8

GOAL

Reliable Technology and Data Governance

FOUNDATION

The information foundation that makes performance measurable, tools trustworthy, and consumer data protected.

8.1 Data governance and dashboard lifecycle. A data strategy with clear ownership, a lifecycle for reports and dashboards, and one source of truth for operational and financial data. It classifies data by consequence: anything affecting clinical outcomes, revenue, certification, accreditation, or contract standing carries a monitoring requirement and a named owner regardless of which team files it, and sets criteria for prioritizing analytics requests. *Dashboards multiply and go stale without anyone noticing, and staff keep their own spreadsheets because official systems do not give them what they need. Consequential submissions leave the building unwatched, so performance carrying real clinical, financial, or regulatory weight becomes visible only after it is settled. Governance is what makes every other goal's measurement trustworthy.*

8.2 Technology governance and lifecycle management. A defined intake and inventory for tools, including artificial intelligence tools, with documented ownership and compliance review, a technology lifecycle, and a structured process for record system enhancement requests with change logging. *Staff adopt tools the technology team does not know about, which creates privacy exposure, and changes to the record system happen without visibility to the people who depend on its data. A governed intake closes both gaps.*

8.3 An integrated decision view. One place that brings the strategic plan, the risk management plan, and the quality improvement program together with the ability to drill into source detail, so leadership can see shared measures and decide what to act on, including performance

approaching a threshold that would require a decision. *These three run on separate tracks today, which makes the whole picture hard to see. Externally scored performance is usually visible only once it can no longer be changed. Seeing a threshold approach during the year is what makes it actionable.*

How this pillar is measured

TOOL GOVERNANCE

Share of tools in active use with documented ownership and a compliance review, with unapproved systems trending toward zero.

Whether the estate is governed rather than accumulated.

REPORTING COVERAGE

Coverage and currency of the reporting estate: strategic measures with live dashboard coverage, risk items with a linked monitoring indicator, and dashboards actively used rather than stale.

Whether what the organization measures is actually visible to it.

IN-YEAR VISIBILITY

Share of externally scored quality measures visible against benchmark during the measurement year rather than at award determination.

Whether performance can be managed while it is still movable.

STAFF PROFICIENCY

Share of technology support requests resolved as skill development rather than a true system issue, as a proxy for staff technology proficiency.

Whether staff can use what they have been given.

Together these cover the two things this pillar has to produce: trustworthy data and usable tools. What is not tracked here is the performance of any individual system, which belongs to the teams that own them.

5

PILLAR 5

Community Partnerships

Make HealthWest predictable to partners and community members.

GOALS

9

Community Presence and Partnership Accountability

DELIVERY

5 initiatives

PILLAR MEASURES

REFERRAL
SOURCE

INTAKE
HANDOFF

PARTNERSHIP
OWNERSHIP

NEEDS
ALIGNMENT

The workgroup that examined this named a pattern the organization already recognizes: HealthWest steps into community initiatives and does not consistently follow through. That is not a community relations failure. It is what an organization looks like when it makes commitments without the structure, documentation, and supervisory capacity to sustain them.

9

GOAL

Community Presence and Partnership Accountability

DELIVERY

What the community and partners experience, and whether HealthWest follows through.

- 9.1 Unified public-facing communication and expectation-setting.** Consistent public and referral-facing information about what HealthWest does, materials that give consumers and families an accurate picture of what a service will actually be like, and referral-source tracking, including outreach to populations HealthWest is authorized to serve but that do not currently see the agency as available to them. *The public and referral partners receive inconsistent information, which drives early drop-off. HealthWest is also understood in the community as serving a narrower population than it is authorized and equipped to serve, a perception gap rather than a capability gap, and one that costs the agency reach it has already earned.*
- 9.2 A partnership accountability framework with named owners.** Documentation of what HealthWest commits to, a named owner for each partnership, review dates, and a defined way to exit a commitment the agency cannot sustain, including pursuing data sharing with the county systems that absorb unmet behavioral health need, such as hospitals, law enforcement, and the courts. *Named owners and documented commitments make follow-through something the agency can enforce rather than something that depends on who remembers. Data sharing belongs here because what happens in emergency departments and jails when behavioral health capacity falls short is recorded in systems the agency does not hold and can only reach through partnership.*
- 9.3 A structured community needs assessment process.** A regular process that gathers existing assessments from the regional entity, schools, the state, and the community health

needs assessment, identifies behavioral health gaps, and connects the findings to program planning. *Service offerings are not consistently updated against what the community actually needs, and useful assessment data sits scattered across other organizations. CCBHC requires that service availability follow community assessment rather than be set arbitrarily, which makes this the process that governs access and crisis scope decisions.*

9.4 External advocacy and coalition capacity. Sustained capacity to make the case for HealthWest and for the public behavioral health system in state-level and coalition settings, grounded in the agency's own data, including evidence of its effects on emergency department use, law enforcement contact, and jail population. *Decisions that shape HealthWest's operating conditions are made in rooms where the agency has limited sustained presence. Legislators have said directly that claims about downstream cost avoidance are not credited when they arrive without data behind them. Building that evidence is within HealthWest's control.*

9.5 System change and strategic readiness. A maintained package of outcomes, cost, and capability evidence that can be mobilized quickly, with a response approach identified in advance rather than assembled under deadline, drawing on the same evidence base that supports advocacy. *Changes to how public behavioral health is contracted in Michigan have been pursued through more than one channel, and the gap between an announcement and a required response likely will not allow building an evidence base from scratch. The same package serves advocacy, board reporting, partner relationships, and accreditation, so maintaining it is useful now and necessary later.*

How this pillar is measured

REFERRAL SOURCE Share of consumers with a documented referral source at admission. Whether the organization knows where people come from.	INTAKE HANDOFF Early drop-off after intake, by referral source and by whether the person received orientation materials. Whether the handoff into service holds.
PARTNERSHIP OWNERSHIP Share of active partnerships with a named owner, a documented commitment, and a review date, with follow-through status versus lapsed. Whether follow-through has an owner rather than depending on memory.	NEEDS ALIGNMENT Community needs assessment completed on schedule, with the share of offerings documented against current needs data. Whether what the agency offers still answers what the community needs.

Together these cover the two things this pillar has to produce: a HealthWest that partners can predict, and a set of services that reflects what the community actually needs. What is not tracked here is the outcome of any individual partnership, which the partners themselves define.

6

PILLAR 6

Physical Infrastructure Capacity

Make space enable the work rather than constrain it.

GOALS

10

Facilities as Enabling Infrastructure

FOUNDATION

1 initiative

PILLAR MEASURES

WORKPLACE
CONDITIONS

AVAILABILITY

DECISION
DISCIPLINESPACE
UTILIZATION

Facilities decisions made under pressure quietly set limits on everything else. What crisis services HealthWest can offer is bounded by available space as much as by funding or staffing, which makes space a strategic variable rather than a maintenance question.

10

GOAL

Facilities as Enabling Infrastructure

FOUNDATION

The physical precondition for access, for staff to function, and for operational sustainability.

10.1 A facilities and fleet evaluation framework. A framework that tests building and fleet decisions three ways: whether the choice supports safe and accessible service delivery, whether it supports staff wellbeing and connection, and whether it advances financial sustainability, covering right-sizing, the balance of in-person and remote work, shared and hub space, lease timing, and the vehicle model. *These decisions are clinical, cultural, and financial at once, which is why they belong to no single department and get settled by whatever is expiring. Made that way, they create costs that constrain every other investment for years. A defined framework is what lets the next lease be a choice rather than a deadline.*

How this pillar is measured

WORKPLACE CONDITIONS Staff satisfaction with the physical work environment, and turnover or absenteeism associated with workspace conditions. What the space costs when it does not work.	AVAILABILITY Building closure days. Whether it is reliably available.
DECISION DISCIPLINE Share of building and fleet decisions evaluated against the defined three-test framework rather than reactively. Whether the organization is choosing its footprint or absorbing it.	SPACE UTILIZATION Space utilization against right-sizing, including the balance of in-person and community-based work. Whether the footprint matches how the work is actually done.

Together these cover whether space is enabling the work or limiting it. What is not tracked here is the condition of any individual building, which belongs to facilities operations.

The three measures the plan turns on

Twenty-four measures spread across six pillars will tell the board whether each part of the organization is working. They will not tell it whether the parts have become one organization, because each measure sits inside a single domain and reports to a single owner, and the condition this plan names is that nobody owns across domains. Ten healthy domain indicators describe the situation the agency is in now.

Three of the twenty-four do something the other twenty-one cannot.

Staff-reported confidence in the quality of service delivery on teams other than their own.

This measure cannot move unless the communication and governance infrastructure exists, because staff do not become confident in work they cannot see. It cannot move unless supervision is holding a consistent standard, because staff do not stay confident in work that varies by team. That is the right place to test the plan's central claim, because that claim is that pressure applied below changes what shows up above.

Rate of rework or returned documentation at defined handoff points. The transactional counterpart. Documents bouncing between departments are the running cost of coordination that depends on relationships rather than defined process. If the work on how work moves succeeds, the rate falls, and it falls in data the agency already generates not in what people report about how they feel.

Planned versus unplanned discharge, with progress against the person's own service plan goals. The consumer-anchored measure, in the strongest available sense, because the standard is the person's own plan rather than an agency definition of a good outcome. It cannot improve unless supervision is coaching to outcomes, and it cannot improve unless documentation standards have reached practice so the goals in the record are real.

Staff perception, agency process, consumer outcome: three views of one claim, each able to fail differently. If confidence rises while rework holds flat, the agency feels better without working better. If rework falls while confidence does not, the process improved without reaching the people delivering care. If both move and goal progress does not, the organization coordinated itself without changing what happens to the person. No single measure can catch all three failures. Together, they can.

PART TWO

The Layered Architecture

The ten goals just read are not a list. They hold each other up, and the order they hold each other in is what makes this a plan rather than a portfolio.

A pillar tells a reader what a goal is about. A layer tells them what it holds up.

GOAL	FOUNDATION	STRUCTURE	CAPABILITY	DELIVERY
1. Reliable Access and Crisis Continuum P1				■
2. Workforce Training That Produces Demonstrated Proficiency P1			■	
3. A Coordinated Operating Model with Defined Roles and Accountable Handoffs P2		■		
4. A Single Authoritative Source of Truth P2		■		
5. Simplified and Automated Operational Processes P2		■		
6. Sustainable Financial Stewardship P2	■			
7. Durable Leadership and Change Architecture P3			■	
8. Reliable Technology and Data Governance P4	■			
9. Community Presence and Partnership Accountability P5				■
10. Facilities as Enabling Infrastructure P6	■			
Goals held at each layer	3	3	2	2

Foundation is technology and data governance, financial stewardship, and facilities and fleet. These three fail in unrelated ways and share one signature: left unmanaged, the organization stops choosing. Space gets decided by circumstance. Financial exposure gets set by whatever arrives. Technology accumulates rather than gets governed. In each case, HealthWest absorbs a decision it did not make, because no one below the executive level has standing to decide across departments. Foundation makes consistent work possible. It does not produce it.

Structure is how work moves and where the definition of that work lives. Communication failure was the top barrier named in every domain of the assessment, and it surfaced as a root condition in seven separate workgroup analyses that began from unrelated problems. Seven groups looking at different things ended in the same place.

Capability is the people who do the work and the supervisors who lead them. Underdeveloped supervisory skill was named as the explicit root cause of the primary workforce issue, and its consequences appear across every other domain.

Structure and Capability are where consistency actually gets produced, and they produce it continuously rather than once. Structure writes down what good work is and how it moves. Capability is the people who can hold that standard. Neither can do the job alone: a documented process with nobody developed to run it degrades quietly, and a well-developed supervisor with no shared standard is left inventing one.

Delivery is where the work meets a person. Nothing sits above it, so its evidence runs the other way. The community partnership pattern is the clearest instance: what presents as a failure of community relations is the absence of structure, documentation, and supervisory capacity behind it. Delivery is not passive as two goals live there, and both are real work. But what happens there is largely determined by what was built underneath it.

All four move at once

The layers describe what rests on what. They do not describe a calendar.

Work proceeds in all four layers at the same time, and the Sequence section makes that concrete: work is already underway in Foundation and in Delivery. What the layers govern is not when work begins, but rather how much weight each layer can carry before the one beneath it is ready.

On a construction site, work runs in parallel constantly. You can pick the bathtub, order it, and have it delivered. What you cannot do is install it before the floor is able to support it.

So this is not a plan where the first year is buildings and budgets and consumers see something in the third. All four kinds of work run at once, and the effort is concentrated in the middle.

Why the middle carries the weight

Foundation alone produces an organization that is housed, solvent, and wired, with no shared definition of how work moves and nobody developed to move it. Equipped, and inconsistent.

Delivery alone produces the organization HealthWest is today: capable of excellent care it cannot yet reproduce.

The seams are a Structure condition. The ability to work across them is a Capability condition.

Pressure on the middle two layers is pressure on the seams, which is why it changes what a staff member and a consumer experience, not only what the organization looks like on paper.

The two halves of the stack also ask for different kinds of effort. Foundation work converges: a governance framework, a decision framework, a facilities framework, each built once and then maintained, each outliving the people who built it. The middle does not converge. Nobody inherits a fully developed supervisor, and a standard nobody is tending drifts back toward the patchwork it replaced. That is why the middle gets sustained pressure across the full three years rather than a project with a finish date.

PART THREE

What the Environment Bounds

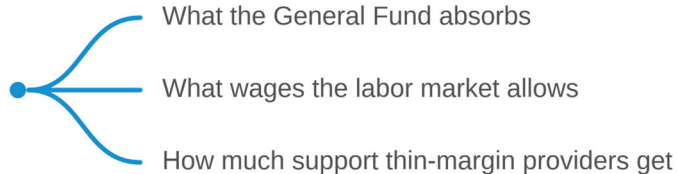
Parts One and Two describe work HealthWest controls. This part describes what it is for.

Three conditions set the boundary of the agency's freedom to act. They are not problems this plan solves. What the plan changes is HealthWest's position against them.

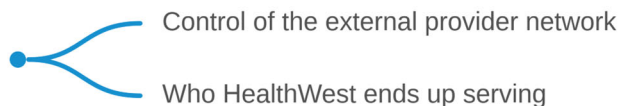
THREE CONDITIONS HEALTHWEST DOES NOT SET

WHAT EACH ONE BOUNDS

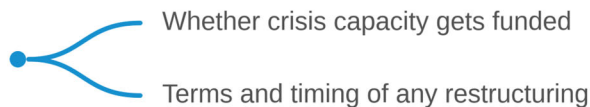
Medicaid funding volatility



Privatization pressure



Instability in state policy



Medicaid funding volatility

Medicaid is the substantial majority of HealthWest revenue, and that concentration is a structural feature of operating as a community mental health services program under a capitated model. It will not change in this planning period.

The pressure is not only that the pool is constrained. Public behavioral health competes for that pool against physical health systems and managed care plans, which makes funding decisions allocation decisions between sectors. Behavioral health's collective standing determines what reaches any single agency. Crisis stabilization unit development is the current example: the cost of operating it has never been built into rates.

What it bounds. It sets what the General Fund absorbs, and the General Fund is the only meaningfully flexible money the agency holds. It bounds what HealthWest and its contracted providers can pay in a labor market where the scarcity is national and the wages are set by rates the agency does not control. And it determines how much support HealthWest can extend to providers whose margins are thin.

Privatization pressure

Restructuring of Michigan's public behavioral health system has been pursued repeatedly. It was proposed through legislation and defeated. It was then pursued administratively, under different leadership, through a request for proposals to privatize the regional structure. A direction that survives a legislative defeat and a change in which party holds power is durable, and the administrative route does not require the legislature to advance.

HealthWest will contest that direction, because the terms of any restructuring are genuinely contestable and because absence from the debate reads as consent. It will also build the capability to operate well inside a changed system, because three years spent contesting an outcome with nothing built is not a plan.

What it bounds. Control of the external provider network, which the administrative proposal sought to place outside HealthWest. And the composition of who the agency serves: the common expectation is that private entrants take the lower-acuity, lower-cost population and leave HealthWest with the most complex. Being irreplaceable for the hardest cases is not a strong position, and under the wrong payment model it is a worse one.

Instability in state policy

Requirements, rates, and reporting expectations change on a schedule HealthWest does not set.

The sharpest version of this is CCBHC certification, the legal basis for the provider relationships HealthWest is building, for serving the mild-to-moderate population, and for billing commercial insurance. Every structural option in this part rests on that designation, and the designation is not permanent. Disruption to it would not mainly cost a quality payment, rather it would remove the authorities the agency intends to compete with.

What it bounds. Whether crisis capacity is built into rates or licensed at all. Whether a wage floor the state sets for direct care workers arrives with funding behind it. It currently does not, which compresses compensation upward through supervisory roles and hits residential providers harder than it hits HealthWest. And the terms and timing of any restructuring.

What the plan does about it

The gates are outside our agency. HealthWest alone cannot open them.

What it can do is remove the grounds on which they stay closed. The state's position is not one lock. It is a set of reasons to say no: the need is not documented, the quality is not demonstrated, the money would not be managed, the system could not deliver if it were given the authority, and the funding is not there.

Four of those reasons are answerable with work, and this plan does the work: a needs assessment the agency owns, demonstrated consistency of care, a financial stewardship framework, and coordination itself. Each one removes a reason.

The fifth is different. Unavailable funding is not a HealthWest deficiency, and no amount of internal capability removes it. It is a question of how money already inside the Medicaid system gets prioritized, and the only way to move that is to argue for it. It is also the reason heard most often, and the one that decides the most. Advocacy carries this argument into the rooms where those decisions are made, grounded in the agency's own data rather than in illustration, because

legislators have said directly that claims about downstream cost avoidance are not credited when they arrive without evidence.

None of those works alone. Together they are a case.

There is a version of this that fails. Capacity built without a durable funding path becomes an obligation the General Fund carries by itself, and the community's need is real whether or not the funding follows it. So the plan holds one line: **HealthWest will not pursue service capacity it cannot sustain under available funding.** Demonstrated need alone is not sufficient justification for capacity the funding environment will not carry.

And every readiness investment in this plan has to hold value if the environment does not change. Work that pays off under only one future is a bet. Work that strengthens the agency under any future is preparation.

Sequence

Twenty-eight initiatives, and they do not all become operational at once. What follows is what happens when, and why.

TWENTY-EIGHT INITIATIVES, SORTED



None of this waits on a calendar. Each opens when what it needs arrives.

One initiative appears in two categories, which is why this totals twenty-nine across twenty-eight.

Already underway

Work is already moving in three places.

The end-to-end pathway from first contact to first service, running through the same-day access project. Data governance and the dashboard lifecycle, where the governance work has begun. And the financial stewardship decision framework, where new budgeting processes and clearer visibility into the General Fund are in development.

Two other efforts are running but sit differently. A workgroup on internal referral has put a pilot process into use, built on the routes that exist now, which will likely need rework if the operating model changes underneath it. A workgroup on clinical documentation is still establishing the size of the problem, because the agency does not yet know how much of it is common enough to solve once for everyone rather than team by team. Both are capable teams working the right problems without the structure to finish them. That is not a reason to stop. It is why the plan puts that structure first.

How the referral work began is worth reporting, because it was not planned. It surfaced while the agency was looking into a customer service matter, and what turned up was that referrals were sometimes sitting for hundreds of days. There was no defined process to move them forward and

nobody watching the ones that stalled. A step that decides whether a person actually reaches care had been running unattended, and it took an unrelated complaint to find it.

That is the condition, discovered by accident.

What limits these initiatives is not permission to begin. It is what sits underneath them, and the same holds across the sequence that follows. The layers do not decide when work starts. They decide how far it gets.

One chain, read start to finish, shows what that means in practice.

Read bottom to top — foundation opens structure opens delivery

1.2 Access and crisis continuity

Delivery — the scope of the crisis continuum itself

GATE

- Opens when billing integrity verifies what each funding stream actually nets. Crisis continuum scope can't expand on revenue that isn't confirmed.

5.2 Billing and payer integrity checkpoints

Structure — verifies what revenue actually supports

GATE

- Opens when the framework defines what counts as a priority claim on the General Fund. Billing work can't rank corrections until that standard exists.

6.1 Financial stewardship decision framework

Foundation — sets what the General Fund can carry

Ready to begin

Twenty initiatives are ready to assign. They are ordered by one rule: anything with a predecessor waits for it, and among the work that is unblocked, how work moves and who leads it goes first.

First. Mapping and owning cross-departmental workflows. Standardizing handoffs and internal referral. Standardizing role and scope definitions. Closed-loop tracking for corrective actions and incidents. Connecting documentation standards to practice. And the structured supervisory and management development system.

Five of those are Structure and one is Capability, and there is nothing else in the group. That is the plan's answer to what happens first.

Second. The competency framework. Technology governance and lifecycle management. The structured pathway for high-complexity needs. Unified public-facing communication. And the facilities and fleet evaluation framework.

Third. Nine initiatives that open when something ahead of them delivers: the community-based service delivery model, the single authoritative source of truth, belonging and culture monitoring, clinical performance and supervision tied to consumer outcomes, standardizing and automating administrative processes, billing and payer integrity checkpoints, the partnership accountability framework, external advocacy capacity, and system change readiness.

Four of those nine are opened by work already underway rather than by work not yet assigned, which is a materially better position. It also creates a dependency worth stating plainly: if the Foundation work now in motion slips, work in other layers slips behind it.

Running on someone else's clock

Two initiatives are already in flight on timelines HealthWest does not entirely set. The structured community needs assessment runs on a multi-year cycle already underway. And the provider relationship work within CCBHC scope depends on a standard contract in development and state approval.

Waiting, and why

Four things are not scheduled, and the reasons differ.

None carries a date. A gate does not open on a calendar. It opens when the material, information, or work it waits on exists or arrives, and the leader closest to that work makes the decision. Assigning a quarter to any of these would describe a preference rather than a condition.

The scope of the crisis continuum waits on the rate structure. The need is documented and the building for a crisis stabilization unit is identified, so neither information nor space is what holds it. What does not exist is reimbursement that would sustain the unit once it opened, and capacity built without a durable funding path becomes an obligation the General Fund carries by itself. This is the governing test applied to the work the agency most wants to do, and it is the clearest case in the plan of a gate HealthWest does not hold. The rate structure could move this year or next or never. What the plan commits to is being ready to move when it does, rather than describing the wait as something it is not.

The decision-intelligence view waits on the governance established in the data governance work, because an integrated view built over ungoverned data would inherit every problem the governance is meant to fix.

The conversion scope of the provider network work waits on what delivery cost and payer alignment turn out to be, which the financial stewardship work will show.

The fourth is different in kind. Whether prescriber recruitment receives dedicated investment, and whether recruitment targeting shifts from filling vacancies to relieving service constraints, is not waiting on information as everything needed to decide it is already known. What is missing is the decision, and decisions like this one are usually made by omission: a budget gets set, vacancies get posted as they occur, and a year later the question has been answered without anyone having asked it. This plan puts it on the table so it gets answered on purpose.

Sequencing adjusts as the work proceeds. Nothing here is a commitment to a calendar.

What the Plan Does Not Do

The four things above wait on something that has not happened yet. What follows is different: choices the agency has already made, each carried with the condition that would reopen it.

One test governs what this plan declines:

THE CONSTRAINT

HealthWest will not commit new recurring cost to unfunded expansion, staffing growth, or new service capacity until unit cost is aligned with reimbursement and the General Fund position is stabilized.

It applies without exception, including to expansion that is clinically compelling, publicly popular, or plainly aligned with the mission. Size does not change the answer, because the test does not scale with the size of the request.

That is why this plan does not pursue growth requiring new clinical capacity, or program investment made ahead of stabilization. Each of those adds recurring cost alongside the volume, deepening the position rather than resolving it, and there is no borrowing instrument available to bridge the gap between investment and return, because HealthWest is a department of the county rather than an independent corporate entity. The test reopens when unit cost is aligned and the surplus is available as local dollars.

Advocacy is worth naming separately, because the board has flagged it. It is in this plan, but it is not the strategy. Restructuring pressure has survived a legislative defeat and a change in leadership, so it is not something the agency can position against by choosing a side, and a strategy premised on continuing to win has no failure mode built into it. What determines HealthWest's position is not its lobbying capacity. It is whether the agency can demonstrate performance and operate coherently when someone else sets the terms.

What the plan does pursue

There is growth available that costs nothing to add.

HealthWest is authorized and staffed to deliver service that currently goes undelivered, inside the population it already serves, using capacity that already exists. The reason it goes undelivered is the condition this plan diagnoses: work stalls at handoffs, people fall out of contact at transitions, coverage lapses for procedural reasons nobody owns, and service that could have been provided and billed is not.

It is the clearest financial consequence of the condition, and unlocking it is one of the few ways the agency generates flexible money at all.

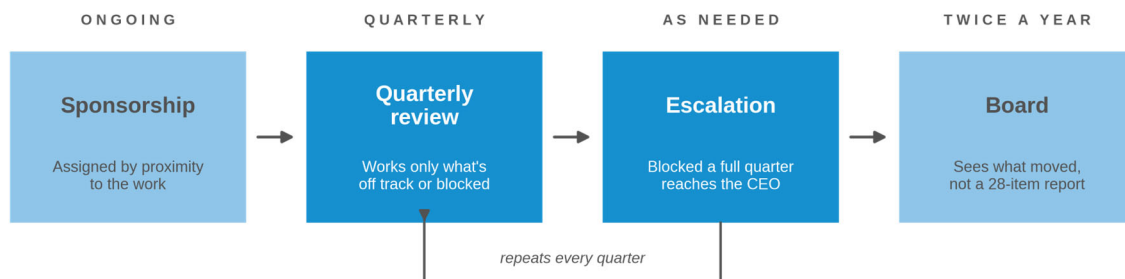
So the plan does not decline growth. It declines the kind that costs more, because there is a kind available that does not, and it builds the capacity to afford the rest.

Governance and Implementation

Seven workgroups ran a substantive process for months, and participants still could not see across the other six groups' work, because the only thing connecting the groups was one role holding it together by hand.

That is the condition this plan names, reproducing itself inside the effort to address it. It is also the argument for what follows: the plan cannot be held together the way the planning was, or it will end up back where the planning started.

HOW THE PLAN STAYS HELD TOGETHER



Sponsorship runs continuously. The loop above repeats four times a year; the board sees it twice.

Sponsorship is assigned by proximity to the work rather than by level. The sponsor of an initiative is the member of the leadership pod who already leads that work and can commit resources, and the leadership pod spans executives, directors, and managers. Sponsorship is concentrated rather than spread. Twenty-eight initiatives do not go to twenty-eight people; a sponsor carries several, which is what makes it possible for one person to see how their pieces affect each other. Rank does not close a gap between two departments. Standing over the actual work does. Assignments are made internally rather than printed here, and they change as need and workload changes.

Sponsors convene quarterly. Everyone reports. The session works only what is off track or blocked, and barriers are classified by what would actually resolve them: a decision, a resource, a dependency, or an external condition.

Off track means two things, and the second is easy to miss. Work can be blocked. And work can be moving without producing the effect it was chosen for. Effort is visible and effect is not, so an initiative consuming attention is easily mistaken for progress. Sponsors can reduce, reshape, or stop work on that basis, and stopping it is not a failure of the plan. Approval commits the organization to the direction, not to every path chosen toward it.

When an initiative is blocked on a cross-departmental decision for a full quarter, it goes to the full leadership pod as a decision request. Behind that, the role facilitating the review reports to the chief executive and can raise it directly, as an available path rather than a routine one. The block appears in the written submission whether or not anyone raises it, which is what does the work.

The board sees this work twice a year. What it receives is not a report on twenty-eight items. It is what moved: work that became ready, work that started, work released because something ahead of it delivered, and work still waiting, with the reason unchanged or changed. A plan whose gates do not open on a calendar is judged on whether things are moving through it, and that is a question the board can ask directly. The measures arrive on the same rhythm once the first cycle has set targets against what the baselines show.

Implementation also produces something to work from. This plan is built with a test, four layers, a sequence, and gates, and none of those are limited to the twenty-eight initiatives named here.

A supervisor deciding whether to take on a request that arrived this morning, a manager weighing two things that both look worth doing, a director asked to absorb something in the middle of a year: none of those choices appear in this document, and every one of them is the same kind of choice this plan makes. So part of implementation is building materials that put the test and the sequencing logic into the hands of the people making those calls, in a form they can use in the moment rather than one they have to interpret.

That is the difference between a plan and a way of deciding. A plan tells an organization what it committed to for three years. A way of deciding tells it what to do about the thing that came up on a Tuesday that nobody planned for.

Sequencing adjusts through the review when barriers warrant it.

What This Buys

Trace any two departments up the org chart and find the first place they meet. At HealthWest, as at most organizations, that place is the top. Below it, coordinating departments across the line is something people do without a defined path for doing it. Some do it readily and often. Others wait on permission. The same question, handed to two different people, gets two different answers, and neither person is doing anything wrong.

But in this industry, nothing that matters lands solely in one department. A funding change, a new mandate, an offer of partnership: each arrives across the whole organization at once. And an organization whose parts meet in only one place has only one place to build a response.

Something will arrive. Naming it here would turn preparation into forecast, but what can be described is what version of HealthWest it meets.

Against the organization as it currently stands, it is absorbed. Space decisions get made by circumstance. Financial exposure gets set by whatever came. Technology accumulates rather than gets governed. Each department answers for its own part, and the whole answer can only be assembled at the one point where the parts meet.

Against the organization this plan builds, the same thing lands differently. It lands on people who know it is theirs and know how to move it. The work travels across the organization instead of up it. And when what lands is an opening or an opportunity rather than a demand, HealthWest can move on it.

FY2030 is a position, not a finish. The pressures named at the front of this plan will still be there, and running an organization under them is permanent work. What is different is that the response is ready before the thing arrives. That is what three years of this work purchases.

Today the response gets assembled after the fact, at the single point where the parts meet, and assembling it takes the time it takes. While it is being assembled, the options close and the path narrows. A direction still gets chosen, but HealthWest is not the one choosing it.

By FY2030, HealthWest chooses.

Appendix: The Gate Chain

Sequence sorted every initiative into Underway, Ready, Someone else's clock, or Waiting. What follows is the same sequence at the initiative level: what each of the twenty-eight waits on, and what it opens in turn.

Documented gates are what the plan states. **Inferred** gates sit at the same level as initiative-level KPI detail. They are implementation, not strategy. The plan argues what depends on what in general; deciding the exact order two adjacent initiatives run in is a judgment made when the work starts, not before.

Pillar 1: Clinical Practice Excellence

INITIATIVE	STATUS	GATE: WHAT IT WAITS ON	OPENS
1.1 End-to-end pathway, first contact to first service	Underway	None	1.3 (<i>Inferred</i>)
1.2 Access and crisis continuity	Waiting	Internal: the financial framework (6.1) sets the criteria first (<i>Documented</i>). External, binding: the state Medicaid rate structure, which HealthWest does not set (<i>Documented</i>)	None
1.3 Community-based service delivery model	Ready, third wave	The end-to-end pathway (1.1) established (<i>Inferred</i>)	None
2.1 Competency framework	Ready, second wave	None	2.2 (<i>Inferred</i>)
2.2 Clinical performance and supervision tied to outcomes	Ready, third wave	The competency framework (2.1) in place (<i>Inferred</i>)	None

Pillar 2: Operational Integrity

INITIATIVE	STATUS	GATE: WHAT IT WAITS ON	OPENS
3.1 Mapped and owned cross-departmental workflows	Ready, first wave	None	4.1 (<i>Inferred</i>), 5.1 (<i>Inferred</i>)

INITIATIVE	STATUS	GATE: WHAT IT WAITS ON	OPENS
3.2 Standardized handoffs and internal referral	Ready, first wave	None	None
3.3 Standardized role and scope definitions	Ready, first wave	None	None
3.4 Closed-loop tracking for corrective actions and incidents	Ready, first wave	None	None
4.1 Single authoritative source of truth	Ready, third wave	Workflow mapping (3.1) defines what the repository has to hold (<i>Inferred</i>)	None
4.2 Documentation standards connected to practice	Ready, first wave	None	None
5.1 Standardized and automated core administrative processes	Ready, third wave	Workflow mapping (3.1): standardize first, then automate (<i>Inferred, and stated as a principle at 5.1 itself</i>)	None
5.2 Billing, documentation, and payer integrity checkpoints	Ready, third wave	The financial framework (6.1) sets what counts as a priority claim (<i>Documented: stated in 6.1's own rationale</i>)	None
6.1 Financial stewardship decision framework	Underway	None	5.2 (<i>Documented</i>), 6.3 conversion scope (<i>Documented</i>), 1.2 scope, internal half (<i>Documented</i>)
6.2 Structured pathway for high-complexity needs	Ready, second wave	None	None
6.3 Provider network structure and stability	Someone else's clock (CCBHC-scope portion) and Waiting (conversion scope)	External: a standard contract in development and state approval (<i>Documented</i>). Internal: what the financial framework (6.1) shows about delivery cost and payer alignment (<i>Documented</i>)	None

Pillar 3: Organizational Culture and Development

INITIATIVE	STATUS	GATE: WHAT IT WAITS ON	OPENS
7.1 Structured supervisory and management development system	Ready, first wave	None	7.2 (<i>Inferred</i>)
7.2 Belonging and culture health monitoring	Ready, third wave	The supervisory development system (7.1): monitoring runs through the supervision conversation it builds (<i>Inferred, close to Documented: 7.2's own text names the mechanism</i>)	None
7.3 Recruitment and workforce pipeline	Waiting	Not an information gate but a leadership decision on prescriber investment and retargeting, which is already answerable (<i>Documented</i>)	None

Pillar 4: Technology Transformation

INITIATIVE	STATUS	GATE: WHAT IT WAITS ON	OPENS
8.1 Data governance and dashboard lifecycle	Underway	None	8.3 (<i>Documented</i>), 9.2 (<i>Inferred</i>), 9.4 (<i>Inferred</i>)
8.2 Technology governance and lifecycle management	Ready, second wave	None	None
8.3 Integrated decision view	Waiting	Data governance (8.1) must be established, or the integrated view inherits every problem the ungoverned data has (<i>Documented</i>)	None

Pillar 5: Community Partnerships

INITIATIVE	STATUS	GATE: WHAT IT WAITS ON	OPENS
9.1 Unified public-facing communication	Ready, second wave	None	None

INITIATIVE	STATUS	GATE: WHAT IT WAITS ON	OPENS
9.2 Partnership accountability framework	Ready, third wave	Data governance (8.1): the data-sharing commitment named in 9.2 depends on it (<i>Inferred</i>)	None
9.3 Structured community needs assessment process	Someone else's clock	External: a multi-year regional and state assessment cycle already underway (<i>Documented</i>)	Informs access and crisis scope decisions (1.2, 1.3) (<i>Documented: 9.3 is named as the process that governs those decisions</i>)
9.4 External advocacy and coalition capacity	Ready, third wave	Data governance (8.1): advocacy runs on the agency's own data (<i>Inferred</i>)	9.5 (<i>Documented</i>)
9.5 System change and strategic readiness	Ready, third wave	The same evidence base that supports advocacy (9.4) (<i>Documented: stated directly in 9.5's own text</i>)	None

Pillar 6: Physical Infrastructure Capacity

INITIATIVE	STATUS	GATE: WHAT IT WAITS ON	OPENS
10.1 Facilities and fleet evaluation framework	Ready, second wave	None	None