From the Chief Executive Officer's Desk

Joseph Sedlock

The Importance of Prevention and Early Intervention

Drug use, including alcohol and tobacco, changes the brain, which can lead to addiction and other serious problems.

“Risk of drug use increases greatly during times of transition. For an adult, a divorce or loss of a job may increase the risk of drug use. For a teenager, risky times include moving, family divorce, or changing schools. When children advance from elementary through middle school, they face new and challenging social, family, and academic situations. Often during this period, children are exposed to substances such as cigarettes and alcohol for the first time. When they enter high school, teens may encounter greater availability of drugs, drug use by older teens, and social activities where drugs are used. When individuals leave high school and live more independently, either in college or as an employed adult, they may find themselves exposed to drug use while separated from the protective structure provided by family and school.”[1]

“Because the brain is still developing, using drugs at this age has more potential to disrupt brain function in areas critical to motivation, memory, learning, judgment, and behavior control.” [1]

Mid-State Health Network provides funding across the region for a variety of prevention programs, most of which are research-based or evidence-based. This means that these prevention strategies are based on current scientific evidence.

Many of these prevention programs work to boost protective factors (such as positive self-image, self-control, or social competence) and eliminate or reduce risk factors (such as peer group choices, genetic predisposition to addiction). See more about risk and protective factors at this SAMHSA link.

In general, research-based prevention programs fall into the following three types of programs:

- **Universal programs** address risk and protective factors common to all members in a given setting, such as a school or community.
- **Selective programs** are for groups of people who have specific factors that put them at increased risk of drug use.
- **Indicated programs** are designed for individuals who have already started using drugs.

The MSHN Prevention Specialists work together with community coalitions, prevention providers and the other assets available in communities to design and deliver evidence-based prevention programs. One study[2] has noted that such programs can return anywhere from a few dollars to more than $65 for every dollar invested in prevention. Medicaid does not pay for prevention services of the types described in this article, so MSHN uses a combination of Substance Use Disorder (SUD) Block Grant and Liquor Tax to fund prevention programming across the region. MSHN allocates at least 20% of its SUD Block Grant to regional prevention activities.

[1] NIDA. 2023, March 23. Preventing Drug Misuse and Addiction: The Best Strategy. Retrieved from http://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/preventing-drug-misuse-addiction-best-strategy on March 27, 2023

[2] Johnston, LD, O’Malley, PM, Miech, RA, Bachman, JG, & Schulenberg, JE (2014).*Monitoring the Future national survey results on drug use: 1975-2013:*

Overview, key findings on adolescent drug use. Ann Arbor: Institute for Social Research, The University of Michigan.

For further information or questions, please contact Joe at Joseph.Sedlock@midstatehealthnetwork.org

Organizational Updates

Amanda Ittner, MBA
Deputy Director

Expanding Services to Children

Michigan Department of Health and Human Services (MDHHS) has identified key priorities for ensuring access to and expanding services to children. A Child-Welfare Task Force was convened in Fall 2020 under the Children's Service Agency (CSA). The Task Force was charged to address the over-representation of children of color in the foster care system in Michigan. Data points indicate children of color enter foster care at higher rates, and stay in care longer, than their white peers. The goal is to fully implement a new approach that improves safety and equity and reduces unnecessary and potentially harmful investigations of Black families. Recommendations to improve equity in group care of children removed from their home include:

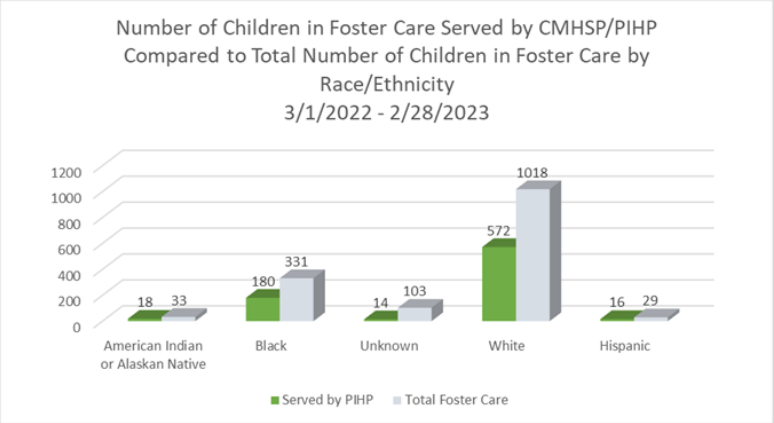
1. Increase specialized services and supports for relative and fictive kin caregivers
2. Implement appropriate services to reduce Child Care Institutions (CCI) placements and length of stay
3. Secure funding to implement the recommendations
4. Implement new Structured Decision Making (SDM) tools
5. Redefine abuse and neglect/physical neglect
6. Increase access to mental health services for children and families

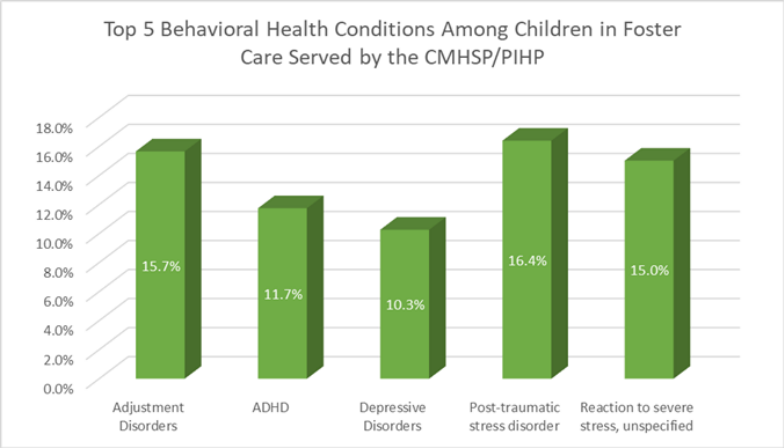
In January 2023, MDHHS announced efforts to provide a wider array of placements to better meet the needs of each child – particularly for youth who need specialized treatment such as intensive behavioral health services. Budget funding signed by Gov. Gretchen Whitmer for the current fiscal year invests additional dollars in the child welfare system. These include:

- $25 million in lump sum payments to congregate care institutions
- Rate increases for child-caring institutions direct care workers
- 20% increase in rates paid to foster parents, independent living providers, relatives, and adoptive parents and guardians
- Improved oversight of congregate care facilities for youth
- A student loan repayment program to help address a shortage of workers in the behavioral health field that has limited options available for children with mental health needs, including those in foster care and the juvenile justice systems

Additionally, MDHHS is seeking to expand Children's Therapeutic Foster Care (CTFC) to four additional sites across the state. CTFC is a Medicaid service offered through the Waiver for Children with Serious Emotional Disturbance (SEDW). This treatment service offers an intensive community-based mental health service alternative to inpatient facilities (acute psychiatric hospitals, Hawthorn Center, and crisis residential centers). This expansion would ensure that more children/youth will be able to access out-of-home mental health services in a community-based family setting.

Mid-State Health Network Leadership supports the state's efforts to ensure children are connected to needed behavioral health services and have started discussions with the state on how MSHN specifically, can support the above initiatives. In the MSHN region, 1,485 children and youth are living in foster care and of those, 53% (784 individuals) received behavioral health services through the CMHSP/PIHP. The below graphs illustrate the number of children in foster care served by the CMHSP/PIHP compared to total number of children in foster care by race/ethnicity; and the top 5 behavioral health diagnoses and the percentage of children in foster care served by the CMHSP/PIHP with each diagnosis.





MSHN will continue to support the state's priorities and work with our community partners, health plans and other stakeholders to undertake initiatives to improve access and care. As our leaders are in the process of strategic planning, expect to hear more about how MSHN can improve the lives of children.

For further information or questions, please contact Amanda at Amanda.Ittner@midstatehealthnetwork.org

Information Technology

Steve Grulke
Chief Information Officer

The Mid-State Health Network (MSHN) Information Technology (IT) team recently reviewed the website www.midstatehealthnetwork.org for updates. Many items older than October 1, 2020 were removed to reduce clutter and confusion. Some new data points were added to the MSHN Data page (found under Stakeholders, then MSHN Data) for Substance Use Disorder (SUD) Withdrawal Management Readmission, Alcohol and Other Drug (AOD) Initiation and Engagement and SUD Michigan Mission-Based Performance Indicator System (MMBPIS) Indicators. Many of the other data measures have been updated to the current period as well. There are plans to make additional changes over the next few months. The changes will be proposed by a work group for this purpose and will likely include improvements in search optimization.

The MDHHS reporting process for encounters starts with the Community Mental Health (CMH) sending their encounters to the MSHN Managed Care Organization software system named REMI. The premise of this system is that it has the same edits in place that the State has, so if an encounter is accepted into REMI it will get accepted at MDHHS. On a weekly basis, MSHN IT staff use REMI to send any encounters from the CMHs that have not been previously accepted, to MDHHS. MDHHS provides a response with either acceptance or rejection for each encounter that is submitted. As you might imagine, there are times when the REMI system validation does not match up with MDHHS and so an encounter gets accepted into REMI but is rejected by the State. This encounter gets resubmitted to MDHHS every week and the same response is received. At this point, the CMH thinks their encounter has been accepted, but MDHHS does not have it. We are currently developing a regular process to notify the CMHs of these errors because many times the errors are ones that can only be corrected by the CMHs submitting different information on the encounter such as the diagnosis, or procedure code.

For further information or questions, please contact Steve at Steve.Grulke@midstatehealthnetwork.org

Finance

Leslie Thomas, MBA, CPA
Chief Financial Officer

MSHN's Finance Team is currently engaged with Roslund Prestage & Company (RPC) to complete work on MSHN's Compliance Examination and Single Audit.

Compliance Examination - Compliance Examination Guidelines require that an independent Auditor examine compliance issues related to contracts between Pre-paid Inpatient Health Plans (PIHPs) and Michigan Department of Health and Human Services (MDHHS) to manage the Concurrent 1915(b)/(c) Medicaid, Healthy Michigan, and the Flint 1115 demonstration. These Compliance Examination Guidelines, however, DO NOT replace or remove any other Audit requirements that may exist, such as a Financial Statement Audit and/or a Single Audit. The main PIHP responsibilities associated with this exam are:

1. Maintain internal control over the Medicaid Contract that provides reasonable assurance that the PIHP is managing the contract in compliance with laws, regulations, and the contract provisions that could have a material effect on the contract.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract. Examples of these would include, but not be limited to: the Medicaid Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200, the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.

In addition, MSHN's Compliance Examination completion is contingent on final Community Mental Health Service Provider (CMHSP) Compliance Examinations as any changes or updates from the region impact the PIHP's final report.

Single Audit – PIHPs that expend $750,000 or more in Federal awards during the fiscal year must obtain a Single Audit in accordance with 2 Code of Federal Regulations (CFR) 200, Subpart F. This Audit must be performed by an independent auditor, and in accordance with Generally Accepted Government Auditing Standards (GAGAS). Federal funds referenced for Single Audit are associated with MSHN's Block Grant dollars. Medicaid and Healthy Michigan reviews are handled within MSHN's financial Audit.

We anticipate completion of both reviews by June 30, 2023.

For further information or questions, please contact Leslie at Leslie.Thomas@midstatehealthnetwork.org

Behavioral Health

Todd Lewicki, PhD, LMSW, MBA
Chief Behavioral Health Officer

Utilization Management & Care Coordination

Skye Pletcher-Negrón, LPC, CAADC
Director of Utilization and Care Management

Conflict-Free Access & Planning: Overview & Next Steps

OVERVIEW

The concept of conflict-free access and planning (CFAP), also known as conflict-free case management, requires that assessment and service planning are separate from the direct delivery of services, with the goal of objectively separating (or "firewalling") potential assessment/eligibility/monitoring, direct service provision, and financial oversight conflicts a case holder or agency may have. A firewall is considered a legitimate way to keep financial interests separate between agencies paid to provide care. The intent of a firewall is that a single agency is not both assessing and identifying what services an individual needs and then providing those services to individuals. Presently, behavioral health services agencies allow the assessor to also provide services to the individual using "safeguards" against conflict. Safeguards are procedural practices intended to separate agency interests including for example, independent facilitation, self-determination, person-centered planning, fiscal intermediary, etc. Safeguards have generally not been regarded as adequate, but that there should be a combination of a firewall and safeguards to ensure full compliance with the strictest interpretation of CFAP. Presently, Michigan has largely relied on the use of safeguards to mitigate potential conflict.

CFAP is codified in four federal policy initiatives: The Balancing Incentive Program within The Affordable Care Act (ACA); Community First Choice (CFC) within the ACA; Home and Community-Based Services (HCBS) Settings Final Rule (CMS 2249F) and The Older Americans Act Reauthorization Act. The Centers for Medicare & Medicaid Services (CMS) has been increasingly focused in recent years on ensuring that state Medicaid programs comply with federal CFAP requirements.

CFAP attempts to define where conflict in service arrangement exist:

- Providers responsible for evaluation, plan development, and direct service may have a financial conflict without adequate firewalls.
- Interest in keeping and serving an individual rather than promoting independence and autonomy.
- Service plans may focus on the convenience of the system, case holder, or service provider rather than a person-centered focus.
- Patterns of provider self-referral and undue influence may compromise individual choice of services or of providers.
- Inadequate oversight of the person-centered plan or quality of services.

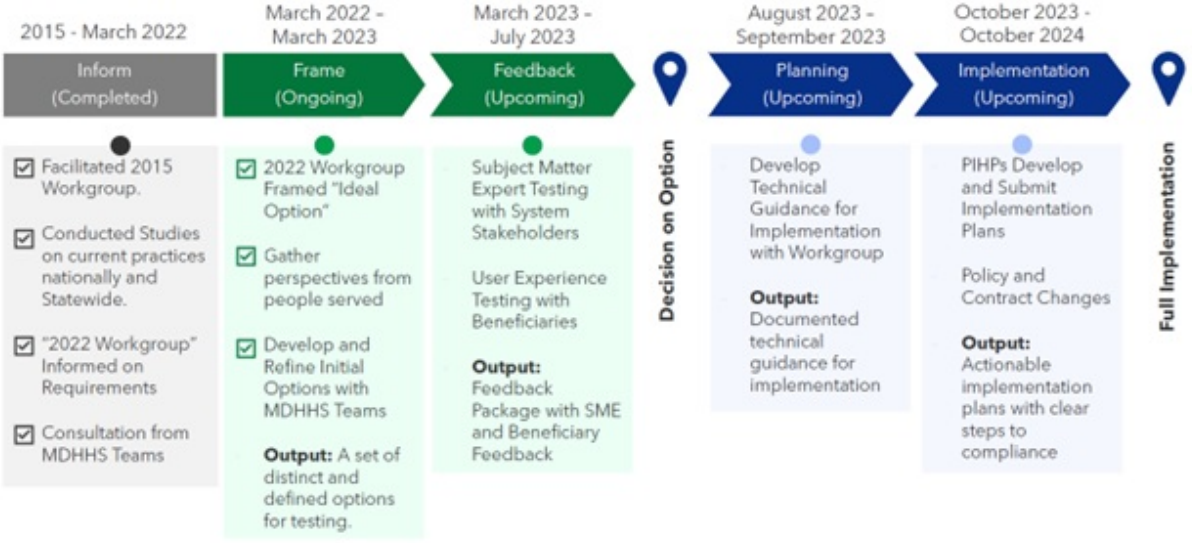
The exception details to CFAP include:

- Exception given to regions without sufficient providers able to serve eligible populations.
- The state determines an exception is allowed.
- Regions granted exceptions must put protections into place, like as they have currently.

The authors of this article do not agree that safeguards in the current Pre-Paid Inpatient Health Plan (PIHP) and Community Mental Health Service Program (CMHSP) system are lacking in reasonable deterrent against conflict. However, to be compliant with federal policy, the state of Michigan feels it must demonstrate to the Centers for Medicare & Medicaid Services (CMS) that even *potential* conflicts of interest are mitigated or eliminated in Michigan's public behavioral health system. The Michigan Department of Health and Human Services (MDHHS) has not been cited by CMS regarding any specific conflict of interest.

To work toward a recommendation for compliance with federal CFAP requirements, the MDHHS convened a statewide CFAP Workgroup in early 2022, tasked with understanding federal CFAP regulations, evaluating current practices, and providing feedback on options for statewide implementation of additional protections and safeguards. The CFAP Workgroup is comprised of representatives from a variety of PIHPs and CMHSPs across the state (including several from the MSHN region), as well as consumer and advocate perspectives. The workgroup's goal was to provide input into strengthening protections against conflict of interest (especially financial) that would prioritize the individual's experience using existing structures wherever possible.

The graphic below illustrates the CFAP Workgroup project plan and timeline for completion:



The stages involved learning more information on the CFAP requirements in the "Inform" phase. Next, moving into the "Frame" phase to define criteria and share perspectives on understanding CFAP. The "Feedback" phase begins a process of reviewing potential models and options for CFAP practice and testing each option. Once a recommendation on an option is made, MDHHS will develop technical guidance for the CFAP workgroup to use, and then lastly, the "Implementation" phase is intended for the PIHPs to develop implementation plans and include policy and contract changes. MDHHS expects this final phase to result in clear steps to compliance and full implementation by October 2024.

In the March 2023 CFAP workgroup meeting, MDHHS revealed the four options they are considering for statewide implementation. The four options under review are:

Option 1:

1) **MDHHS** contracts with PIHPs
2) **PIHPs** contract with:
   - **Access and Planning Providers**-functions include:
     - Crisis services
     - Screening
     - Integrative assessments
     - Plan development
     - Plan monitoring
     - Requests for service
     - Referral
   - **Direct Service Providers**
     - Specific assessment
     - Direct service delivery
3) **PIHPs** maintain these functions:
   - Eligibility determination
   - Level of care determination
   - Provider network management
   - Payment processing
   - Quality oversight and improvement
   - Utilization management
     - Authorization
     - Denial
     - UM review

Option 2:

1) **MDHHS** contracts with **PIHPs**
2) **PIHPs** contract with:
   - **Access and Planning Providers**-functions include:
     - Crisis services
     - Screening
     - Integrative assessments
     - Eligibility determination
     - Level of care determination
     - Plan development
     - Plan monitoring
     - Requests for service
     - Referral
   - **Direct Service Providers**
     - Specific assessment
     - Direct service delivery
3) **PIHP**s maintain these functions:
   - Provider network management
   - Payment processing
   - Quality oversight and improvement
   - Utilization management
     - Authorization
     - Denial
     - UM review

Option 3:

1) **MDHHS** contracts with **Access and Planning Providers** and **PIHPs**
2) **Access and Planning Providers**-functions include:
   - Crisis services
   - Screening
   - Integrative assessments
   - Eligibility determination
   - Level of care determination
   - Plan development
   - Plan monitoring
   - Requests for service
   - Referral
3) **PIHPs** contract with:
   - **Direct Service Providers**
     - Specific assessment
     - Direct service delivery
4) **PIHPs** maintain these functions:

Option 4:

1) **MDHHS** contracts with **Access and Planning Providers** and **PIHPs**
2) **Access and Planning Providers**-functions include:
   - Crisis services
   - Screening
   - Integrative assessments
   - Eligibility determination
   - Level of care determination
   - Plan development
   - Plan monitoring
   - Requests for service
   - Referral
   - Utilization management
     - Authorization
     - Denial
     - UM review
3) **PIHPs** contract with:

- Provider network management
- Payment processing
- Quality oversight and improvement
- Utilization management
  - Authorization
  - Denial
  - UM review

- **Direct Service Providers**
  - Specific assessment
  - Direct service delivery

4) **PIHPs** maintain these functions:
   - Provider network management
   - Payment processing
   - Quality oversight and improvement

In all four options, the CMHSP is profoundly changed . **One thing is certain - each of the options being considered by MDHHS will result in significant changes for CMHSPs and PIHPs.** These CFAP proposed options splinter CMHSPs, add additional layers of system oversight and management, and most importantly, alter the individual's experience with accessing and receiving services, now through a more disconnected and fragmented system. The implementation of CFAP represents a significant change to accessing care, altering the pathways to care that individuals know. It will affect treatment relationships and already-established trust, as well as the sense of continuity and stability for individuals. Individuals served are not at the center of this proposed CFAP change. MSHN and its partner CMHSPs embrace the individual as the focus of their shared mission, not a fragmented system of care.

NEXT STEPS
Viable alternatives to the four options have yet to be developed. The Community Mental Health Association of Michigan (CMHAM) will be working closely with its member organizations in the coming weeks to develop immediate feedback and alternative options to present to MDHHS. Additionally, CFAP Workgroup members from the MSHN region will engage in continued advocacy during the upcoming "Feedback" Phase (March 2023-July 2023). Advocacy efforts will focus on solutions that leverage the use of safeguard mechanisms within CMHSPs to mitigate potential conflicts. PIHP functions will be reviewed to ascertain where further safeguards can be developed as well strengthen existing ones. This will be a significant topic for discussion at the upcoming MSHN Board of Directors' Strategic Planning session scheduled on May 9, 2023. Thoughtful planning will be required to prepare the MSHN region for these upcoming changes, regardless of which option is selected by MDHHS.

For any questions, comments or concerns related to the above, please contact Todd or Skye at Todd.Lewicki@midstatehealthnetwork.org or Skye.Pletcher@midstatehealthnetwork.org

Substance Use Disorder Policy, Strategy and Equity

Dr. Dani Meier, PhD, LMSW, MA
Chief Clinical Officer

A study published last month (March 2023) in the *Journal of Studies on Alcohol and Drugs* offered promising outcomes for reducing overdose deaths (ODD) which was achieved by 30% through the use of community-based strategies. The study's authors at the University of Pittsburgh argue that instead of a piecemeal approach with multiple agencies—public health agencies, community coalitions, providers—each engaging in interventions in isolation from each other, a coordinated effort informed by community-based input resulted in an estimated 1,818 opioid-related deaths that were prevented over two years.

The study's senior author and professor of pharmacy and therapeutics at the Pitt School of Pharmacy, Janice Pringle, PhD, said, "Our study is one of the first to show that a community approach is how you move the needle on preventing ODD." When each of those stakeholders works together, the impact is more pronounced, Pringle said. "If the opioid crisis is a tree," she continued, "1,000 steak knives [are] not going to chop it down. We need [everyone's] hands ... on the chainsaw."

"The idea ... is that community members and people on the front lines know what's best for their community," co-author Renee Cloutier, PhD, echoed. "The team worked to develop and activate community coalitions to clarify the problems in their community, generate plans and act on them." Two-thirds of the counties that used the community-focused approach saw a reduction in ODDs compared to just 47 percent of the counties using a standard approach without that community coordination.

As MSHN's *Equity Upstream* learning collaborative pilot launches this spring with the goal of reducing overdose death disparities, we recognize the value of data-informed and evidence-based interventions like Medication-Assisted Treatment (MAT) and Medications for Opioid Use Disorder (MOUD) in particular. At the same time, the Pittsburgh study reminds us that community voices are also key to understanding upstream and systemic barriers in access to care. Learning collaborative members will work with MSHN to ensure that interventions are designed to incorporate community-informed perspectives. Towards that end, we welcome suggestions of community leaders located in Saginaw, Lansing and Jackson, in particular, where communities of color face rising rates of overdose deaths.

If we're going to truly impact the overdose death crisis in our region, we have to target those communities where the ODD rates are rising, and in Michigan and nationally, those overdose death rates are rising precipitously in Black, Hispanic and Native American communities.

Contact Dani with questions, comments or concerns related to the above and/or MSHN SUD Treatment and Prevention at Dani.Meier@midstatehealthnetwork.org

Substance Use Disorder Providers and Operations

Dr. Trisha Thrush, PhD, LMSW
Director of SUD Services and Operations

Evidence-Based Practices Coming to the MSHN SUD Provider Network

To help support the substance use disorder (SUD) provider network, the MSHN Clinical Team has been gathering feedback on needed training. The provider network has responded with a number of requests that have included Trauma-Informed Yoga, Cognitive Behavioral Therapy (CBT), Solution-Focused Brief Therapy (SFBT), and training related to grief and loss. Over the next 6 months, MSHN will be offering training to support each of these areas.

Loss, Grieving, & Substance Use: *Available virtually April 4-5, 2023*

Grieving does not only occur after the death of a loved one. Rather, some level of grieving follows any loss. For individuals with substance use, mental health, or other issues, as well as those with any disability, losses occur frequently throughout life. Losses are also experienced by family members and by professionals who provide services to these individuals. Physical and behavioral manifestations of grief are explored as they are often viewed as medical or psychiatric symptoms. As not addressing losses impacts a person's ongoing functioning and ability to reach their potential, it is essential to recognize and acknowledge them for each of these groups. This training focuses on losses experienced by these individuals, families, and service providers.

Trauma Informed Yoga: *Available May 9-10 in Bay City & May 17-18 in Okemos*

Trauma doesn't just affect the mind — it can also be held in the body. This means that mind-body practices like yoga can be challenging, and even harmful, for those who have endured any form of trauma — whether acute or complex. Trauma-informed yoga (TIY) describes an approach to the practice that addresses the specific needs and symptoms of trauma survivors by being conscious of trauma and understanding how trauma intersects with the practice. While many regular yoga classes encourage students to move through emotional discomfort, trauma-informed yoga creates a safe space for people to pay attention to signs of dissociation and distress that may come up, and to stop whenever they need.

Solution-Focused Brief Therapy (SFBT): *Coming virtually June 1-2*

Solution-Focused Brief Therapy (SFBT) is a short-term goal-focused evidence-based therapeutic approach, which incorporates positive psychology principles and practices, and which helps clients change by constructing solutions rather than focusing on problems. In the most basic sense, SFBT is a hope friendly, positive emotion eliciting, future-oriented vehicle for formulating, motivating, achieving, and sustaining desired behavioral change.

Cognitive Behavioral Therapy (CBT): *Coming virtually August 28-29*

Cognitive behavioral therapy (CBT) is a form of psychotherapy that is effective in treating a range of mental health issues including mood disorders, anxiety disorders, and substance use disorders. CBT utilizes a range of techniques to support individuals that include cognitive restructuring or reframing, guided discovery, exposure therapy, journaling and thought records, activity scheduling and behavior activation, relaxation and stress reduction techniques, and role playing.

For questions related to these evidence-based practices, or feedback on additional training opportunities, please contact Trisha Thrush at Trisha.Thrush@midstatehealthnetwork.org.

Contact Trisha with questions, comments or concerns related to the above and/or MSHN SUD Treatment and Prevention at Trisha.Thrush@midstatehealthnetwork.org

Quality, Compliance & Customer Service

Kim Zimmerman, MBA-HC, LBSW, CHC
Chief Compliance and Quality Officer

MSHN Regional Consumer Advisory Council

The Regional Consumer Advisory Council (RCAC) was established in September of 2014 as the primary source to provide consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports and substance use disorder requirements in the region. The Consumer Advisory Council includes primary and secondary consumers from all twelve (12) Community Mental Health Services Program (CMHSP) Participants of the region and represents adults with mental illness, adults with developmental disabilities, children with mental illness, children with developmental disabilities, and individuals with substance use disorders. The RCAC meets bi-monthly and has utilized remote video teleconferencing during the pandemic. During the upcoming year, the RCAC participants will be offered the option of attending the meetings in person, as well as continuing to offer teleconferencing for those who wish to participate remotely.

The RCAC responsibilities include providing representation to MSHN on behalf of the local consumer councils; advise the MSHN Board of Directors relative to strategic planning and system advocacy efforts for public mental health; advise MSHN Board of Directors related to regional initiatives and consumer directed options; provide recommendations related to customer satisfaction, consumer involvement opportunities, quality and performance improvement projects and other outcome management activities; provide recommendations regarding MSHN policies and procedures related to customer service; and focus on region-wide opportunities for stigma reduction

related to mental health and substance use disorder issues.

During Fiscal Year 2022, the RCAC provided feedback regarding a variety of topics including revisions to the Consumer Handbook; Quality Improvement Performance Measure Reports; consumer satisfaction survey results; MSHN's 2022-2023 Strategic Plan; results from the delegated managed care reviews; activities related to diversity, equity and inclusion; and exploring advocacy opportunities regarding public behavioral health redesign.

In addition, among the upcoming goals for Fiscal Years 2023/2024, the Council has identified a focus on providing input on regional educational opportunities for stakeholders; ongoing strategies for the assessment of primary/secondary consumer satisfaction; group advocacy within the region for consumer related issues as well as for the Public Behavioral Health System Redesign Advocacy.

Contact Kim with any questions, comments or concerns related to MSHN Quality, Compliance and Customer Service at Kim.Zimmerman@midstatehealthnetwork.org

Our Mission:

To ensure access to high-quality, locally-delivered, effective and accountable public behavioral health & substance use disorder services provided by its participating members.

Our Vision:

To continually improve the health of our communities through the provision of premiere behavioral healthcare & leadership. MSHN organizes and empowers a network of publicly funded community partnerships essential to ensure quality of life while efficiently, and effectively addressing the complex needs of the region's most vulnerable citizens.

Mid-State Health Network | 530 W. Ionia Street, Suite F |Lansing, MI| 48933
P: 517.253.7525 | F: 517.253.7552 | www.midstatehealthnetwork.org