

## Kicking Off the 2010 Mentorship Program

It's time again to gather the ingredients for another successful ACMHA mentorship class under the guidance of the Leadership Committee.

With three cycles completed, we're looking for folks who want to participate in the Mentorship Program during 2010 in one of three ways: as a learner, a mentor, or a co-facilitator.

The Mentorship Program pairs mentors and learners who meet regularly by conference call or in person (as location allows). The mentor-learner dyad establishes and works together on the learner's professional devel-

opment goals.

In addition to the individual meetings each mentor-learner dyad has, the mentorship class meets as a group telephonically several times during the year to share experiences and to discuss key topics around leadership and professional development.

Each mentorship class is co-facilitated by two ACMHA members.

Learners are recruited through ACMHA, but they may or may not be members of the College.

The size of the mentor-

ship class is determined by the number of members who step up to serve as mentors.

As a volunteer-driven effort, ACMHA's mentorship model relies on members being willing to serve as mentors and co-facilitators.

Look for an email within the next month that announces the start of recruitment for the 2010 class.

In the meantime, to express interest in participating, please contact either Kris Ericson at [executive.director@acmha.org](mailto:executive.director@acmha.org) or Colette Croze at [crozec@aol.com](mailto:crozec@aol.com).

### Save the date:

**A NEW ERA IN  
 BEHAVIORAL  
 HEALTH:  
 CHARTING THE  
 COURSE**

**SUMMIT 2010  
 MARCH 24-26  
 SANTA FE, NM**

**REGISTRATION  
 OPENS JANUARY  
 2010**

## Summit 2010: Charting the Course for a New Era

The 2010 Summit will be your navigational guide or GPS (Global Positioning "Summit") for the shifting private and public behavioral health landscape.

Framed by thought leaders and building on the expert knowledge base of the behavioral health leaders in attendance, the Summit will ask, "Are we ready?" to effectively steer system change both internally and as part of the larger health-care reform movement.

The 2010 Summit will emphasize engagement, participation, and cultivation of ideas from ACMHA members and other leaders in attendance.

Specific topic areas will include:

- The impact of national healthcare reform efforts;
- Addressing budgetary constraints and developing innovative financing and funding models;
- The role of health infor-

mation technology;

- "Next generation" service delivery models; and
- Cultivating leaders.

The 2010 Summit is your opportunity to take part in essential conversations and strategy development to equip the behavioral health field to navigate the changing environment.

Plan now to set your course for Santa Fe and join your ACMHA colleagues March 24-26, 2010.

### Inside this issue:

CALL TO ACTION ON HEALTH REFORM  
 BY RON MANDERSCHIED **2**

MOVING THE ACMHA SUMMIT **2**

PEER-OPERATED SERVICES AND INTEGRATION  
 BY LAURA VAN TOSH & PEGGY SWARBRICK **3**

WELCOMING NEW ACMHA MEMBERS **3**

ACMHA'S NEW LISTSERV ADDRESS **4**

GETTING TO KNOW THE MEMBERSHIP:  
 JOHN C. WADSWORTH **4**

## A Call to Commitment and Effective Action on National Health Reform

Ron Manderscheid, PhD,  
Global Health and Civil Services Sector, SRA International, Inc. and  
Bloomberg School of Public Health, Johns Hopkins University

In mid-March 2008, 200 leaders from the mental health and substance use care and prevention communities gathered for the annual ACMHA Summit to discuss "Impacting Healthcare Reform '08: Moving the Mental Health and Substance Use Care Agenda." (Originally, I published a summary of the 2008 Summit in the May 2008 issue of Behavioral Healthcare: [Energized by the ACMHA Summit.](#))

Participants sought information and strategies to help them take personal action to influence the direction in which presidential candidates would move National Health Reform, to influence state universal health insurance coverage initiatives, and to evolve our joint agenda toward integration of mental health, substance use, and primary care services.

Now, 18 months later, we can and should take stock and ask what has been accomplished during the intervening period.

### Key Steps Undertaken in 2008 & 2009

After the 2008 Summit, a number of very important steps were taken by the Whole Health Campaign (WHC) to put mental health and substance use care on the national agenda, including:

- A highly successful "Recovery Room" was hosted at the Democratic National Convention to focus attention on mental health and substance use issues.
- The three principles of the WHC (equitable coverage, integrated care, and effective prevention) were incorporated into the Democratic and Republican national party platforms.
- The WHC briefed the Agency Transition Team on core mental health and substance use concerns going forward.
- The WHC provided testimony to the Federal Panel on Comparative Effectiveness Research.
- The WHC completed a series of

eight policy papers on National Health Reform, now available at [www.wholehealthcampaign.org](http://www.wholehealthcampaign.org)

- The WHC briefed House staff on inclusion of mental health and substance use in National Health Reform.

### Need for Continuing Action in the Waning Months of 2009

President Obama has undertaken National Health Reform as a core agenda of his administration. His speech to a Joint Session of Congress on September 9 highlighted key features of his plan—universal coverage, a "public" option, system reform to improve quality and to slow cost increases, and a new focus on disease prevention and health promotion.

To read R. Manderscheid's full text, visit:

[http://www.acmha.org/library/current\\_events.cfm](http://www.acmha.org/library/current_events.cfm)

## Moving the ACMHA Summit: Why Leave Santa Fe?

2010 will be the last year, at least for a while, that the ACMHA Summit takes place in Santa Fe.

The Board of Directors has consistently received comments from members that Santa Fe is too expensive, too difficult to get to, and takes too much travel time.

In response, the board has been considering moving the Summit from Santa Fe for several years.

A major factor tipping the decision now is the strong commitment of the College to nurture younger leaders and consumer, family, and recovery community leaders. We need to encourage their participation in all activities of the organization, including the Summit.

The cost of traveling to and staying in Santa Fe, as well as the travel time away from work, can be particularly prohibitive for these members.

In choosing a new venue, the board considered a number of factors, including the fact that 50 percent of the ACMHA membership resides on the East Coast.

We sought a venue that was a major hub, so that most attendees could get there on lower cost airlines and would not need to change planes.

We also wanted to select a location that had reasonable temperatures in March, was "walkable," and provided interesting sights and activities for visitors.

In consideration of all these factors and following a robust discussion, the board has voted to try a different venue in 2011.

The 2011 Summit will be in New Orleans. We will carefully track how this change impacts attendance of all participants, but particularly those constituents noted earlier.

We hope that you will be able to join us in New Orleans in 2011! In the meantime, please take advantage of one last year in Santa Fe and plan to attend the 2010 Summit March 24 - 26 at the Eldorado Hotel and Spa.

## Peer-Operated Services and the Journey Toward Integration

Laura Van Tosh, ACMHA Member

Peggy Swarbrick, PhD, OTR, CPRP, Collaborative Support Programs of New Jersey

### Integration and Behavioral Health Care

Integration is not a new idea; however, it has become part of the dialogue within the health care reform debate currently underway. Integration, as it pertains to behavioral health care, brings forward the necessity for the care system to consider the whole person – meaning the necessary preventive, medical, and recovery-oriented services one might need – and to coordinate this care within a medical home.

Integration has definite benefits for consumers whose whole care has been limited or non-existent. The potential marriage between behavioral health care with primary care shows great promise, yet the mental health field has not examined integration's impact on those various parts of the delivery system, including consumer (peer) operated services.

### New Challenges for Peer Operated Services

Integration offers new opportunities and peer operated service should position themselves by being proactive and ready to partner and collaborate.

Peer operated services could benefit from a close examination towards integration, similar to other providers as they move towards supporting integra-

tion and integrated community service, while at the same time working hard to remain faithful to the many characteristics which set peer operated services apart from non-peer operated services.

This may be a challenge, but is not impossible. Peer operated services will need to re-examine the focus of services, unmet needs in the community, and realign services in order to be effective in working collaboratively with partners and stakeholders. Peer operated services will need to adjust and be prepared to work within a new framework.

They will likely need to:

- compete with non-peer operated services for funding,
- overcome limitations of some services, and
- be open to collaboration and partnerships.

### Whole Health and Wellness Focus

Peer operated services will need to clarify a focus (whole health and wellness) and be sure peer providers are competent (training, accountability, and infrastructure supports).

Key roles or opportunities for peer operated services include:

- front line workers (an ideal job for entry-level peer providers) who can help people through mentoring and hope, with practical assistance;
- mid-level workers who can apply rehabilitative counseling techniques, deliver wellness management and self care strategies, and help people access community resources; and
- specialists who have some combination of unique knowledge and skills in areas ranging from financial education to benefits management to supported employment and education, etc. Needless to say, many specialist roles are well oriented to front-line peer providers, such as dual recovery coaches, peer wellness coaches, supported parenting workers, etc.

To read L. Van Tosh and P. Swarbrick's full text, visit:

[http://www.acmha.org/library/current\\_events.cfm](http://www.acmha.org/library/current_events.cfm)

## New Members Elected to College

The Board of Directors and Membership Committee would like to extend a warm welcome to ACMHA's newest members, each of whom brings talent and commitment to the College!

- **David S. Mandell, ScD**

Assistant Professor  
University of Pennsylvania School of Medicine

- **Laysha A. Ostrow, BS**  
Policy Analyst  
Human Services Research Institute
- **Kelly Phillips-Henry, PsyD**  
Chief Operating Officer  
Pikes Peak Behavioral Health Group
- **Jay Roundy, MA, DPA**  
Head of Public Sector Programs

Aetna Behavioral Health

- **Christina M. Trenton, LCSW-C, CAC-AD**  
Chief of Program Operations  
Baltimore Substance Abuse Systems, Inc.
- **John C. Wadsworth, BS**  
Data Architect  
Intermountain Healthcare

[www.acmha.org](http://www.acmha.org)

7804 Loma del Norte Rd NE  
Albuquerque, NM 87109-5419

Executive Director  
Kris Ericson, PhD  
[executive.director@acmha.org](mailto:executive.director@acmha.org)  
505-822-5038

## ACMHA Has a New Listserv Address

In response to a surge in spam, ACMHA has changed its listserv address to [acmhamembership@acmha.org](mailto:acmhamembership@acmha.org).

Posting a message to the listserv is as simple as sending an email. Just send your email to the listserv address and you've posted to the listserv!

The College listserv is a tool for members to communicate with each other about news and items of importance to the field. Please feel free to make use of this resource.

Questions? Contact Kris Ericson at [executive.director@acmha.org](mailto:executive.director@acmha.org) or 505-822-5038.

---

## Getting to Know the ACMHA Membership

John C. Wadsworth, BS, Data Architect  
Intermountain Healthcare, Salt Lake City, UT

### Tell us a little about yourself.

I work as a data architect for Intermountain Healthcare in Salt Lake City. A data architect is a fancy name for someone who captures data and builds databases to support a business entity. Believe me, it's a real conversation stopper when someone asks about my work. I've resigned to respond by saying, "I work with computers."

I'm also an amateur woodworker. I love to build furniture. And with four kids who also love the woodshop, we've supplied the neighborhood with enough rubber-band guns and wooden swords to outfit an army.

### What made you decide to join ACMHA?

For the last four years I have worked for Intermountain's Primary Care Clinical Program (PCCP). A major focus has been on chronic management of asthma, diabetes, and depression. In 2008, I attended my first ACMHA summit on recommendation from our PCCP Director, Wayne Cannon, MD. I was impressed by the conference and the attendees.

In 2009 I returned to the conference and with encouragement from members, I applied for membership. I am honored to be a part of this productive organization.

### How can the behavioral health field benefit from embracing information technology?

Electronic Medical Record (EMR) adoption must become a part of the mental healthcare field. Information technology can provide standard, efficient methods of capturing valuable information regarding behavioral health patients.

We can capture a range of data, including medication orders/refills, visits with accompanying diagnosis, which providers have seen a patient over some time period, and complete medical and treatment histories.

With this information in IT systems, analysis can provide insight into areas of success and failure. Data may be scrutinized to understand patient resource utilization and to create staffing models. Registries can be built to track patients and outcomes over time. Further analysis of any of these processes can serve as feedback mechanisms to reduce waste, increase efficiencies, and improve outcomes.

### What is a data warehouse?

The purpose of a data warehouse is to copy data from source systems (e.g., financial, clinical, claims & billing databases) and put them into one massive data store. Analysis can be done on data within the warehouse without

taxing the original source systems. Population studies can be performed. Actionable reports can be sent to clinicians to help manage their patient populations.

The warehouse is usually organized into meaningful data sets aligned with a business or program. For example, within Intermountain's data warehouse, we have a primary care data mart which I maintain. It contains information on diabetes, asthma, and mental illness within the Primary Care Clinical Program.

### What should people in the behavioral health field know about working effectively with people from the IT world?

One of the challenges of working with people from the IT world is communication. We often prefer the virtual world to the real world. IT staff need invitations to partner with behavior health professionals.

By supporting clinical programs IT should never be in the driver's seat. Clinicians must drive the requirements for tools they want developed by IT. The role of IT staff is to support the care delivery process with technology and work closely with the program to ensure that technology represents and meets the business requirements.