Path Behavioral Healthcare
2022-23 Strategic Plan

UPDATED 1/1/23

Mission

PATH is an acronym for Positive Advocates Teaching and Helping. We felt it was important to choose a name that put positivity first as we believe seeing themselves in a positive light is crucial to our client's success.

We also intentionally choose the term "advocates" for our employees because advocates are defined by the support they provide. Our team is happy to serve in support of your success!

Services

- Outpatient Therapy (UT and OH)
- Community Psychiatric Support and Treatment (UT and OH)
- Therapeutic Behavioral Services (UT and OH)
- Medication Management (UT and OH)

How We develop the Strategic Plan

We gather information for our annual plan via treatment team and staff meetings, community forums, online surveys of the people we serve and their families, our staff, and stakeholders. We analyze our organization's strengths, and weaknesses and emerging opportunities and potential threats. Out of this process a strategic plan is formulated and the "critical issues" for the agency are developed, and measurable goals are then developed to address planning needs. We gather information from surveys, suggestions boxes, and community forums,

We welcome your ideas and input regarding improvements in services that we currently provide as well as any new services you think we should develop and implement. Please email your suggestions to our CEO.

Our Strategic Plan will be shared, as relevant to the population served, with persons served, personnel and other stakeholders.

Expectations of persons served

Based on consumer and stakeholder satisfaction data, our consumers and their families desire locally based, accessible, and small to medium sized offices, to provide treatment. Path Behavioral Healthcare will meet these criteria and desire to maintain a 85%+ satisfaction rate. Path Behavioral Healthcare offices are excellent because the Agency office is easily accessible by automobile or public transportation.

Expectations of other stakeholders. Our stakeholders include Managed Care Organizations and local clinicians. Path Behavioral Healthcare stakeholders desire

agencies having an array of services who are responsive to their regulatory requirements and provide measurable, quality, cost effective services.

The competitive environment
When marketing our services to managed-care companies and preferred provider organizations we offer and cover comprehensive needs.

In the age of health care reform and increased use of contracts with health maintenance organizations (HMOs), managed care organizations (MCOs) preferred provider organizations (PPOs), and other groups, the demand for behavior health and intellectual/developmental disability providers continues to decline. This phenomenon, being driven by "carve outs," has created a competitive market, resulting in customer service being a critical factor. From this perspective, the customer identified as payor is managed care organizations. They clearly drive the large percentage of referrals within the industry.

Financial Opportunities
Path Behavioral Healthcare has sufficient cash flow and reserves to operate in 2022-2023. Path Behavioral Healthcare Services must become considerably more sophisticated than our competitors in order to remain competitive. The likely future of agencies that are like Path Behavioral Healthcare is that they will go out of business or be acquired in 2022-2023 thus increasing Path Behavioral Healthcare's market share. .

Our research indicates the most viable sustainable services will continue to be mental health and substance use related. The greatest opportunity for Path Behavioral Healthcare will be to :

- Expand its substance use services in OH and UT.
- Service more children in the OhioRise program.
- Start 10 new offices in OH

Financial Threats
In light of the Covid 19 pandemic Path Behavioral Healthcare must develop service lines that will be sustainable in the likelihood that the pandemic will continue. The more diverse we are the more stable we will be. An additional threat is legislation or rule making about telehealth. At present we can freely utilize telehealth but that is uncertain in the future.

[Updated 1/1/23] A financial threat to the organization is having unfilled clinical positions. We have updated our Workforce Development Plan to focus on recruiting and retaining clinical and medical staff particularly in Utah.

Financial Needs
Path Behavioral Healthcare needs to allocate money to accomplish goals in 2022-2023. Specifically:

- $50,000 to become CARF accredited.
- $20,000 for information technology
- $10,000 for CARF related staff training
- ~1% of revenue for electronic health record.

- ~$100,000 for expanded startup costs to start 10 new offices in OH
- ~ $10, 000 to star providing substance use services
- ~15,000 for staff recruitment efforts

The organizations capacities
The owner, officers and directors are knowledgeable. Staff are satisfied with Path Behavioral Healthcare and dedicated to our clients. One area we have identified we need to have more capacity is in corporate compliance . We will hire a compliance officer in 2022.

[Updated 1/1/23] We have contracted with an external compliance officer in 2022

The organization's relationships with external stakeholders.
Our stakeholders include state, MCOs, and local clinicians. In general, the agency has excellent relationship with our referral sources and regulators.

The regulatory environment.
While the Medicaid expansion provides a larger customer base for some of our services it also has risks as the cost of the Medicaid match grows exponentially over time. The federal response to the COVID pandemic has brought billions of dollars to states. This inflow of new dollars is unsustainable. At some point the states will not be able to afford the Medicaid match. Path Behavioral Healthcare must be diligent about monitoring the regulatory environment.

The legislative environment.

The OH Legislature is considered a "purple or swing state: . One of its main planks is expansions of health care. The ~~OH~~ Utah (correction) Legislature is considered a " red" or Republican state: One of its main planks is containing the costs of health care. CMS and the state will likely promulgate rules to meet Affordable Care Act demands. The turmoil and lack of a unified clear policy position in Congress will most likely impact service funding in some way. Path Behavioral Healthcare will need to close watch these dynamics.
Social Determinants of Substance Abuse
Several biological, social, environmental, psychological, and genetic factors are associated with substance abuse. These factors can include gender, race and ethnicity, age, income level, educational attainment, and sexual orientation.10 Substance abuse is also strongly influenced by interpersonal, household, and community dynamics.

Family, social networks, and peer pressure are key influencers of substance abuse among adolescents. For example, research suggests that marijuana exposure through friends and siblings was a primary determinant of adolescents' current marijuana use.11 Understanding these factors is key to reducing the number of people who abuse drugs and alcohol and improving the health and safety of all Americans.

References
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Social Determinants of Mental Health

Major mental disorders like schizophrenia, bipolar disorder, depression, and panic disorder are found world-wide, across all racial and ethnic groups. They have been found across the globe, wherever researchers have surveyed. In the United States, the overall annual prevalence of mental disorders is about 21 percent of adults and children
This general finding about similarities in overall prevalence applies to minorities living in the community. It does not apply to those individuals in vulnerable, high-need subgroups such as persons who are homeless, incarcerated, or institutionalized. People in these groups have higher rates of mental disorders. The Surgeon General's Report of 1999 concluded the following:

- Minorities have less access to and availability of mental health services.
- Minorities are less likely to receive needed mental health services.
- Minorities in treatment often receive a poorer quality of mental health care.
- Minorities are underrepresented in mental health research.

More is known about the disparities than the reasons behind them. Many barriers deter minorities from reaching treatment. These barriers operate for all Americans: cost, fragmentation of services, lack of availability of services, and societal stigma toward mental illness. But additional barriers deter racial and ethnic minorities: mistrust and fear of treatment, racism and discrimination, and differences in language and communication. The ability for consumers and providers to communicate with one another is essential for all aspects of health care, yet it carries special significance in the area of mental health because mental disorders affect thoughts, moods, and the highest integrative aspects of behavior. The diagnosis and treatment of mental disorders greatly depend on verbal communication and trust between persons served and clinician.

With a multitude of cultural sub-groups and individual variations, culture is important because it bears upon what all people bring to the clinical setting. It can account for variations in how persons served communicate their symptoms and which ones they report.

Some sets of symptoms are much more common in some societies than in others. Often culture bears upon whether people even seek help in the first place, what types of help they seek, what coping styles and social supports they have, and how much stigma they attach to mental illness. All cultures also feature strengths, such as resilience and adaptive ways of coping, which may buffer some people from developing certain disorders.

The effectiveness of mental health treatment across cultures has been documented, according to Mental Health: A Report of the Surgeon General. There is evidence that racial, ethnic, and disability-related minorities benefit from mental health treatment. Untreated mental disorders can have dire consequences — distress, disability, and, in some cases, suicide. Every person, regardless of race, ethnicity or disability, should seek help if they have a mental health problem or symptoms of a mental disorder.

The cultures of racial, ethnic and disability-related minorities influence many aspects of mental illness, including how persons from a given culture communicate and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment. Likewise, the culture of the clinician and the service system influence diagnosis, treatment, and service delivery. Culture is a concept not limited to persons served. It also applies to the professionals who treat them. Every group of professionals embodies a "culture" in the sense that they too have a shared set of beliefs, norms, and values.

[New 1/1/23 in anticipation of starting substance use services
Social Determinants of Substance Abuse

Children and Adolescents- On an average day in 2006, youth used the following substances for the first time: 7,970 drank alcohol; 4,348 used an illicit drug; 4,082 smoked cigarettes; and 2,517 used pain relievers nonmedically.8
Daily marijuana use increased among students in 8th, 10th, and 12th grades from 2009 to 2010. Among 12th graders, marijuana use was at its highest point since the early 1980s, with 6.1 percent of all high school seniors reporting marijuana use.

Prescription medications, such as painkillers, and over-the-counter cough and cold medicines are some of the most abused drugs among high school seniors.8
13.8% of students in 8th grade, 28.9% of students in 10th grade, and 41.2% of students in 12th grade consumed at least 1 drink in the past 30 days. Youth who used alcohol in the past month drank an average of 4.7 drinks per day on the days they drank.

Adults-People ages 18 to 25 had the highest rates of current drug use of any age group, at 21.2%. This is largely driven by the widespread use of marijuana among this age group (18.1%). 41.7% of young adults age 18 to 25, 36.3% of adults age 26 to 34, and 19.2% of people age 35 or older reported binge drinking in 2009.Adults dependent on alcohol report higher rates of illicit drug use and nonmedical use of prescription drugs compared with the general population.

Several biological, social, environmental, psychological, and genetic factors are associated with substance abuse. These factors can include gender, race and ethnicity, age, income

level, educational attainment, and sexual orientation.10 Substance abuse is also strongly influenced by interpersonal, household, and community dynamics.

Family, social networks, and peer pressure are key influencers of substance abuse among adolescents. For example, research suggests that marijuana exposure through friends and siblings was a primary determinant of adolescents' current marijuana use.11 Understanding these factors is key to reducing the number of people who abuse drugs and alcohol and improving the health and safety of all Americans.

Sensory Impairment (Deaf, Hard Of Hearing, Blind)

Statistics vary greatly depending on the definition of "deaf." The National Center for Health Statistics places the number of profoundly deaf in the U.S. at more than 400,000, while people classified as hard-of-hearing number over 20 million, or about 8 percent of the total population. Within the actual ranks of deaf people, more than half reportedly use American Sign Language (ASL) on a regular basis
Deaf people may refer to their culture in terms of their use of sign language and the camaraderie it brings. But it is also the knowledge that they are a minority faced with certain restrictions.

Individuals who are deaf-blind, regarded as "most significantly disabled" by state vocational rehabilitation agencies continue to face significant social, economic, educational and psychological barriers. The lack of available services and resources is often an obstacle to achieving self-sufficiency for individuals who are deaf-blind.

Throughout the United States this low incidence diverse community remains unserved and under served. The impact on the individual and the service delivery system continues to be a challenge.

Individuals who are deaf-blind make up a diverse group. The degrees and kinds of hearing and vision losses vary: hard of hearing and low vision, deaf and tunnel vision, hard of hearing and blind in addition to totally deaf-blind. The age of onset also varies from being born with both losses, born with one loss and experiencing the other loss at some point in their lives, or experiencing both losses due to aging, illness, or injury. Because of this variable in degrees, age of onset, and etiology, communication methods become diverse: American Sign Language (close up or tactile), assistive listening devices, Braille equipment. Moreover, deaf-blind people have diverse socioeconomic backgrounds, family support, and education.

More than 25 million Americans report experiencing significant vision loss. The term vision loss refers to individuals who reported that they have trouble seeing, even when wearing glasses or contact lenses, as well as to individuals who reported that they are blind or unable to see at all. This estimate pertains to a nationally representative sample of the noninstitutionalized civilian population 18 years of age and over. Approximately 24.7 million Americans who have vision loss indicated one race and 419,000 indicated two or more races. Of those who indicated one race, 20.5 million are white, 3.0 million are black or African American, 2.8 million are Hispanic or Latino, 886,000 are Asian, and 265,000 are American Indian or Alaska Native.

Ethnic/Racial Considerations African-Americans

For African Americans who live in the community, rates of mental illness appear to be similar to those for whites. In one study, this similarity was found before, and in another study, after controlling for differences in income, education, and marital status. But African Americans are overrepresented in vulnerable, high-need populations because of homelessness, incarceration, and, for children, placement in foster care.
African Americans have less access to mental health services than do whites. Less access results, in part, from lack of health insurance, especially for the working poor who do not qualify for public coverage and who work in jobs that do not provide private health coverage.

About 25 percent of African Americans are uninsured. Yet better insurance coverage by itself is not sufficient to eliminate disparities in access because many African Americans with adequate private coverage still are less inclined to use services.
African Americans with mental health needs are less likely than whites to receive treatment. If treated, they are likely to have sought help in primary care, as opposed to mental health specialty care. They frequently receive mental health care in emergency rooms and in psychiatric hospitals.

They are overrepresented in these settings partly because they delay seeking treatment until their symptoms are more severe. For certain disorders (e.g., schizophrenia and mood disorders), errors in diagnosis are made more often for African Americans than for whites. The limited body of research suggests that, when receiving care for appropriate diagnoses, African Americans respond as favorably as do whites. Increasing evidence suggests that, in clinical settings, African Americans are less likely than whites to receive evidence-based care in accordance with professional treatment guidelines.

American Indians and Alaska Natives

Existing studies suggest that American Indian/Alaska Native youth and adults suffer a disproportionate burden of mental health problems and disorders. As one indication of distress, the suicide rate is 50 percent higher than the national rate. The groups within the American Indian/Alaska Native population with the greatest need for services are people who are homeless, incarcerated, or victims of trauma.
About 20 percent of American Indians/Alaska Natives do not have health insurance, compared to 14 percent of whites. The appropriateness and outcomes of mental health care for American Indians and Alaska Natives has not been adequately studied according to the Surgeon General's Report.

Asian Americans and Pacific Islanders

Available research suggests that the overall prevalence of mental health problems and disorders among Asian Americans/Pacific Islanders does not significantly differ from prevalence rates for other Americans. Contrary to popular stereotypes, Asian Americans/Pacific Islanders are not, as a group, "mentally healthier" than other groups. Refugees from Southeast Asian countries are at risk for post-traumatic stress disorder as a result of the trauma and terror preceding their immigration.

Nearly half of Asian Americans/Pacific Islanders have problems with availability of mental health services because of limited English proficiency and lack of providers who have appropriate language skills.

About 21 percent of Asian Americans/Pacific Islanders lack health insurance, but again there is much variability. The rate of public health insurance for Asian Americans/Pacific Islanders with low income, who are likely to qualify for Medicaid, is well below that of whites from the same income bracket.

Asian Americans/Pacific Islanders have lower rates of service utilization compared to whites. This under-representation in care is characteristic of most Asian American/Pacific Islander groups, regardless of gender, age, and geographic location. Among those who use services, the severity of their condition is high, suggesting that they delay using services until problems become very serious. Stigma and shame are major deterrents to their utilization of services.

There is very limited evidence regarding treatment outcomes for Asian Americans/Pacific Islanders.

Because of differences in their rates of drug metabolism, some Asian American/Pacific Islanders may require lower doses of certain drugs than those prescribed for whites. Ethnic matching of therapists with Asian American/Pacific Islander clients, especially those who are less acculturated, has increased their use of mental health services.

Hispanic Americans

Hispanic Americans have overall rates of mental illness similar to those for whites, yet there is wide variation. Rates are lowest for Hispanic immigrants born in Mexico or living in Puerto Rico, compared to Hispanic Americans born in the United States. Hispanic American youth are at significantly higher risk for poor mental health than white youth are by virtue of higher rates of depressive and anxiety symptoms, as well as higher rates of suicidal ideation and suicide attempts.

About 40 percent of Hispanic Americans in the 1990 census reported that they did not speak English very well. Very few providers identify themselves as Hispanic or Spanish-speaking. The result is that most Hispanic Americans have limited access to ethnically or linguistically similar providers.

Of all ethnic groups in the United States, Hispanic Americans are the least likely to have health insurance(public or private). Their rate of uninsurance, at 37 percent, is twice that for whites.

Hispanic Americans, both adults and children, are less likely than whites to receive needed mental health care. Those who seek care are more likely to go to primary health providers than to mental health specialists.

The degree to which Hispanic Americans receive appropriate diagnoses is not known because of limited research. Research on outcomes, while similarly sparse, indicates that

Hispanic Americans can benefit from mental health treatment. Increasing evidence suggests that Hispanic Americans are less likely in clinical settings to receive evidence-based care in accordance with professional treatment guidelines.

Spirituality

In recent years, the Association of American Medical Colleges (AAMC) has placed significant attention on social determinants of health (SDH) as making significant contributions to patient health and outcomes (AAMC, 2012). Although the medical community has long understood the influence of a patient's lived environment on health, medical education has only recently incorporated SDHs into its curriculums, generally defining them as the social, political and economic influence on race, ethnicity, poverty level, socioeconomic status and education level. I contend that this definition is incomplete. Spirituality and religion (SR) informs behaviors that have health implications to at least an equal degree, and therefore should be included as a social determinant of health, and given equal weight to the aforementioned (Idler, 2014). Currently, most relevant literature focuses on the ethicality of SR and medicine or the specific health benefits associated with various religions. Future research should go beyond these questions and address SR as a SDH because SR can inform patient health beliefs, practices and behaviors (Idler, 2014). Not only does SR act as a social determinant of health, it acts as a social mediator of health (SMH). Although certain religious practices promote common behaviors among groups that have health specific implications (i.e. following a SR that proscribes alcohol influences health behaviors in regard to alcohol consumption), individuals in the same group might understand or respond differently to illness (health beliefs). In this way, SR can act as social mediator of health during an illness experience- Gross, Christopher, 2015 ,
https://core.ac.uk/download/pdf/46929357.pdf

LGBTQ+

Research related to healthcare disparities experienced by LGBTQ+ identifying clients are limited.

LGBTQ+ individuals experience significant rates of healthcare discrimination in the US. In Lambda Legal's 2010 survey of LGBT people and people with HIV, "When Healthcare Isn't Caring"[1]:

- Over 50% of LGB study participants reported one or more of the following: being refused care, having their healthcare provider refuse to touch them, excessive use of precautions when being treated, being blamed for their health status, or having their healthcare provider verbally abuse them.
- Transgender people reported having experienced discrimination and barriers to accessing healthcare at as much as 2 to 3 times the rate experienced by LGB people.
- LGBT people of color and people of lower socioeconomic status were also more likely to report facing discriminatory or substandard care.

The 2015 U.S. Transgender Survey[2], the largest survey to date examining the experience of transgender individuals in the U.S, found:

- Of the respondents who saw a health care provider in the past year, 33% had at least one negative experience related to being transgender.
- Negative experiences included being denied care, being harassed or assaulted, or having to educate their provider about what identifying as transgender means to them and basics about the healthcare they are seeking in order to get appropriate care.
- 23 percent of respondents did not seek needed medical care in the past year because they feared being mistreated as a transgender person, and 33 percent did not seek care due to financial barriers.

Lambda Legal's 2009 Healthcare Fairness Survey found that within the LGBT community, people of color experience disproportionate levels of healthcare discrimination compared to those who are white or who are not transgender.[3]

Health Disparities

The following are just a few of the most notable health related disparities LGBTQ people
face, as reported in 2011 by the Institute of Medicine[5]:

- LGB youth are at higher risk for suicidal ideation, suicide attempts, and depression
- A disproportionate number of LGB youth are homeless
- Lesbians and bisexual women may have a higher risk of obesity and breast cancer than heterosexual women, and be less likely to receive preventative care
- Men who have sex with men (disproportionately affected are black and Latino men) are still disproportionately impacted by HIV/AIDS
- LGB adults may have higher rates of smoking, alcohol use, and substance use
  than heterosexual adults (most of this research was conducted on women).
- Limited research indicates substance use is a concern for the transgender population as well.
- See the report: https://www.kff.org/report-section/health-and-access-to-care-and-coverage-lgbt-individuals-in-the-us-impact-of-changes-in-the-legal-and-policy-landscape-on-coverage-and-access-to-care/

Demographics of potential service users

An examination of the demographics of our service are show that our services are needed. US Census, https://www.census.gov/quickfacts/fact/table/sciotocountyohio/PST045222, retrieved 12/1/21 & Updated 7/1/22.

Population Estimates, July 1 2022, (V2022)	**NA**
PEOPLE	
Population	
Population Estimates, July 1 2022, (V2022)	**NA**
Population Estimates, July 1 2021, (V2021)	73,346
Population estimates base, April 1, 2020, (V2022)	NA
Population estimates base, April 1, 2020, (V2021)	74,008
Population, percent change - April 1, 2020 (estimates base) to July 1, 2022, (V2022)	NA
Population, percent change - April 1, 2020 (estimates base) to July 1, 2021, (V2021)	-0.9%
Population, Census, April 1, 2020	74,008
Population, Census, April 1, 2010	79,499
Age and Sex	
Persons under 5 years, percent	5.5%
Persons under 18 years, percent	21.8%
Persons 65 years and over, percent	18.8%
Female persons, percent	50.4%
Race and Hispanic Origin	
White alone, percent	94.1%
Black or African American alone, percent (a)	2.8%
American Indian and Alaska Native alone, percent (a)	0.6%
Asian alone, percent (a)	0.4%
Native Hawaiian and Other Pacific Islander alone, percent (a)	Z
Two or More Races, percent	2.1%
Hispanic or Latino, percent (b)	1.6%
White alone, not Hispanic or Latino, percent	92.8%
Population Characteristics	
Veterans, 2017-2021	4,573
Foreign born persons, percent, 2017-2021	0.7%

Housing	
Housing units, July 1, 2021, (V2021)	33,087
Owner-occupied housing unit rate, 2017-2021	68.3%
Median value of owner-occupied housing units, 2017-2021	$107,600
Median selected monthly owner costs -with a mortgage, 2017-2021	$1,130
Median selected monthly owner costs -without a mortgage, 2017-2021	$414
Median gross rent, 2017-2021	$669
Building permits, 2021	4
Families & Living Arrangements	
Households, 2017-2021	28,152
Persons per household, 2017-2021	2.52
Living in same house 1 year ago, percent of persons age 1 year+, 2017-2021	87.2%
Language other than English spoken at home, percent of persons age 5 years+, 2017-2021	1.4%
Computer and Internet Use	
Households with a computer, percent, 2017-2021	85.8%
Households with a broadband Internet subscription, percent, 2017-2021	80.5%
Education	
High school graduate or higher, percent of persons age 25 years+, 2017-2021	86.0%
Bachelor's degree or higher, percent of persons age 25 years+, 2017-2021	16.4%
Health	
With a disability, under age 65 years, percent, 2017-2021	18.6%
Persons without health insurance, under age 65 years, percent	⚠ 7.9%
Economy	
In civilian labor force, total, percent of population age 16 years+, 2017-2021	**46.5%**
In civilian labor force, female, percent of population age 16 years+, 2017-2021	45.1%
Total accommodation and food services sales, 2017 ($1,000) (c)	117,733
Total health care and social assistance receipts/revenue, 2017 ($1,000) (c)	765,068
Total transportation and warehousing receipts/revenue, 2017 ($1,000) (c)	47,998
Total retail sales, 2017 ($1,000) (c)	930,903
Total retail sales per capita, 2017 (c)	$12,246
Transportation	
Mean travel time to work (minutes), workers age 16 years+, 2017-2021	27.1
Income & Poverty	
Median household income (in 2021 dollars), 2017-2021	$43,266
Per capita income in past 12 months (in 2021 dollars), 2017-2021	$23,958
Persons in poverty, percent	⚠ 23.9%
BUSINESSES	
Businesses	
Total employer establishments, 2020	1,240
Total employment, 2020	19,183
Total annual payroll, 2020 ($1,000)	721,708
Total employment, percent change, 2019-2020	1.8%
Total nonemployer establishments, 2019	3,670
All employer firms, Reference year 2017	965
Men-owned employer firms, Reference year 2017	538
Women-owned employer firms, Reference year 2017	150
Minority-owned employer firms, Reference year 2017	57
Nonminority-owned employer firms, Reference year 2017	737
Veteran-owned employer firms, Reference year 2017	60
Nonveteran-owned employer firms, Reference year 2017	704

The use of technology to support efficient and effective operations.
Pathways Behavioral Healthcare must place an emphasis on developing its Information Technology in 2022. Specifically, the agency should focus on the following:
In 2022 a gap analysis was conducted. It was determined that the agency needed concentrate on the following IT areas:

- Technology acquisition- The agency will update a user-friendly website and buy 30 new desktops
- Technology maintenance-The agency will develop sufficient knowledge and resources to maintain existing technology.
- Technology replacement- The agency will replace 10 laptop computers with new models
- Training- The agency will update its online training for staff in cyber security.

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SWOT Analysis
Purpose: Organizations establish a foundation for success through strategic planning focused on taking advantage of strengths, weaknesses, opportunities, and threats.

The agency has identified the following during its SWOT exercise:

Strengths	**Weaknesses**
Client Focused Resilient Philosophical Framework Cares for Staff Promotes Personal Growth Community Involvement Succession Plan for Key Persons	Difficulty recruiting licensed professionals More focus on compliance as company grows Needs greater clinical oversight as company grows
Threats	**Opportunities**
MCO Competition Covid 19 pandemic	Other Agencies going out of business Expanding outpatient services Providing greater array of services to people with substance use.

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Specific strategic initiatives to continuously develop, strengthen, and improve services offered by **Pathways Behavioral Healthcare in 2022-2023**

Initiative: Expand our substance use services in OH and UT.

Priority: High

Who responsible: CEO

Resources Needed: ~$10, 000

By When: 4/1/23

Initiative: **Service more children in the OhioRise program.**

Priority: Moderate

Who responsible: CEO

Resources Needed: ~$10, 000

By When: 4/1/23

Initiative: **Start 10 new offices in OH**

Priority: High

Who responsible: CEO

Resources Needed: ~$100,000

By When: 4/1/23

[New 1/1/23] Initiative: Maintain less than a 10% vacancy rate for clinical and medical positions.

Priority: High

Who responsible: Management Team

Resources Needed: ~$15,000

By When: 3/1/22 for Utah and 12/31/23 in Ohio.