COMMUNITY MENTAL HEALTH AUTHORITY
CLINTON • EATON • INGHAM

Community Mental Health Authority of Clinton, Eaton, and Ingham Counties

Shaping and Responding to the Changing Health Care Environment

Strategic Plan 2012 - 2015

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of Clinton, Eaton, and Ingham Counties
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"… the speed by which opportunities and threats emerge, the lack of solid data on emerging opportunities and threats, and the length of the traditional strategic planning process makes traditional strategic planning no longer as valuable as in the days when trends could be seen and measured, well in advance.

"…most accurate and action-focused planning is the result of: the application of hard-data analysis; an organization knowing its strengths, abilities and its industry; the application of experience-informed intuition; the cultivation of an entrepreneurial spirit and learning culture within the organization; the synthesis of the views of many observer and actors in the organization's environment; and the continual clear-eyed review and revision of approaches."

Preface to this plan: Strategic Doing

This document and the processes used to develop it did not follow the traditional strategic planning process. This more traditional process, which calls for an environmental scan (often including: surveys of constituents, key informant interviews, focus groups, literature searches, data analysis and similar methods), the development of a range of options clustered around strategic platforms, and the detailed development and articulation of detailed work plan is a lengthy one and is not nimble nor responsive enough to adapt to and/or anticipate opportunities and threats in the environment.

Based on the experience of this organization, over the past decade, and the writing of Henry Mintzberg, Andrew Campbell, and Laura Nash, a more active information gathering and synthesizing approach was used. 1 These authors argue that the speed by which opportunities and threats emerge, the lack of solid data on emerging opportunities and threats, and the length of the traditional strategic planning process makes traditional strategic planning no longer as valuable as in the days when trends could be seen and measured, well in advance. They are argue, and this plan reflects, an approach, lately tagged by others as "Strategic Doing". While building on this organization's past plans and operations, this plan is action oriented, synthesizing a number of observations, applying both hard data analysis with experience-based intuition in order to allow for rapid anticipatory actions (pre-emptive, when appropriate) and responses to a wide range of large scale (adaptive) and more technical environmental demands.

This approach can be most clearly seen in the fact that while some of the actions proposed by this plan are new to the organization, some are well underway, and some are in the early stages of their development. It is the view that the most accurate and action-focused planning is the result of: the application of hard-data analysis; an organization knowing its strengths, abilities and its industry; the application of experience-informed intuition; the cultivation of an entrepreneurial spirit and learning culture within the organization; the synthesis of the views of many observer and actors in the organization's environment; and the continual clear-eyed review and revision of approaches.

1 The Rise and Fall of Strategic Planning, Mintzberg, Henry; 1994; The Free Press, New York, New York;
A Sense of Mission, Campbell, Andrew and Nash, Laura L;1992; Addison-Wesley Publishing, Reading, Massachusetts

Executive Summary

The health care environment, always in flux, has been changing even more rapidly over the past several years, with a focus on improved integration between physical and behavioral health care. In an effort to **shape and respond to these changes**, the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMH) has, for the past several years, embarked on a number of initiatives, spanning many dimensions of the organization's operations.

The **major drivers of these initiatives** include:

1. The emergence of the **triple aim** as a unifying principle across the health care sectors. The triple aim framework drives the nation's health care system to:

- Improve the patient (consumer) experience of care (including quality and satisfaction)
- Improve the health of populations
- Reduce the per capita cost of health care

2. The recognition of the need for better health care integration and coordination to fulfill the triple aim – often fulfilled by organizations playing the role of **"integrators"** 2

3. The projected **increase in the demand for a wide range of behavioral health care and developmental disability services** - as a result of greater access to health care coverage and the growing recognition of the importance of behavioral healthcare as a core component of this nation's health care system.

4. The growing recognition that the continued strength and **centrality of state's public behavioral healthcare and developmental disability service system this system**, one of the most advanced in the nation, as a key component key to advancing Michigan's health care system and its ability to achieve the triple aim.

5. The value of using the concept of identifiable market segments to link, in strategy and action, the factors regarding increased demand and the desire to retain the central role of Michigan's public behavioral care system. By tailoring its approach to the needs of the consumers and payers within each of these markets, CMH can best ensure that it thrives and provides high quality, outcome-driven, cost-efficient care.

2 The triple aim and the roles of the integrator are discussed in what has become a seminal article by Berwick, Nolan, and Whittington, in Health Affairs [*Health Affairs* 27, no. 3 (2008): 759–769] and are reinforced in the Triple Aim Concept Design of the Institute for Healthcare Improvement.

CMH's multi-dimension approach
Seeing the issue of integration of primary and behavioral care as requiring action on a number of fronts, this CMH initiated a number of parallel efforts. These efforts centered around the following dimensions of health care integration:

1. Pursue a **multi-faceted health care integration initiative**:
2. Develop into a **comprehensive range behavioral health and developmental disabilities (MI, DD, and SUD) care manager and provider**
3. Expand access to services for previously un-served or underserved persons and build CMH's expertise, exposure, and experience in healthcare markets which are **emerging in the changing health care environment**
4. Operate an **in-house pharmacy** to foster the coordinated management of physical health and mental health medications
5. Operate and continually develop of sound **electronic health record,** ensure continued progress toward interoperability with other healthcare systems, and pursue active involvement in state and local electronic medical record technology initiatives.
6. Address the health care needs **of persons with patterns of utilizing high levels of health care resources**
7. Continually apply **evidence-based and promising practices** in meeting the behavioral health and developmental disability needs of the community.
8. Ensure a **strong role for the behavioral and developmental disability provider sector and this organization within the changing healthcare environment**:
9. Ensure that CMH's **workforce is of the capacity, diversity, and skill level** needed to meet the growing demand for a diverse behavioral healthcare and developmental disability services
10. **Ensure that consumers have health insurance coverage** and that CMH can meet the demands of multiple payers and coverage options
11. Ensure that CMH has a **welcoming environment and a customer orientation** at all of its sites and in all of its interactions with all stakeholders: consumers, families, community partners, and CMH colleagues
12. Ensure that CMH has a valid, reliable, flexible, relevant, and sustainable **outcome measurement system** – refining it within the behavioral health care domains and expanding it to reflect physical healthcare measures
13. Revise and expanded the **identity, role and purpose of this CMH** to match its work
14. Establish a **central, internal clearinghouse and learning venue** for organizing CMH's work in this effort

In pursuing this work – as described below- **CMH assumed a number of roles:**

- **Catalyst or convener for integration and innovation**
- **Leader of integration and innovation efforts**
- **Partner within integration or innovation efforts**

A. Introduction: Purpose of this Strategic Planning Effort

Purpose of this Plan: This plan builds upon the organization's preceding strategic plans - those for fiscal years 2000 through 2012 – while working to address threats and opportunities that are emerging in the health care environment in which this organization works. It focuses our work on those issues that revolve around the rapidly changing health care environment:

- some of these changes are related to the federal Patient Protection and Affordable Care Act (ACA)
- some are more longstanding trends which are occurring and have been occurring in the health care environment and will continue to do so, regardless of the implementation speed or breadth of the ACA

This plan aims to address the opportunities and threats created by the rapidly changing health care market and does not attempt to address the myriad of activities in which the organization is or could be involved. In fact, most of the day-to-day operations of the organization are not be addressed in this plan.

The **goal of this plan** is to **focus on efforts** that will address the most powerful ACA-related opportunities and threats and the activities that hold the greatest leverage relative to the ability of the organization to fulfill its mission. Similarly it is designed to **keep the organization from pursuing other initiatives**, designed to address other environmental forces which, while valuable, are not those identified as key to the organization's ability to survive and thrive.

As noted in the Preface to the document, while building on past plans, this effort is more action oriented, synthesizing a number of observations, applying both hard data analysis with experience-based intuition in order to allow for rapid anticipatory actions (pre-emptive, when appropriate) and responses to a wide range of large scale (adaptive) and more technical environmental demands.

B. Impetus behind the Innovation and Integration effort

The health care environment, always in flux, has been changing even more rapidly over the past several years, with a focus on improved integration between physical and behavioral health care. Some of the key drivers of these changes, with greatest relevance to the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMH) and those whom this organization serves include:

1. Triple Aim: The emergence of the triple aim as a unifying principle across the health care sectors. **The triple aim framework** drives the nation's health care system to:

- Improve the patient (consumer) experience of care (including quality and satisfaction)
- Improve the health of populations
  - This includes the growing recognition of the need to prevent he premature death of persons with serious mental illness
- Reduce the per capita cost of health care

- This includes reducing the inappropriate use or over-use of a range of health care and human services to meet the needs of persons with developmental disabilities, substance use disorders, or mental illness and children and adolescents with emotional disturbance

2. Key role of Integrators: The recognition of the need for better health care integration and coordination to fulfill the triple aim – often fulfilled by organizations playing the role of "integrators"

Role of integrator: Leading thinkers, writers, and policy makers underscore that the triple aim can be achieved only with several preconditions, one of which is an organization, known as integrator, that accepts responsibility for all three aims for a given population. As described by Don Berwick, et al (Dr. Berwick is the former Director of the federal Centers for Medicare and Medicaid Services (CMS)), "the integrator's role includes at least five components: 3

- partnership with individuals and families
- redesign of primary care
- population health management
- financial management
- macro system integration

While such integration efforts can take many forms, this CMH (and all health care providers) will be forced to wrestle with pressures to redefine their role and practices to address this movement toward integration. Two of the most widely discussed models for healthcare integration are Patient Centered Health Homes (PCHH) (sometimes referred to as Patient Centered Health Homes) and Accountable Care Organizations (ACO), some components of which are proven; some in their infancy). These models are discussed below. These models are discussed below.

A. Patient Centered Health Homes (PCHH): The PCHH is an approach to providing comprehensive healthcare by fostering a partnership between the individual and his/her identified lead health provider. These health homes are marked by a whole-person orientation – the health home is responsible for providing for appropriately arranging care with other qualified professionals. This includes care for all dimensions and stages of life including physical health care, behavioral health care, developmental disability services, acute care, chronic care, preventive services, and end of life care.

Care is coordinated and/or integrated, by the PCHH, across all elements of the complex health care system (e.g.,subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner.

3 The triple aim and the roles of the integrator are discussed in what has become a seminal article by Berwick, Nolan, and Whittington, in Health Affairs [*Health Affairs* 27, no. 3 (2008): 759–769] and are reinforced in the Triple Aim Concept Design of the Institute for Healthcare Improvement.

B. Accountable Care Organizations (ACO): ACOs are groups of providers, including primary care physicians, specialists, behavioral health and developmental disability providers, and hospitals, that agree to be held accountable for the cost and quality of care delivered to a specific population or group of beneficiaries in exchange for financial rewards for cost savings, assuming that certain quality outcomes and consumer protections are met. The payments may be made in a capitated, case rate, or other methods outside the more traditional fee-for-service system

Whereas the ACO is a broad network of providers, linked together fiscally and clinically, the PCHH is a primary or behavioral health care provider who links a network of providers, clinically and not fiscally, to coordinate care for an individual patient.

In addition to full fledged PCHHs and ACOs, a number of federal, state, and commercially-financed initiatives (including: the Duals Plan led by MDCH and the federal Centers for Medicare and Medicaid and the Michigan Primary Care Transformation Project (MiPCT) sponsored by MDCH and Blue Cross/Blue Shield) are requiring that key components of health homes and ACOs be integrated into health care delivery and care management efforts.

3. Increased Demand for Behavioral Healthcare: Over the next few years, health care systems will see a steady, sometimes dramatic, increase in the demand for a wide range of behavioral health care and developmental disability services - as a result of greater access to health care coverage (as a result of a number of public and private efforts, including but not limited to the federal Patient Protection and Affordable Care Act (ACA)) and the growing recognition of the importance of behavioral healthcare as a core component of this nation's health care system.

With the passage of the Patient Protection and Affordable Care Act (ACA), a number of opportunities and challenges arise for this CMH and its staff, the Community Mental Health Affiliation of Mid-Michigan of which it is a member (and for which it serves as the Prepaid Inpatient Health Plan), the consumers of this CMH, and those persons who will receive health care coverage under the ACA.

While the ACA has many components, there are a few which demand the attention of this organization regarding increases in the demand for behavioral healthcare services:

"… the number of persons enrolled in Medicaid, in the tri-county community could grow by approximately 50% with another 50% with newly acquired health insurance coverage."

- Increased health care coverage for a large number of the region's residents
- The creation of the state Insurance Exchange
- The pursuit, by the state of any of a number of ACA demonstration projects or State Medicaid Plan Amendments (SPA)

a. Increased health care coverage via Medicaid : There will be a significant increase in the number of this region's residents, currently without health care coverage, who could have health care coverage on January 1, 2014, or thereafter, if Medicaid expansion is implemented in Michigan. While estimates vary widely, the estimates of CEI staff as to the number of persons who will obtain health care

coverage due to the ACA are outlined below:4

	Current (pre-ACA) Medicaid enrollment (January 2011)	Expected Medicaid enrollment using Congressional Budget Office estimates	Persons eligible for enrollment in the state's Insurance Exchange
Clinton, Eaton, and Ingham Counties	73,150	35,690	34,740
Eight counties served by the Affiliation	113,212	46,480	45,250

While these data indicate significant growth in those persons who could obtain health care coverage, the number whom will become potential consumers of this region's CMH/PIHP system will be impacted by the following variables. All parties agree that the impact of these variables is difficult to predict and will be known, in more concrete terms once enrollment begins. The variables include:

- the actual Medicaid enrollment patterns
- the rate at which persons will enroll in the health plans offered through the state's Insurance Exchange
- the penetration rate (the percentage who present for services) of these new enrollees (in both Medicaid and the Exchange) are variables

A more detailed description of the types of persons who will acquire health care coverage through Medicaid expansion and, with it, access to CMH – what we call the Medicaid Expansion Market Segment in this paper – are discussed below.

From these rough figures, the number of **persons enrolled in Medicaid, in the tri-county community could grow by approximately 50% with another 50% with newly acquired health insurance coverage.**

b. The creation of the state Insurance Exchange: The ACA requires states to establish health insurance exchange(s) or join a regional or national exchange for individuals and small businesses by January 1, 2014. Exchanges will be a portal through which individuals will determine their eligibility for various private insurance plans and federal subsidies.

A health insurance exchange is a government or quasi-government organized body designed to facilitate insurance transparency, promote prevention services, and ensure access to insurance in such a way as to "spread risk" appropriately. Exchanges contract with private insurers, making specific requirements about benefit design, cost sharing, and coverage in order to promote access to affordable, quality

4 Data provided by Health Management Associates

"While many persons who now have little access to behavioral health care, because they lack health care coverage, will have access due to the ACA, the competition for the provision and care management of services to these persons is likely to be considerable.

"Providers who had not, formerly, been interested in serving these persons, may now be interested in entering this market given the new sources and levels of reimbursement and financing which the ACA makes available. The continued strength, centrality, and focus of Michigan's public behavioral healthcare system, one of the most advanced in the nation, is key to advancing Michigan's health care system and its ability to achieve the triple aim."

coverage. Several groups have made the analogy that an exchange should function like a travel website, such as Travelocity, that also includes information about quality (e.g., on-time arrivals, lost luggage, and friendliness of the staff).

The ACA requires states to include both bare-bones and more extensive insurance options (bronze, silver, gold, platinum), and mental health and substance abuse disorder services are required in even the lowest tiered option.

c. The pursuit, by the state, of any of a number of ACA demonstration projects or State Medicaid Plan Amendments (SPA): The ACA allows states the opportunity to apply for demonstration project designation in a wide range of areas addressed by the ACA. These demonstration projects provide flexibility, and in most cases funding, for states to begin the planning and implementation of ACA components, prior to the full implementation of the Act, on January 1, 2014.

The demonstration projects or SPA-related changes with the greatest import for CMH include:

- the state's Plan to Integrate Care for People Eligible for Medicare and Medicaid (often known as the Duals Plan)
- the SPAs related to the creation of Health Homes for persons with chronic health conditions (including serious mental illness, serious emotional disturbance, developmental disabilities and/or substance use disorders).

4. Central Role of the Public Behavioral and Developmental Disability Services System: The state's public behavioral healthcare and developmental disability service system has served, for decades, as the safety net provider system for persons with a wide range of mental health, substance use disorder, and developmental disability needs**.** While many persons who now have little access to behavioral health care, because they lack health care coverage, will have access due to the ACA, the **competition for the provision and care management of services to these persons is likely to be considerable**.

Providers who had not, formerly, been interested in serving these persons, may now be interested in entering this market given the new sources and levels of reimbursement and financing which the ACA makes available. **The continued strength, centrality, and focus of Michigan's public behavioral healthcare system, one of the most advanced in the nation, is key to advancing Michigan's health care system and its ability to achieve the triple aim.**

"In working to conceptualize an approach to dealing with increased demand and potentially increasing competition in the behavioral health care market, the use of a market segment approach is useful. The value of this approach is clear with the recognition of the number of distinct health care markets.

" By tailoring its approach to the needs of the consumers and payers within each of these markets, CMH can best ensure that it thrives and provides high quality, outcome-driven, cost-efficient manner."

5. Linking factors regarding increased demand and the central role for the public system by focusing CMH's work on the identifiable market segments which are emerging in the health care environment: In working to conceptual an approach to dealing with increased demand and potentially increasing competition in the behavioral health care market, the use of a market segment approach is useful. The value of this approach is clear with the recognition of the number of distinct health care markets which exist and are emerging.

By tailoring its approach to the needs of the consumers and payers within each of these markets, CMH can best ensure that it thrives and provides high quality, outcome-driven, cost-efficient care.

Segment 1 - CMH's traditional Medicaid population: Medicaid enrollees with serious mental illness, developmental disabilities, emotional disturbance or substance use disorders

Segment 2 – Medicaid enrollees with mild to moderate behavioral healthcare needs: Medicaid enrollees, enrolled in Medicaid Health Plans, with behavioral health needs not severe enough to make them eligible for CMH's core Medicaid and non-Medicaid services. These persons have a 20 session behavioral health care benefit that is managed by the Medicaid Health Plans (MHP).

Segment 3 - Expanded Medicaid population: Persons with incomes below 133% of the federal poverty limits (FPL) but not currently on Medicaid:
a. Children and adolescents in families with incomes above the current Medicaid income threshold
b. Adults without chronic health conditions or disabilities or with mild to moderate or non-chronic conditions (conditions not severe nor chronic enough to make them eligible for the current Medicaid program)

Segment 4 - Exchange enrollees with less than 250% FPL: Persons purchasing health care through the Exchange, with incomes below 250% of FPL. This segment, some have projected, will move in and out of Medicaid, given the instability of their employment-related income. Given that, they may look like Segment 2 – New Medicaid enrollees, but will need transition assistance between health plans and the differences in the benefits covered by Medicaid and the Exchange-based plans.

Segment 5 - Exchange enrollees with more than 250% FPL: Persons purchasing health care through the Exchange, with incomes above

250% of FPL and below 400% of FPL. This segment, some have projected, will not move in and out of Medicaid, given the greater stability of their employment-related income. In fact, many of these persons will have long term employment histories with small employers or employers who have not, in the past, provided health insurance for their employees. This group will probably not need transition assistance between health plans and the differences in the benefits covered by Medicaid and the Exchange-based plans.

Segment 6 – Employer-funded commercial market: Persons with incomes above 400% FPL. For this group, the health insurance subsidies cease, making those with incomes above 400% of FPL look like the current commercial market: either self-insured or those with employer-paid insurance.

A. Current benefits which CMH has not previously accessed

B. Benefits which will be added as part of the changing health care environment (The addition of autism treatment services to the benefit package covered by Michigan's commercial health insurance providers, as required by the recently passed Michigan statute, is an example of such a set of benefits)

Segment 7 – Dual-enrollee (Medicare and Medicaid) market: Persons who are dually enrolled in Medicaid and Medicare. While this CMH manages and provides the Medicaid benefits to which these persons are entitled, the state's move toward an integrated care management and provider system for both the Medicaid and Medicare benefits will require alterations to the practices of the CMH system and other health care providers.

C. Strengths and momentum of this CMH relative to the demands of the changing health care environment

This CMH is already involved in work that fits well with the demands of the changing health care environment. This work provides this CMH with strengths and momentum (so that this CMH is not starting from scratch) as it moves into the emerging health care world. These strengths include:

1. Longstanding history of applying principles and practices required by the emerging environment

A long (four decades) track record of providing services in the manner promoted by the emerging environment: a **non-traditional, patient/consumer-centered array of multidisciplinary team-based, community-based services and supports, which apply evidence based practices**

2. Strong consumer involvement at all levels

Strong consumer involvement at all levels of the organization's operations: governance, advice and guidance, employment, and person centered planning practices. **CMH consumers are active members of CMH's Board of Directors and Advisory Councils, and are employed, in significant numbers, at CMH.**

2. Pioneer of community-based care

This CMH (and the PIHPs and CMHSPs, statewide) have, over the past several decades, **taken a system that was heavily hospital based and made it almost entirely community-based** –

fitting well with the quality, outcome, and cost control aims fostered by the emerging environment.

3. Proven ability to control cost

This CMH (and the PIHPs and CMHSPs, statewide) – through the use of a range of person-centered, community-based services - have kept per-enrollee **cost increases at 2.2% per year** over the past decade (far below cost increases experienced in other parts of the health care market) while operating in a risk-based financing structure.

4. Measureable high quality services

In line with the health care market's focus on quality measures, this CMH has a **strong decades-long track record of quantifiable performance** as measured by the Michigan Mission-Based Performance Improvement System and a proven quality improvement system to ensure high levels of quality

5. Multi-dimensional health care integration efforts

This CMH is involved in a number of efforts aimed at integrating physical health and behavioral health and developmental disability services, including many of the components of a **Accountable Care Organization (ACO) and a Patient-Centered Health Home (PCHH).** These efforts include: a wide range of bi-directional co-location efforts (CMH behavioral care provider at a primary care site; and primary care providers at a CMH behavioral care site); joint educational efforts of behavioral and primary care providers; healthy lifestyles education, by consumers, with consumers; the use of an in-house pharmacy to foster the coordinated management of physical health and mental health medications.

Additionally, this CMH has many of the components of a **Patient Centered Health Neighborhood (sometimes called a Community Care Organization)** – those which address a number of needs outside of the traditional health care sphere: housing, employment, income maintenance, corrections, access to food and clothing, recreation, integration into the faith community, corrections and law enforcement, academic performance.

6. Electronic Health Record available to large provider network

This CMH has a **robust integrated data system, including a certified electronic health record (EHR), a data warehouse and a powerful data analysis system**. This system provides consumer/patient information to over **700 providers at over 60 sites** and **remotely (via cellular and wireless laptops**).

D. CMH's multi-dimension parallel entrepreneurial approach

Seeing the issue of integration of primary and behavioral care as requiring action on a number of fronts and the need for continued innovation in this and a number of other dimensions of its work, this plan calls for this CMH to **initiate, where efforts have not begun, and continue, in earnest, efforts that are underway, a number of parallel efforts**. These efforts centered around the following dimensions of health care innovation and integration

1. Pursue a **multi-faceted health care integration initiative**:
    A. Establishing **bi-directional co-location** initiatives:
        1. Behavioral care providers at primary care sites
        2. Primary care providers at a CMH behavioral care site
    B. **Partnering with primary care provider for house calls** to aging CMH consumers
    C. **Facilitated referrals** for CMH consumers, by CMH, with primary care providers
    D. **Healthy lifestyles education**, by consumers, with consumers
    E. **Expanded health checks** within the behavioral health care visit
    F. **Joint educational efforts** (coordination of care learning events) of behavioral and primary care providers

2. Develop into a **comprehensive range behavioral health and developmental disabilities (MI, DD, and SUD) care manager and provider**
    A. Becoming the **Substance Use Disorder Coordinating Agency (CA) for the 8 county region surrounding Lansing.**

3. **Expand access to services for previously un-served or underserved persons** and build CMH's expertise, exposure, and experience in healthcare markets which are **emerging in the changing health care environment**
    A. Serve previously unserved and underserved persons with a range of behavioral health and developmental disability needs
    B. Development of **regional autism center**, to serve persons previously unserved and underserved
    C. Expanding services to **children served in the public child welfare system**

4. Continue the long-time partnership with an **in-house pharmacy** to foster the coordinated management of physical health and mental health medications

5. Operate and continually develop of sound **electronic health record,** ensure continued progress toward interoperability with other healthcare systems, and pursue active involvement in state and local electronic medical record technology initiatives.

6. Address the health care needs **of persons with patterns of utilizing high levels of health care resources**
    A. **Joint financing of sub-acute detox center** by local hospitals, county health plans, substance abuse coordinating agency, and CMH
    B. **Coordination of care between emergency departments** within local hospitals and the CMH system

C. **Joint effort with Medicaid Health Plans**, in addressing the needs of high utilizers of health care resources

7. Continually apply **evidence-based and promising practices** in meeting the behavioral health and developmental disability needs of the community.

8. Ensure a **strong role for the behavioral and developmental disability provider sector and this organization within the changing healthcare environment**:

A. Participation in **state level policy discussions** related to the changing health care environment

B. Actively participate in the design and formation of a **21 county regional Medicaid Prepaid Health Plan**

C. Participation in statewide, regional, and local community **health care coalitions**

9. Ensure that CMH's **workforce is of the capacity, diversity, and skill level** needed to meet the growing demand for a diverse behavioral healthcare and developmental disability services

A. **Aggressive recruitment, retention, and promotion strategies**

B. On-going **tailored training of CMH staff and stakeholders** on a range of issues related to the changing health care environment

10. **Ensure that consumers have health insurance coverage** and that CMH can meet the demands of multiple payers and coverage options

11. Ensure that CMH has a **welcoming environment and a customer orientation** at all of its sites and in all of its interactions with all stakeholders: consumers, families, community partners, and CMH colleagues

12. Ensure that CMH has a valid, reliable, flexible, relevant, and sustainable **outcome measurement system** – refining it within the behavioral health care domains and expanding it to reflect physical healthcare measures

13. Revise and expanded the **identity, role and purpose of this CMH** to match its work

In order to effectively address the challenges and opportunities in the changing health care market, this CMH is examining the broadening of its role to a more encompassing one – one that allows it to use its considerable clinical, fiscal, operational, and collaborative expertise to fulfill its purposes of advancing the common good, serving as the public safety net, and providing high quality, cost-effective, community-based services

14. Establish a **central, internal clearinghouse and learning venue** for organizing CMH's work in this effort

In pursuing this work – as described below- **CMH assumed a number of roles:**

- **Catalyst or convener for integration and innovation**
- **Leader of integration and innovation efforts**
- **Partner within integration or innovation efforts**