From the Chief Executive Officer's Desk

Joseph Sedlock

By now, most readers will have heard news of the Sunday, July 27, 2025, mass stabbing, that seriously injured 11 people in Traverse City. Most will also know that several bystanders subdued the perpetrator. Many will also know that other customers of the store where this incident took place assisted the injured. Some will see news reports of the perpetrators' history of involvement with the legal system and the mental health system. To be sure, there is much to consider when looking back to try to determine how this kind of thing could have happened.

Some have already used this terrible tragedy to further condemn the public behavioral health system as broken; even asserting it is beyond repair. I have no information about the individual responsible for this event other than what I see in the media. But there are a few things I know as a person who has served the public in the mental health system for over three decades.

Unless there is a court order mandating treatment for a mental illness, persons served can choose when, how, how much, where, by whom, or even if they receive treatment. This is a fundamental set of rights for all people.

Treatment works. In addition to other supports and services, often the success of mental health care depends on the individual's compliance with medication regimens. These regimens frequently require several adjustments to find the right dose or combination that works for the individual. Sometimes individuals choose to stop using prescribed medication because of how it makes them feel or other undesirable side effects. Outcomes for the overwhelming majority that stay with a medication protocol are very positive, allowing healing and restoration to an adaptive level of functioning.

The informed consent of the individual (or their legal guardian) to medication therapy is required before those medications are prescribed, used, or administered. A fundamental right of all persons served – as noted above - is to withhold consent, to choose. To change their mind. To stop the medication. To quit other services or supports. Most don't, but some do.

The rights of individuals served by the behavioral health system are fundamental, important, and can't be compromised – especially when viewed against our history of abusive maltreatment of persons with brain disorders.

While as a people we search for answers, let's resist the all-to-easy temptation to "blame the system." Let's also resist pursuing solutions that strip beneficiaries of their rights to choose.

I had a close friend that was diagnosed with a terminal condition. There were treatment options that improved life expectancy by many months. Some of those options were invasive. Some were side effects of medications and other therapies. My friend was confronted with decisions about when, how, how much, where, by whom, or even if they receive treatment. My friend chose not to undergo treatment for anything other than pain management. I wouldn't have it any other way – for any other person – for any other reason…including mental illnesses.

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

Organizational Updates

Amanda Ittner, MBA
Deputy Director

NEW Medicaid Program - MI Coordinated Health

In 2022, the Centers for Medicare & Medicaid Services (CMS) released a final rule, CMS 4192-F, that significantly impacted Michigan's MI Health Link (MIHL) program. Under the rule all State Medicare-Medicaid Plans (MMPs), like MIHL, terminated on December 31, 2023, unless the program was converted to an "integrated" Dual Eligible Special Needs Plan (D-SNP). To convert to the new program structure/model, Michigan submitted its initial "transition plan" to CMS on September 30, 2022.

In February 2023, Michigan Department of Health and Human Services (MDHHS) leadership announced their plan to:

- Facilitate a phased approach by first transitioning the MI Health Link program on January 1, 2026, and pursuing statewide expansion thereafter.
- Develop a new Managed Care program for the Highly Integrated Dual Eligible (HIDE) + Long Term Services & Supports (LTSS) Special Needs Plan (SNP) model that directly contracts with, and capitates, participating plans to allow for stronger quality oversight at the State level.
- Procure HIDE + LTSS SNPs by October 31, 2024, for a January 1, 2026, contract effective date.
- Limit coordination-only D-SNPs to regions that do not have procured HIDE + LTSS D-SNPs to promote integration.
- Require Exclusively Aligned Enrollment in the new HIDE + LTSS SNP model.
- Limit enrollment in the new HIDE + LTSS SNP to full benefit dual who are 21 years or older.
- Maintain the current MI Health Link benefit package to the extent possible through the contracting process, including 1915(c) Home and Community Based Services (HCBS).
- Develop and require integrated materials, including appeals and grievance materials, for new HIDE + LTSS SNP model.
- Develop a robust quality oversight program, similar to the existing MI Health Link program, that evaluates the HIDE + LTSS SNPs at the plan level rather than the parent organization level.
- Organize a Beneficiary Advisory Committee for the new HIDE + LTSS SNP model to inform program improvements and quality initiatives.
- Maintain an Ombudsman Program to support beneficiaries through the transition to the new model and with the new model moving forward.
- Continue to facilitate stakeholder engagement opportunities to gather input and inform the new program's constructs.

MDHHS conducted a procurement in October 2024 and announced in November 2024 the awardees, including the counties applicable, located here: MDHHS issues updated award recommendations for nine health plans to provide new MI Coordinated Health dual eligible benefit program.

Prosperity Regions 1, 8, and 10 will launch on January 1, 2026. Mid-State Health Network's twenty-one counties will be included in the program on January 1, 2027.

The resulting program is driven by five project pillars:

- Fostering integration and continuity
- Reducing racial disparities
- Improving care delivery
- Promoting self-determination
- Building a culture of quality

Visit the MDHHS website to learn more about the Highly Integrated Dual Eligible Special Needs Plan.

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

Information Technology

Steve Grulke
Chief Information Officer

The recently published **Medicaid Fraud Control Units (MFCU) FY2024 Annual Report** highlights the critical need for robust cybersecurity and compliance infrastructure across healthcare organizations. It offers valuable insights into current enforcement trends that every healthcare organization should be aware of. With **1,042 individuals or entities excluded from federally funded programs and $1.4 billion in recoveries,** the message is clear: enforcement is escalating, and risk exposure is real.
In order to avoid these penalties, organizations should have a comprehensive program which demands a complete ecosystem, including:

- **Policies & Procedures** tailored to fraud prevention and patient safety
- **Training programs** that empower staff to detect and report misconduct
- **Hotline systems** to enable anonymous reporting and early intervention
- **Audit trails** and analytics to spot patterns before they become liabilities

MSHN leadership has been working on all of these avenues to help prevent these problems from occurring within the MSHN ecosystem. An anonymous compliance reporting option has been in place for a really long time. A KnowB4 phishing training and testing process has been in place for over a year. Over the last year, new policies and procedures have been put in place, including an Artificial Intelligence policy and a Cybersecurity Awareness Training and Phish Testing Procedure. Finally, we recently began a network logging process to develop the ability to audit the activities occurring within the MSHN network. MSHN leadership will continue working to prevent any misguided activity from becoming harmful.

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 actively engaged in the following activities for FIscal Year (FY) 2026.

- Based on the Michigan Department of Health and Human Services (MDHHS) rate dissemination timeline, MSHN's region will not have a draft nor final rate certification. The Region's Chief Financial Officers Group will engage in methodology discussions to estimate approximate FY 26 revenue for budgeting purposes. Because the board will be evaluating contracts in September 2025, Community Mental Health Service Provider (CMHSP) revenue amounts will be rough estimates which in turn makes the calculations of surpluses and deficits somewhat unreliable. As a reminder, for the past several fiscal years, the Prepaid Inpatient Health Plan (PIHP) utilized draft certification information to develop revenue and although figures were subject to change, the PIHP at least had a basis for the numbers presented to the board. In addition to blindly developing rates, the last MDHHS rate setting meeting indicated a few significant changes to their process as follows:

    - MDHHS will move to region specific rates in FY 26 which is a favorable update as variables exist between PIHPs such as rate of expense increases and rate of change for Medicaid enrollees.
    - MDHHS supports and encourages PIHP feedback. As a side note, this change primarily comes from the work Wakely is performing around reviewing Milliman's actuarial assumptions. Feedback was provided for the FY 25 rate assumptions, and an FY 26 rate considerations letter was sent to MDHHS earlier this week.
    - MDHHS will be moving to a direct payment model for Certified Community Behavioral Health Centers (CCBHC) programs beginning FY 26. This means a portion of CCBHC amounts that were previously included in capitation will be removed from the PIHP rates. The State has estimated reducing approximately $97M from capitation, however MSHN is only calculating $46M should be removed. Many PIHPs voiced concerns and MDHHS committed to having internal discussions before finalizing the CCBHC reductions.

- MSHN is working on the following contracts:

    - Substance Use Disorder (SUD) Contracts - MSHN's Provider Network for SUD supports and services which includes prevention.
    - Administrative Contracts - Contracts to conduct retained Managed Care functions and other items such as Accounting and Auditing.
    - Medicaid Subcontracting Agreement - Contract between MSHN and the CMHSPs for all disbursed payments. In addition to standard boiler plate language, the contract includes a funding exhibit (anticipated revenues) and CMHSP reporting requirements.
    - Applied Behavioral Analysis (ABA) - CMHSPs use this contract template for their work with Autism Service Providers.
    - Inpatient - CMHSPs use this contract template with hospitals for individuals receiving Mental Health Inpatient care.
    - Financial Management Services (FMS) - The purpose of FMS Providers is to manage an individual budget and make payments as authorized by the person served for individuals assisting in their care. An FMS provider may also render a variety of supportive services that assist the person in self-directing their care.

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

Behavioral Health

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

The What, Why, When, and How of the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0): Embracing the Philosophy of the Home and Community Based Services (HCBS) Rule

The Michigan Department of Health and Human Services (MDHHS) discontinued the use of the Supports Intensity Scale (SIS) in March of 2023. The SIS was for adults with intellectual and/or developmental disabilities (IDD) and was used to target eligibility and service needs from a person-centered, strengths-based perspective. Later that same fiscal year, MDHHS partnered to convene the Assessment Panel Workgroup, consisting of MDHHS staff, advocates, family members, Community Mental Health Service Program (CMHSP) and Pre-Paid Inpatient Health Plan (PIHP) staff for the purpose of selecting a new tool for adults with IDD. In January 2024, the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) was selected by the workgroup. The WHODAS 2.0 is a standardized tool developed by the World Health Organization (WHO) for the purpose of assessing health and disability across cultures and illnesses. The WHODAS 2.0 also aligns with the WHO International Classification of Functioning, Disability, and Health (ICF) and is very complementary with the requirements of the Home and Community Based Services (HCBS) Rule.

The role of the ICF is important in establishing the foundational structure of the WHODAS 2.0. The ICF is a standard language and structure for relating health and disability at individual and population levels. The ICF switches the focus of disability from the traditional medical model to a biopsychosocial model of health. The medical model has been long followed as a standard of care in the medical system. It involves assessing an individual and defining the chief complaint, diagnosing it, and prescribing a treatment. The treatment is intended to resolve or better manage the diagnosed illness. The main criticism of the medical model has included that the holistic focus on the individual is lost for an interest on the medical diagnosis. Ostensibly, the individual is defined by their illness, which is not person-centered or person-first, and thus, a strength of the ICF is its focus on person-

centered care. The ICF examines bodily functions and structures, activities, participation, environmental, and personal factors. This is also the basis for the biopsychosocial model of health.

The biopsychosocial model of health is a comprehensive framework that accounts for the interaction of the biological, psychological, and social factors of an individual's functioning. This approach is holistic and person-centered, broadly applied across all health conditions, supports integrated care, enables measurement of outcomes, evaluates interventions, and enhances plans of service, as well as promotes equity and inclusion. These are extremely important for successful care and are directly related to the requirements of federal and state Medicaid law related to the Home and Community-Based Services (HCBS) Rule. Thus, the underpinnings of the ICF and the biopsychosocial models endorse the processes and outcomes of the WHODAS 2.0 in support of adults with IDD by inherently promoting HCBS Rule compliance, person-first, person-centered, strengths-based perspectives on services and supports to the individual.

The WHODAS 2.0 is a 36-item tool that can be administered through a brief interview with a staff, with assistance from a proxy (i.e., family, friend, caregiver), or through self-report, which further promotes autonomy and individual voice. Administration is expected to take between 5-20 minutes depending on who is completing the tool. It evaluates six domains, which include: cognition, mobility, self-care, getting along, life activities, and participation. The WHODAS 2.0 emphasizes the person-first perspective by focusing on the six domains which are biopsychosocial aspects of functioning and lived experience as opposed to the medical model-oriented diagnosis or impairment. In avoiding medical model approaches, the WHODAS 2.0 does not reduce a person to their medical condition, thereby enabling a deeper focus and understanding of the biopsychosocial, ICF holistic approach to the person in environmental context (social factors), psychological context (mood, trauma history, etc.), and biological factors (genetics, physical health, etc.). Ultimately, the outcomes of the WHODAS 2.0 instrument support person-centered planning by helping providers to focus on what matters most to the individual and shifts the focus from the medical model which asks, "What's wrong?" to the biopsychosocial/ICF approach to "With participation of the individual, what support is needed for full inclusion and belonging?" It is the latter that reinforces the HCBS Rule as well as the contention that environmental and social barriers contribute to disability, which is not shaped alone by medical conditions.

The complementary nature between the WHODAS 2.0 and HCBS Rule is illustrated by their mutual focus on person-centered and rights-based approaches to support of the individual. This complementarity is essential to ensure that there is consistency and relevance in MDHHS policy in supporting and furthering major requirements such as the HCBS Rule as well as exemplifying support at an ethical level in recognizing an individual's right to autonomy. The WHODAS 2.0 supports HCBS Rule compliance by identifying functional supports the person may need to live and thrive in their community like any other person. It will also reflect the HCBS expectation for inclusion and engagement, that individuals are functioning well and participating fully to their level of interest, even in settings presumed to have more restrictive traits. This ultimately ensures there is meaningfulness and empowerment in the lives of all persons served. The use of the WHODAS 2.0 is anticipated to be fully implemented by summer 2026.

For questions or more information, please contact Todd at Todd.Lewicki@midstatehealthnetwork.org

Population Health and Integrated Care

Skye Pletcher-Negrón, LPC, CAADC, CCS
Chief Population Health Officer

MSHN Centralized Access for Substance Use Disorder Services - Early Outcomes

As board members are aware, MSHN implemented a new regional centralized access process at the beginning of this fiscal year (10/1/2024) for Substance Use Disorder (SUD) withdrawal management, residential, and recovery housing services. There were many reasons which contributed to MSHN's decision to implement a new process however, foremost was to improve the experience of individuals seeking services. Previously, individuals seeking those services could call any SUD provider to receive screening and be admitted to treatment. Unfortunately, that often led to individuals calling multiple providers looking for an open bed resulting in the person receiving duplicate screenings and having to repeat their story. One of the primary goals for centralized access is for a person to receive one screening from the MSHN access center, who then assists the person with securing an admission appointment and shares the information with the SUD provider with the person's consent.

Despite some significant challenges that occurred during the initial implementation period last fall, MSHN is pleased to report that centralized access functions have been operating smoothly since January. MSHN monitors several data points to measure the effectiveness and efficiency of its access operations. Data from 10/1/2024 – 6/30/2025 (FY25 Quarter 1 – Quarter 3) shows positive trends toward improving the experience of persons served:

- The MSHN Access Center receives between 265 – 300 incoming phone calls each week, on average.
- Despite the high volume of incoming calls to the MSHN Access Center, calls are answered within 30 seconds or less, on average.
- Michigan Department of Health and Human Services Access Standards require a screening to be provided within 24 hours when an individual requests SUD treatment services. MSHN remains fully compliant with ensuring all screenings are conducted within 24 hours, with the majority being completed during the same business day when the request is made.
- MSHN has eliminated over 700 duplicate screenings compared to the same period of time last year (FY24 Quarter 1 – Quarter 3), leading to a more trauma-informed experience for individuals seeking treatment by reducing the number of times they are required to tell their story.

It is our intention to create the best access experience possible once an individual makes the decision to seek SUD treatment services. We welcome feedback from beneficiaries, providers, and stakeholders around areas where we can continue to improve the process. Please offer your feedback and input through our access email at access@midstatehealthnetwork.org.

Contact Skye with questions, comments or concerns related to the above and/or MSHN Population Health & Utilization Management at Skye.Pletcher@midstatehealthnetwork.org

Substance Use Disorder Policy, Strategy and Equity

Dani Meier, PhD, LMSW, MA
Chief Clinical Officer

We Should Not Conflate Mental Illness & Homelessness with Crime & Social Disorder

On July 26, 2025, Mental Health America (MHA), a leading national nonprofit dedicated to the promotion of mental health and well-being, released a statement cataloguing concerns in response to the July 24, 2025 White House Executive Order titled "Ending Crime and Disorder on America's Streets." This order mistakenly conflates mental illness and homelessness with criminal behavior. It rejects successful strategies like harm reduction and undermines decades of progress in advancing mental health care and housing policy, thus jeopardizing the safety of vulnerable populations by undermining evidence-based prevention, treatment and recovery support strategies.

"Every person deserves the safety and dignity of a place to live and access to care that supports their long-term well-being," writes MHA's Chief Executive Officer, Schroeder Stribling. Stability, housing, and community-based care are essential for recovery, in contrast to the Executive Order's emphasis on surveillance, forced institutionalization, and increased sharing of protected health information. These measures will likely deter individuals from seeking help and will further stigmatize those experiencing mental illness, substance use disorders or housing insecurity.

Consistent with MHA's position, the Substance Abuse and Mental Health Services Administration (SAMHSA) promotes trauma-informed, *voluntary* treatment and *supportive* housing as core elements of recovery-oriented systems of care. SAMHSA's Guiding Principles of Recovery emphasize respect, empowerment, and peer support over coercive interventions (SAMHSA, 2010). Similarly, the Centers for Disease Control and Prevention (CDC) National Center for Healthy Housing encourages community-based mental health services that integrate housing, reduce stigma, and address social determinants of health—strategies shown to reduce both mental health crises and justice system involvement (CDC, 2022).

A 2024 report from the National Low Income Housing Coalition (NLIHC) further underscores the urgent need for affordable housing as a public health imperative. *The Gap: A Shortage of Affordable Homes* found that no state in the U.S. has an adequate supply of affordable rental housing for its lowest-income renters, contributing directly to cycles of instability and poor health outcomes. Criminalizing homelessness and mental illness, as written into the executive order, not only ignores these systemic issues but exacerbates them by diverting resources away from effective, evidence-based solutions.

Moreover, numerous studies confirm that supportive housing paired with mental health and/or SUD services leads to improved outcomes and *reduced public costs* in emergency care, law enforcement, and incarceration. These models, implemented successfully in states like Utah, New York, and California, demonstrate that stable housing and accessible care are more humane and cost-effective than punitive or institutional approaches.

The administration's simultaneous efforts to cut Medicaid, to withhold CDC funding for reducing fentanyl use and to retool SAMHSA will impact MSHN's behavioral health services by further eroding the infrastructure needed to address these issues effectively and compassionately. These changes will negatively impact underserved communities already experiencing provider shortages, high unmet need and higher rates of mental illness, suicide and overdose deaths.

Increased policing or institutionalization can only marginally impact public safety in contrast to MSHN's adopted stance which supports a renewed focus on systemic solutions rooted in extending access quality care, community collaboration, prevention, and dignity to *every individual* in our region's twenty-one counties.

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

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

Medications for Opioid Use Disorder (MOUD) Access and Policy Concerns: Medicaid Coverage Changes Pose Emerging Barriers

As of early March 2024, Michigan had renewed coverage for over 1.24 million individuals since June 2023, but more than 500,000 had already lost coverage - many due to procedural reasons like paperwork delays - not actual ineligibility. According to state projections, Michigan's Medicaid caseload is expected to gradually decline back to pre-pandemic levels by October 2026, following initial steep losses during the unwinding period (Michigan Advance, 2024).

Recent policy shifts in Medicaid eligibility and renewal rules are presenting new challenges to increasing access to Medications for Opioid Use Disorder (MOUD) - notably buprenorphine and methadone - which are proven, life-saving treatments.

Background: Medicaid Continuous Enrollment Unwinding

Under the COVID-19 Public Health Emergency, the Families First Coronavirus Response Act (FFCRA) required states to maintain continuous Medicaid enrollment. That safeguard ended in April 2023, triggering states' eligibility redetermination ("unwinding") process. During unwinding, many individuals lost coverage — not due to ineligibility, but from procedural terminations (failure to submit paperwork, outreach breakdowns, or low adoption of automated "ex parte" renewals).

Evidence of Impact on MOUD Access

1. A recent analysis in *JAMA Network Open* documented early declines in buprenorphine dispensing paid by Medicaid during the unwinding period. While average reductions were modest, they signal potential longer-term disruptions in treatment continuity across states (PMC, 2025). These findings raise concern especially in areas with high overdose burden and historically lower MOUD penetration.

Medicaid Expansion & MOUD Utilization Trends

Separately, evidence from pre-2020 Medicaid expansion states show tangible benefits. Health Affairs data reveal a 36% increase in specialty Substance Use Disorder (SUD) treatment admissions in expansion vs. non-expansion states over four years, with substantial uptake in MOUD use. Another study shows that in expansion states, the ratio of individuals diagnosed with Opioid Use Disorder (OUD) who received buprenorphine grew from ~33% to ~75% by late 2018, though with notable disparities across rural, racial, and income groups.

Collectively, these trends illustrate that Medicaid coverage plays a central role in enabling access to MOUD.

Key Recommendations from National Best Practice for Increasing Access to Medication Assisted Treatment (MAT)/MOUD

1. Expand the MOUD workforce - especially in rural and underserved areas
2. Leverage Telehealth & Mobile Units for Greater Reach
3. Reduce Medicaid Churn and Administrative Dropouts
4. Expand MOUD Access Points in Emergency and Justice Settings
5. Address Stigma and Structural Barriers

MSHN Region - Activities

To help support the ongoing need for MOUD services in MSHN's 21-county region, the SUD Clinical Team has been actively working to support several of the key recommendations from the National Best Practices listed above. This includes leveraging telehealth and mobile units for greater reach, as well as expanding the MOUD workforce, especially in rural and underserved areas.

MSHN has been working with a new provider to develop MAT/MOUD services in rural and underserved counties like Osceola, Mecosta, Newaygo, Ionia, Montcalm, Hillsdale, Shiawassee, Huron, and Tuscola. Service implementation in these areas is targeted for FY26.

In relation to addressing stigma and structural barriers, the SUD Clinical Team is proud to announce that the work that has been undertaken over the past year to develop a media campaign and resources for addressing stigma will be launched in August 2025!

For source information or questions, please contact Trisha at Trisha.Thrush@midstatehealthnetwork.org

Quality, Compliance & Customer Service

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

Mid-State Health Network Customer Service

Customer Service involves processing customer inquiries, facilitating communication, and taking action in response to inquiries. Customer Service is a conduit to provide easy access for consumers, providers, stakeholders, and other MSHN staff to file a complaint, grievance, or appeal; ask for information; technical assistance; and customer support. MSHN maintains a dedicated Customer Service Phoneline intended to provide easy access to Customer Service for consumers, providers, stakeholders, and other MSHN staff. Regional information, technical assistance, and customer support are provided. As contacts occur, the Customer Service and Rights Manager records various data points. This data is used to aid in quality improvement efforts throughout the MSHN region.

During Fiscal Year 2025 (Q1 and Q2), the following occurred:

- 74 Customer Service complaints were investigated by MSHN Customer Services
  - Categories identified the most were consumer discharge, provider practices, and general assistance
- 152 appeals were completed region wide
  - 61 of the appeals had the agency decision upheld
  - 87 of the appeals had the agency decision overturned
  - 4 of the appeals had the agency decision partially upheld/overturned
- 95 grievances were completed region wide

- 64 of the grievances were substantiated
- 31 of the grievances were unsubstantiated
- Categories identified the most were member rights, access and availability, and quality of care

The MSHN Customer Service Committee reviews the data above and provides recommendations to improve customer service relations. The following are the current Customer Service recommendations based on data trends from previous quarters:

- The MSHN Customer Service Committee (CSC) will review data aggregation reporting based on the quarterly Michigan Department of Health and Human Services (MDHHS) Grievances and Appeals data.
  Status: The Customer Service Committee reviews the quarterly Michigan Department of Health and Human Services (MDHHS) Appeal and Grievance Analysis Report to identify any trends or areas of concern. The FY25 Q2 MDHHS Appeal and Grievance Analysis Reports were reviewed during the May 2025 CSC meeting. Members discussed the data for any trends or areas of concern. No areas of concern were noted.

- MSHN Customer Service Committee Professionalism Training
  Status: During the June 2025 MSHN Consumer Advisory Council meeting, members discussed and provided information to assist the MSHN CSC in developing scenarios for the staff professionalism training.

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.

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