MHCA

ExecutiveReport

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San Diego Hosts MHCA Summer Conference

Clear your calendar – it's San Diego in August! MHCA's 2007 Summer Conference convenes August 7-10 in San Diego at the Westin Horton Plaza Hotel, right downtown and convenient to everything this great Southern California city has to offer.

Our Keynoter Bill Sturtevant will command your attention as he concentrates his fund development message on essential roles - the Board, the CEO and others. Following his Wednesday morning presentation, a Marketing/Fund Development Focus Group will delve into the challenging details of forming a successful fundraising element within behavioral healthcare organizations. This topic will continue in general session on Thursday morning when a panel of MHCA members shares real-life fund development experiences with the focus more specifically on the role of the CEO. CEOs and Fund Development staff members alike should plan to take advantage of this focused study.

Thursday morning's general session will include a member showcase on Southwest Housing Solutions, delivered by CEO John Van Camp, and a demonstration of newly developed online access procedures for MHCA's Benchmarking Survey presented by Doug Philipon of iCentrix and Nancy Maudlin, MBA, Director of MHCA's National Data Center.

On both Wednesday and Thursday afternoons an Applied Research Focus Group will explore elements of this growing field within behavioral healthcare. MHCA Applied Research Committee Chair Greg Speed will coordinate this session.

On Thursday afternoon we will also present the first of our Learn About It Series, a program created to demonstrate tangible benefits of MHCA membership. This first offering will be delivered by Nicholas Bozzo, Administrative Director, and Marilyn Udis, Vice President of Negley Associates and will describe the insurance products of Mental Health Risk Retention Group. Though most MHCA members are somewhat familiar with MHRRG through regular exhibit information provided at our quarterly conferences, many have expressed an interest in a more detailed explanation of how MHRRG serves the specific needs of behavioral healthcare organizations. Our Learn About It Series will continue at future conferences on topics including MHCA's Customer Satisfaction Management System, our Benchmarking Survey, Compensation Survey, and Website Resources among others. The Series is intended to educate not only our newer members but all members wishing to gain greater value from their membership.

Those participating in the MHCA/IOM Transformation Work Group will be involved in that meeting on Tuesday the 7th from 8:30 am–3:00 pm.

Some of you will want to come early to San Diego for the Padres vs Giants baseball games in PETCO Park (August 3-5), a visit to Seaworld, Balboa Park, and any of a myriad selection of coastal and citywide experiences

Meeting registration materials were sent in early June – don't forget to make your hotel reservations directly with the Westin (619-239-2200) AND register online for the meeting with MHCA (www.mhca.com). ❖

Our Keynote Speaker: William T. Sturtevant

Bill Sturtevant is VP-Planned Giving and Trust Relations at the University of Illinois Foundation, a position he has held since 1980. He arrived at the University of Illinois at the onset of its first fund drive. Over a five-year period more than $225 million in private gifts were secured. He has also played a central role in the University's recent $1 billion campaign.

His first fundraising experience was in public television and at the Western Michigan University Foundation where he formed his planned and major gifts skills.

Sturtevant is a nationally recognized specialist in major and deferred gifts and planning and solicitation strategies. He regularly assists a variety of charitable organizations with complicated or unusual gift situations.

He is author of *The Continuing Journey: Stewardship and Useful Case Studies in Philanthropy* published in 2000. It is the companion to his best selling book *The Artful Journey: Cultivating and Soliciting the Major Gift* published in 1997. A teacher as well as a doer, he is rigorous in his pursuit of professionalism in fundraising and committed to the highest ethical standards. His guiding tenet is that dedication to the best interest of our donors is the only way to achieve the objectives of the charitable organizations we serve. Learn more about this speaker at www.sturtevantfundraising.com ❖

A Message from the President

LET'S GET ON THE BUS

Don Hevey

Think of a time when an idea you heard about became real, when it caught fire, so to speak, and made vision a reality. Diana Knaebe, CEO of Heritage Behavioral Health in Decatur, Illinois, heard a leadership breakfast speaker not long ago and realized that what he had to say should be shared with her MHCA colleagues. The speaker was William E. Strickland, Jr., President/CEO of the Manchester Bidwell Corporation (MBC) in Pittsburgh, Pennsylvania. MBC is an organization of diverse entities in Pittsburgh that combine to create a model for arts, education, training, and hope to reshape the business of social change. The story Strickland told was fascinating – an idea that had ignited to change lives time after time.

Knowing that MHCA was soon headed for Pittsburgh, Diana lost no time lobbying for a group tour of MBC during our stay there. And what a success that tour was – participants called it "excellent, inspirational, thought-provoking, remarkable" – and agreed that MHCA would do well to arrange similar experiences at future conferences.

That's where you come in. Have you heard a similar speaker, learned of an inspiring program, gotten news of a dynamic program that MHCA might visit? Is your own organization within tour-range of one of our conferences and open for a visit? Do you partner with another entity that we could learn from while in their neighborhood?

We learn best when we learn first-hand, and we have much to learn from each other as well as from industries other than our own. MHCA members are curious, open and eager to embrace best practices...help us find them. We'll hire the tour bus!

Introducing Coe and Pour

New to MHCA are two interim CEOs filling leadership positions at member organizations in Virginia and Vermont. David Coe, Director of Planning and Development at Colonial Community Services in Williamsburg, VA has assumed the role as Interim Executive Director there. Dennis Wool has vacated that position. In Vermont, Tom Pour, former VP-Chief Financial/Operating Officer, has been named Interim President/CEO at Community Care Network/Rutland Mental Health on the departure of Mark Monson. MHCA welcomes both Coe and Pour and encourages all members to help them get to know our organization.

Retirements Announced

Three MHCA member CEOs have announced their approaching retirements. Jess Jamieson of Compass Health in Everett, Washington introduced incoming CEO Tom Sebastian at our recent conference in Pittsburgh. Both Bob Ward, CEO of Bayview Center in North Miami, Florida, and Paul Gorman, CEO of West Central Behavioral Health in Lebanon, New Hampshire have announced that their organizations have formed search committees as they will retire this summer. Congratulations to Jess, Bob and Paul on jobs well done!

MHCA MISSION STATEMENT

MHCA is an alliance of select organizations that provide behavioral health and related services. It is designed to strenthen members' competitive position, enhance their leadership capabilities and facilitate their strategic networking opportunities.

THE EXECUTIVE REPORT

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143 Members in 34 States

Members on the ListServe

Raising a Question

We recently had a situation where a resident of an adult licensed group home (mental health) was ordering weapons through catalogues and having them delivered to the group home by US Mail. He never opened the mail in public and would hide the contents of packages he received in his private room. Staff entering the room for routine matters never saw the contents of the packages. However, he was hospitalized and requested staff to bring him a change of clothing from his room. In the course of getting the clothing, the cache of knives was found.

We feel we were very lucky this time but want to be proactive about situations with potential weapons, illegal or prescription drugs, alcohol or other items that might pose either a danger to self or others or be a violation of program rules if they were found. We have used the concept that further search, with the client present, is warranted if problem items are in view in the normal course of business (same concept as the police searching when they pull someone over for a seat belt violation and they see a gun in the back seat). When they are not obvious, but we are suspicious, we take a case by case approach. We feel we need to have a better answer. However, we also want to respect client rights (all of our clients are voluntary). Our state mental health agency does not have a policy statement, nor does our state licensing agency. The client rights groups have been adamant about the right to personal privacy and have taken stands against allowing searches.

Does anyone have a policy/procedure that outlines the circumstances under which searches can be used? Have you run into any client rights issues?

Diane Manning
President/CEO
United Services, Inc
Dayville, CT

Stephenson Named Ohio's Director of Mental Health

MHCA Ohio member Sandra Stephenson has been appointed Director of that state's Department of Mental Health and assumed her new duties on June 4, 2007.

Stephenson has served since 1987 as Executive Director of Southeast, Inc. in Columbus where she oversaw 350 staff members and several statewide locations and developed the company's annual budget from $4 million in 1987 to its present $27 million.

Associate Executive Director Bill Lee is serving in the interim leadership position at Southeast.

Offering a Response

I suppose it may depend on whether you see the place as home or as a treatment environment. With regard to homes for legally free adults, we treat our places as "home" and impose as few special restrictions as possible. I agree that it is a client rights issue and privacy is a real concern. For example, our resident agreement tries to stay as close as possible to normal conditions of tenancy. We have no categorical requirements re: medication compliance drug/alcohol abstinance, overnight visitors, etc. If a problem is developing with an individual that threatens tenancy, we intervene as a part of the individual care plan. We do have a no weapons policy. Whether a knife constitutes a weapon depends on the size and type. A Swiss Army knife would generally not arouse great concern. A Gerber tactical knife with a 6 or 8" blade certainly would.

It is a balance and no solution is perfect. As with a standard for hospitalization, you will always have the risk of situations in which you wish that you had done more and situations in which you did too much. That being said, I have seen few programs that are too protective of privacy and many that are far less protective than they should be. We start with an assumption of client privacy but act thoughtfully when a real threat is present. It seems to be a balance that works.

The emerging fidelity standards for supportive housing (SAMHSA funded) would support a balance of this nature.

So, with regard to policy for room searches...our policy is that people's homes are their homes and we work hard to respect that. We do searches only when we have real reason to suspect that an illegal or dangerous condition exists. We try to do it with two staff. We involve the resident if possible. We involve the police if we are very nervous or suspect that the weapon is very dangerous. We do not do routine searches unless it is a part of an individual care plan and justified by very clear and immediate reasons. This would be an unusual circumstance. It seems to work well for us. Hope this helps.

Anthony M. Zipple, Sc.D., MBA
Chief Executive Officer
Thresholds
Chicago, IL

2007 Spring Conference

Leading and Learning in Pittsburgh

At the confluence of the Allegheny, Monnongahela and Ohio Rivers, Pittsburgh commands an impressive and welcoming site for visitors. MHCA members thoroughly enjoyed being guests in this up and coming city of 720 bridges when we met there for our Spring Conference, May 29 – June 1.

Keynoter Frank Bucaro's address on ethical leadership fit well with MHCA's mission and was well received by attendees who appreciated his forthright style. Following the keynote message, participants had tough decisions to make about how to spend their afternoon. A tour to the Manchester Bidwell Corporation in downtown Pittsburgh lured 30+ who reported a meaningful and inspirational visit to this unique, positive training facility (see full report on page 2). Others could choose from an Information & Technology Focus Group, an Executive Assistants Focus Group, the Applied Research Committee and Marketing Committee. Each offered a full agenda with learning and planning opportunities.

Keynoter Frank Bucaro (left) was welcomed to Pittsburgh by MHCA Chair Erv Brinker.

General Session presentations on Thursday introduced us to the Institute for Behavioral Healthcare Improvement, the CHOICES school-based and family-centered early intervention program of Northwood Health Systems, and integrated health care efforts being made by both Michigan's Washtenaw Community Health and Indiana's Center for Behavioral Health.

Tuesday's pre-conference Workgroup on the MHCA/IOM (Institute of Medicine)'s Transformation project explored plans to provide input to national efforts for behavioral healthcare delivery improvements. MHCA members interested in this Workgroup should contact MHCA CEO Don Hevey as the group will close to new participants after our Summer Conference. They will meet at each MHCA quarterly conference for an all-day Tuesday meeting over the next 18 months, and Workgroup members are expected to participate regularly.

Our conference was enhanced by the generosity of corporate sponsors: Janssen Pharmaceutica, Genoa Healthcare, QoL meds, and Northwood Health Systems ❖

Top (from left): ***MHCA Data Center Director Nancy Maudlin, MBA, Neal Adams, MD MHP, of CiMH, MHCA CEO Don Hevey, and Allen Daniels, EdD, University of Cincinnati - leaders in the MHCA/IOM Transformation Workgroup.***

Middle (from left) ***Standing: Mark Games and Peter Radakovich, CEO; Seated: Perry Stanley, Helen Wilhelm, Lynn Manalac and Nikki Kacmarik - all players in the successful Northwood Health Systems CHOICES program.***

Bottom: ***Donna Sabourin of Washtenaw County CSTS and Dennis Morrison, PhD, of Center for Behavioral Health - Integrated Health Care presenters***

Peer Collaboration Supports Growth and Creative Change

by William J. Sette with Wesley R. Davidson, Ervin R. Brinker and Melvin J. Smith

Lasting strategic and transformational change does not occur because of gurus, technology, or the latest templates. It occurs when our staffs become invested in the process of creating change in their culture. As leaders our task is to design and direct change consistent with our organization's values and to foster an environment that encourages staff to embrace that change.

Organizations of the future will need to promote continuous learning. Many of us have converted to e-learning processes for much of our corporate education, but guided, experiential and interactive learning is required for cultural change. In "Built to Change" Lawler and Worley said that "senior execs need to spend as much time making decisions about the acquisition, allocation, development and retention of human capital as they spend making decisions about other kinds of capital."

In 1998 Peer Partners developed a methodology to support, promote, and encourage cultural change. We called the method Peer Collaboration, a process to create an environment of human networks that advance change, support innovation and develop quality improvement in partnership with our greatest resource, our trusted peers. Peer Collaboration offers guidelines for communicating and engaging CEOs and staff in the process of change.

All of us in behavioral healthcare confront the common issues of customer service, access, performance and productivity, quality improvement, communication, cost containment, and financial support to name a few. There are no quick fixes for any of these challenges. Instead, a process such as Peer Collaboration helps us learn from each other and create synergies for new ideas and growth.

Through Peer Collaboration, CEOs and other organization leaders visit each other and work together to help staff see the bigger picture required for cultural change. This process benefits our organizations and supports positive outcomes. To maximize the process one needs good participant-observer skills, open communication and trust, the ability to challenge and question staff practices without threatening them, and the ability to lead groups of individuals or teams in a communication process that helps them identify issues and solutions. The training we have designed simulates the process, demonstrates the skill-sets and allows for practice.

Peer Partner centers have all grown at a pace that outperforms their local markets.

Summit Pointe, a Michigan-based behavioral healthcare organization, significantly increased their unrestricted fund balance by 229% over the last six years and redirected resources to expand their service system. This was the result of a combination of implementing The Ken Blanchard Companies' High Performance Teams Model (HPT), and guiding and supporting that process through Peer Collaboration with three other behavioral healthcare organizations. Much of the success achieved by Summit Pointe was the result of people working within a structured team environment. The Peer Collaboration process provided staff with additional tools for tracking accountability and improving communication, which is critically important in any significant change initiative.

Peer Partner centers have all grown at a pace that outperforms their local markets.

Preferred Behavioral Health of New Jersey (PBH) has had similar results using the High Performance Team Model and Peer Collaboration. PBH's annual budget expanded by 250% in the last ten years. While many factors influenced this growth, Peer Collaboration and HPT accelerated the rate by which the organization could adapt to these changes. During this same period PBH reduced the percentage of its budget allocated to general and administrative costs by 30% and reduced the total number of supervisors and middle managers. Savings used to upgrade salaries and improved morale in an HPT environment lead to a 50% reduction in turnover rates. Additionally, productivity in programs that existed in the baseline year grew by as much as 250% without a proportional increase in expenses. Productivity was driven by teams' goals and an improved access system that doubled the number of first time appointments. PBH's involvement with HPT and an improved access system were both outcomes of Peer Collaboration.

Similar results were reported by Aroostook Mental Health Service, Inc. (dba AMHC) in Caribou, Maine and ProCare, part of the Resurrection Healthcare system in Chicago. Outcomes reported by these Peer Collaboration organizations reflect applied field experience and significant results specific to identified need and desired change.

Peer Partners is currently working to refine outcomes work to meet a more rigorous standard by establishing common and comparative data sets. We have found that High Performing Teams and Peer Collaboration as parallel processes have a synergistic effect and have enhanced our organizations by improving morale, increasing productivity, reducing overhead and creating learning environments that adapt to change quickly. Participating organizations have supported each other in team development through the Peer Collaboration process. These combined processes have helped our staff embrace change on a constant basis. When staffs become the drivers of change it reduces the need for administrative interference.

Please visit our website at *www.peerpartnersllc.com*, and look for a more comprehensive report on our ROI to be released in the near future. ❖

Clinical Decision Support Tools in Risk Management

by Center for Behavioral Health

Winner: Chairman's Award, 2007 Negley Awards for Excellence in Risk Management

Perhaps more than at any other time, behavioral healthcare, particularly community behavioral healthcare, is under attack by payers seeking fiscal recoupment. The Health and Human Services Office of the Inspector General (OIG) has set aggressive goals for paybacks. The Deficit Reduction Act alone is estimated to accrue *$350* million in recoupment from behavioral healthcare providers[1]. The State of Iowa has experienced a 65% payback in all Medicaid claims because they were found to be erroneous during an OIG audit in that State[2]. Much of the providers' risk in these initiatives is related to the inaccurate documentation of services. We identified two areas that needed to be addressed if we were to decrease our risk of payback.

The first problem cited in these audits is that providers had not shown a clear link between 1) an assessed need that is 2) related to a diagnosable condition which 3) leads to specified outcomes by 4) way of appropriate interventions. This is a difficult standard to reach technologically made worse by the sheer volume of clinical transactions done by provider organizations. For example, here at Center for Behavioral Health (CBH) we did over 250,000 clinical transactions in FY06 of which approximately 90% were Medicaid. Nonetheless, we believed that if we could find a way to document this "golden thread" (assessed need - diagnosis - outcome - intervention), our risk of payback in an audit would be substantially decreased.

The second problem that contributes to the documentation errors might best be called "clinical drift". This manifests itself when even excellent clinicians begin addressing needs that are not identified on the client's approved treatment plan. These services may be clinically helpful or necessary but they are usually not defensible when audited. Clinicians are at even higher risk for this today because of increased productivity requirements. We believed we could both improve quality of care and mitigate our payback risk if we could help clinicians focus their documentation on the services approved on the treatment plan.

We addressed these problems by developing an entirely new kind of treatment plan and progress note to integrate into our existing Electronic Health Record (EHR). Though CBH has been paperless since 2003, we were unable to address this problem using our existing treatment plan and progress note. The new documents included sophisticated Clinical Decision Support (CDS) functionality that, to our knowledge, does not exist in any commercial behavioral healthcare EHR soft-ware. We named these products PsychRemix™ and are applying to patent it.

CDS is defined as ". . . active knowledge systems which use two or more items of patient data to generate case-specific advice".[3] CDS is well established in medical-surgical electronic medical records partly because medical practitioners have an abundance of quantifiable data available to them in the form of measurements and lab values. Consequently, it is easy to see how software could be written that would review two lab values and make a suggestion for further care. On the other hand, behavioral healthcare does not use quantifiable indicators as much as medical care, relying instead on textural descriptions of services rendered. While such notes might be more understandable (though even this is often arguable) they do not lend themselves to CDS.

One of the challenges posed by external auditors is a preference for an assessed need or problem as the driving force in treatment planning. Though not all assessments need to be objective and quantifiable, those that are, are less easily challenged in an audit. Because of this we integrated into our system an objective functional measure that would assess the needs of clients, automatically calculate a DSM-IV Axis V GAF score with high inter-rater reliability, and have those assessed needs pre-populate the treatment plan. The clinicians would then link each need with a diagnosis, identify what outcomes the client would likely expect, and identify what interventions would yield those outcomes.

All of this is done in the treatment plan, but it was our goal not just to ask the clinicians to do these tasks but rather to build CDS logic into the treatment plan to assist them. For example, when the clinician chooses an outcome to link with a problem, PsychREMIX™ has a library of outcomes that we created based on internal practice patterns and best practices in the industry. All include the behavioral descriptors "as evidenced by" so that outcomes can be measured. PsychREMIX™ preselects a list of the most likely outcomes for the client based on his functional level. The clinician can pick one of the pre-selected outcomes or expand the list to choose another outcome or create a new one. Groups of commonly associated outcomes can be combined into outcome groups.

For each outcome the clinician has chosen, she must associate one or more interventions from a library of all the treatment interventions offered here at CBH. Again, we wanted to assist the clinicians by pre-selecting a list of the most likely used interventions for this

problem. However, in this case a more sophisticated algorithm that uses the unique combination of age, diagnostic related group, and functional level of the client generates the pre-selected list. The clinician can choose one or more of the pre-selected interventions, but she may not define one because all the interventions we offer are listed, including the 20+ Evidence Based Treatments we have implemented. It should be noted that the choices of outcomes and interventions are easily done collaboratively with the client's input. The result is a treatment plan like the one shown in Figure 1. Note that the golden thread is clearly documented to include assessed need, diagnosis, outcome and intervention.

Similar CDS functionality was designed into the progress note and it was then integrated with the treatment plan. To complete a progress note and bill for a service, the provider must select which problems were addressed in this treatment session from a pre-selected list that only displays those impairments germane to this service.

For example, if the service rendered was to observe the client taking his medications, PsychREMIX™ would not allow the provider to choose "Grooming" as the problem addressed by this billable service. Rather, something like "Medication Non-compliance" would be offered for the clinician to choose. The only problems available for this progress note are those that were originally identified on the treatment plan, and the only outcomes available are those originally identified on the treatment plan. However, newly identified needs/problems can be easily added to the treatment plan from the PsychREMIX™ progress note.

The clinician must then rate the client's progress on each problem addressed in this session using a seven point scale that ranges from "Complete" to "Much Worse". To further mitigate potential risk, any goal the clinician rates as "Much Worse" triggers an alert asking whether this change in status warrants a suicide or homicide risk assessment. If the clinician indicates "Yes", PsychREMIX™ asks for a disposition or plan. If the client is not at risk, the clinician simply clicks "No" and completes the note as usual. Our goal is not to dictate practice to clinicians but to remind them to assess for risk when clients' progress toward goals takes a turn for the worse in any area of their lives.

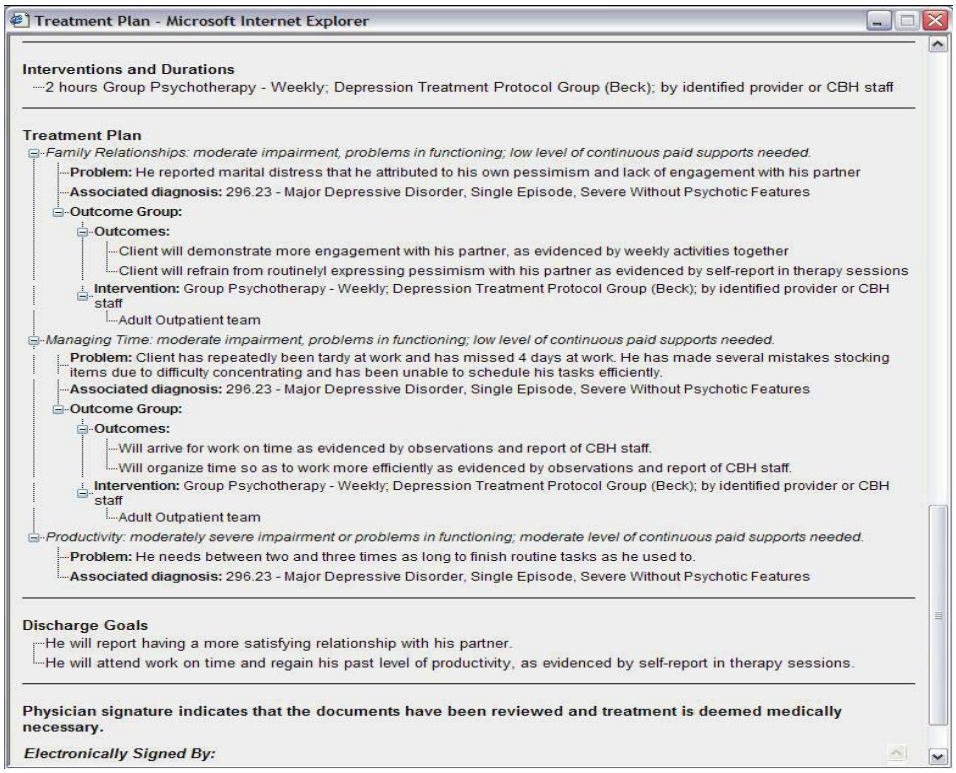
To assist the clinician writing the note, PsychREMIX™ presents context-appropriate keywords that are specific to the particular service being rendered. These words are verbs that auditors and consultants have told us best describe what actually occurred in this type of service. For example, billing Life Skills Training would present verbs such as "Aided", "Coached" and "Trained" while billing for Medication Monitoring might present such words as "Observed" or "Monitored". If a clinician clicks on the word "Coached", that word is then automatically inserted into the text field that describes the billable service and the clinician can type in the remainder of the sentence around that word. An example of a completed progress note can be seen in Figure 2 (shown on page 8).

There is much more functionality available in the PsychREMIX™ product that can not be described in the space available, however, the reader can see that the documentation trail is substantially enhanced with PsychREMIX™. Lethality assessments are now automatically prompted based on the functional status of the client in real time; clinician "drift" is mitigated by requiring them to associate billable services with assessed needs and outcomes and to document progress towards goals for every outcome at every session; and hotlinked, context-sensitive keywords remind them how to accurately document this particular service.

The impact of PsychREMIX™ on our organization has been very positive. Both the treatment plan and

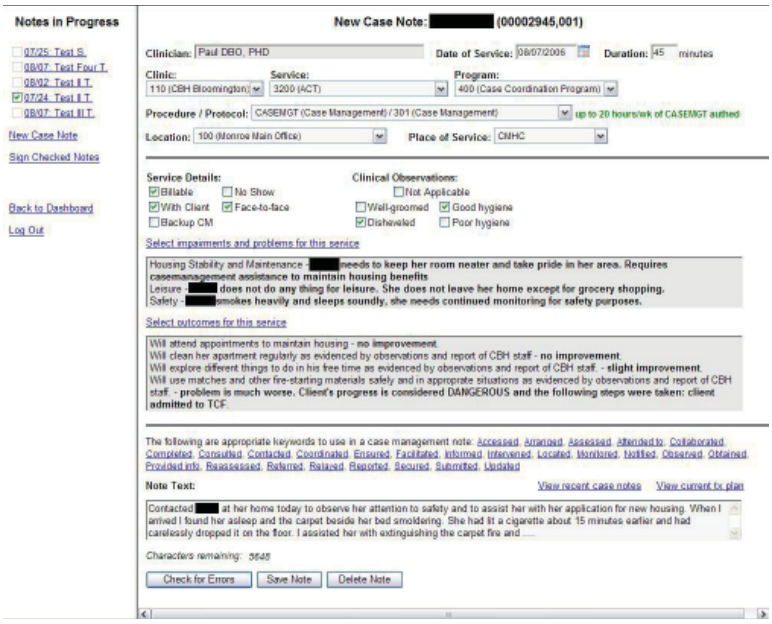
See CDS on page 8

Figure #1



CDS, continued from page 7

Figure #2



progress note were uniformly well received but of the two, the progress note received the most accolades by clinical staff. Both were developed with the clinician work flow in mind which they appreciated. It takes 30-50% less time to do a treatment plan now than in the past, and progress notes require very little typing compared to old free-form text blocks. Quality of care is enhanced because the system focuses the attention of the clinician on the assessed need of the client, not on the "problem *du jour*". We have not been audited since implementing these products, but they have been reviewed by a well known consultant in the area of Medicaid compliance and she not only approved of them but asked if she could share what we have done with her other clients.

Having an EHR admittedly makes this easier to implement but this technology is portable to any organization willing to put the time and energy into it. The assessment tool we use is commercially available, and the outcomes, interventions and risk assessments were all developed in-house. The primary impetus for moving in this direction was to realign the organization before we were audited based both on the OJG's expressed recoupment goals and on the advice of some respected consultants in our industry. The enhancements described herein are fully implemented in our agency. This is how we do business and as a result, we believe our risk is significantly reduced. ❖

References

1. Thornton, Mary, *Issue Brief New Medicaid Compliance Issues from the Deficit Reduction Act.* National Council for Community Behavioral Healthcare: http://www.nccbh.org/POLICY/ThorntonDRAandMedicaidCompliance.pdf

2. *Audit of Iowa's Adult Rehabilitation Services* Program, (A-O7-O3-03041) March 28, 2005 http://oig.hhs.gov/oas/reports/region7/70303041.htm

3. Wyatt J, Spiegeihalter D, 1991 *Field trials of medical decision-aids: potential problems and solutions.* Proc Annu Symp Comput Appl Med Care 3-7.

About Center for Behavioral Health: *Incorporated in 1967, CBH now serves 9000 clients annually. JCAHO accredited. Member of both MHCA and the National Council (NCCBH). Located in Bloomington, Indiana. CEO is Dennis P. Morrison, PhD. Phone 812-337-2302.*

CALENDAR

MHCA 2007 Summer Conference
Dates: August 6-10, 2007
Location: Westin Horton Plaza
San Diego, California
Phone: *619-239-2200*
Rate: $ 249 single/double
Deadline: July 12, 2007

IIMHL 2007 Leadership Exchange
Dates: August 27-31, 2007
Location: Ottawa, Canada
Information: www.iimhl.com

MHCA 2007 Fall Conference
Dates: October 30-
November 2, 2007
Location: JW Marriott Desert Ridge
Phoenix, Arizona
Phone: *800-835-6206*
Rate: $249 single/double
Deadline: September 27, 2007

MHCA 2008 Annual Meeting
Dates: February 19-22, 2008
Location: Don CeSar Beach Resort
St. Pete Beach, Florida
Phone: *800-282-1116*
Rate: $264 single/double
Deadline: January 17, 2008

Florida and Alabama Additions Boost Southeast Membership


Steven Ronik, EdD


J. Tuerk Schlesinger

In March, MHCA gained two new service providers, bringing our total membership to 143.

Joining from Florida is Henderson Mental Health Center (Fort Lauderdale), CEO: Steven Ronik, EdD. From Alabama, first in the state, is Mobile Mental Health Center, (Mobile), CEO: J. Tuerk Schlesinger. We welcome both of these fine organizations and leaders to MHCA. ❖