Mental Health First Aid

Mental Health First Aid is a groundbreaking public education program that introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. It allows for early detection and intervention by teaching participants about the signs and symptoms of specific illnesses like anxiety, depression, schizophrenia, bipolar disorder, eating disorders, and addictions.

One in five Americans has a mental illness and many are reluctant to seek help or might not know where to turn for care. The symptoms of mental illness can be difficult to detect which means that all too often, those in need of mental health services do not get them until it is too late.

There is growing support in the U.S. Congress for widespread adult and youth Mental Health First Aid training. The Mental Health First Aid Act of 2013 (S. 153/H.R. 274) authorizes $20 million in grants to fund Mental Health First Aid training programs around the country. Participants would be trained in:

- Recognizing the symptoms of common mental illnesses and addiction disorders
- De-escalating crisis situations safely
- Initiating timely referral to mental health and substance abuse resources available in the community.

Training programs under this demonstration project would be offered to emergency services personnel, police officers, teachers/school administrators, primary care professionals, students, and others – ultimately, with the goal of improving Americans’ mental health, reducing stigma around mental illness, and helping people who may be at risk of suicide or self-harm and referring them to appropriate treatment. Mental Health First Aid is a live training course, which uses role-playing and simulations to demonstrate how to assess a mental health crisis; select interventions and provide initial help; and connect persons to professional, peer and social supports as well as self-help resources.

The National Council for Behavioral Health has partnered with the Maryland Department of Health and Mental Hygiene and the Missouri Department of Mental Health to adapt the program to the U.S., develop and standardize the curriculum and training standards, and disseminate the program to all audiences. Training is offered in the form of an interactive 12-hour course that presents an overview of mental illness and substance use disorders in the U.S. and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. Those who take the 12-hour course to certify as Mental Health First Aiders learn a 5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care.

For additional information please visit www.mentalhealthfirstaid.org.

Source: The National Council for Community Behavioral Healthcare

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Failure to properly supervise or provide direct oversight of the activities of licensed or non-licensed staff may result in harm to patients and potential liability for the health center or free clinic. Written policies and procedures related to supervision of clinical and non-clinical staff and chain of command are essential.

Health centers and free clinics can use the following checklist to ensure robust policies and procedures related to supervision of clinical and nonclinical staff:

- Establish a one-page table of organization or an organizational chart that clearly aligns clinical and nonclinical staff to their direct supervisor.
- Develop clear policies and procedures that speak to the direct supervision and clinical oversight of licensed staff or advance practice professionals (e.g., licensed practical nurses, registered nurses, physician assistants, nurse practitioners, social workers, dental hygienists).
- Investigate the scope of practice for each licensed and non-licensed clinical staff member to ensure that their job descriptions and responsibilities include only those functions outlined in state regulations. Scope of practice guidelines can vary by state; therefore, it is important to familiarize staff with the regulations.
- Ensure that functions performed by unlicensed staff (e.g., medical assistants) do not require a license under state scope-of-practice requirements.
- Have written supervisory agreements or practice agreements between physician assistants and supervising clinicians so that all individuals understand their duties and supervisory responsibilities (see the American Academy of Physician Assistants’ Guidance on Practice Agreements, American Medical Association’s Guidelines for Physician/Physician Assistant Practice, and the National Commission on Certification of Physician Assistants’ [NCCPA] Competencies for the Physician Assistant Profession).
- Have written collaborative agreements between nurse practitioners and collaborating physicians, if applicable (see the National Organization of Nurse Practitioner Faculties’ Competencies for Nurse Practitioners.)
- Review supervisory and collaborative agreements in accordance with state guidelines and standards of practice, and file all necessary paperwork with the state.
- Clearly define in writing the roles and responsibilities of the supervising or collaborating clinician and make sure that the clinician understands the importance and accountability associated with the position.
- Define what constitutes “supervision and control” (e.g., whether the supervising clinician is available on-site or physically present when the procedure is performed). Whichever method of supervision is chosen, the supervising clinician must be available for consultations in-person, by telephone, or by other means (in compliance with state law) when needed.
- Establish a chain of command that reflects lines of authority for administrative and clinical decision making when issues cannot be resolved between the provider who is caring for the patient and the supervising clinician. Include this information in supervisory and collaborative agreements.
- Provide education to providers and staff on the health center’s supervision and chain-of-command policies. Include clear guidance on effective communication skills to promote clear exchanges of information regarding patient care (see the Communication and Disclosure Training Program).

Want to learn more? Refer to the Guidance Article Human Resources on the Clinical Risk Management Program website. All resources are provided for FREE by ECRI Institute on behalf of HRSA. Don’t have access or want to attend a free, live demonstration of the website? E-mail Clinical_RM_Program@ecri.org or call (610) 825-6000 ext. 5200.

Ohio’s Patient-Centered Primary Care Collaborative (OPCPCC) is a coalition of primary care providers, insurers, employers, consumer advocates, government officials and public health professionals who are joining forces to create a more effective and efficient model of healthcare delivery in Ohio.

The OPCPCC Coordinating Council is conducting a health information exchange survey among primary care providers who are recognized PCMH sites or are working toward recognition. The goal of the survey is to establish a baseline for evaluating the state’s progress in making electronic clinical information available to PCMH providers for care coordination purposes. The survey was designed to be comprehensive and completed online in approximately 15 minutes. If you have already completed this survey after receiving it from another member organization, we thank you for your participation.

To access the survey, click https://www.surveymonkey.com/s/opcpcchiesurvey.

Please complete the survey by May 31.
Telebehavioral Health

HRSA defines telehealth as the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Behavioral health care in the U.S. is generally harder to access than other health services, due to factors like a shortage of qualified behavioral health providers and coverage limits by public and private payers. The ability to provide telehealth services can offer some opportunities to breaking down these barriers and creating access for hard to reach patients in both rural and urban settings.

A 2013 summary report from HRSA titled Increasing Access to Behavioral Health Care Through Technology discusses the opportunities and challenges of Health Centers to provide behavioral health services via telehealth technologies.

The need for telebehavioral services is great since depression is the third most common reason for a visit to a HRSA Health Center, after diabetes and hypertension. The report continues to show the value of all types of telehealth, including telebehavioral health, in terms of potential cost savings, efficiencies, and expanded access to services.

Improved Care Delivery. Telebehavioral health can support the health system’s move toward collaborative and integrated approaches by strengthening relationships within a team and across agencies. (i.e. PCMH)

Expanded Staff Capacity. Telehealth can give providers more mobility in terms of new freedom to deliver health care while on-the-go and in different venues—expanding the walls of a clinic’s service offerings.

Enhanced Training Opportunities. Telebehavioral health can also be used to conduct trainings for staff when sessions are devoted to sharing of insights and best practices.

High Levels of Patient Acceptance. Telebehavioral health programs have found telehealth to be an effective way to work around patient fears over accessing services at a certain clinic or neighborhood.

Cost Savings. Telehealth can cut the cost of care delivery.

To access the full report please be directed to the following link.

FREE Telebehavioral Health TA from CIHS

The Substance Abuse and Mental Health Services Administration/ Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions (CIHS) is sponsoring a Free Telebehavioral Health Training and Technical Assistance Series to HRSA-funded safety net providers and rural health clinics.

This Telebehavioral Health Training and Technical Assistance Series is designed to help you increase access to behavioral health services through telemedicine offered via interactive educational sessions with telebehavioral health subject matter experts. Each educational session will be followed by separate Q&A/technical assistance session. Subject matter experts in the field will be available to assist you in your implementation.

After completing this training and TA series, participants will be able to:

- Identify for their own organization, one or more telebehavioral health service models that are clinically appropriate and a pathway to sustainability;
- Identify and engage the range of stakeholders necessary to successfully establish telebehavioral health services;
- Coordinate their telebehavioral health activities with pertinent local, state and federal partners.

The T/TA Series is targeted to organizations that have determined that telebehavioral health services are part of their future and want to move forward. The training uses the Triple Aim and Patient Centered Medical Home (PCMH) Practice Transformation as a framework. To view the complete schedule and register for sessions, please click here.

RESOURCE ALERT: The Health Policy Institute of Ohio’s April 2013 policy brief titled Looking ahead: Understanding telehealth in Ohio
AHRQ’s Mental Health Resources

When treating mental health conditions, it is important for you and your patients to have access to evidence-based resources to determine which treatments work best for individual patients. The Agency for Healthcare Research and Quality (AHRQ) offers a growing library of clinician and patient resources to ensure you have reliable, evidence-based information on various mental health conditions.

AHRQ’s Effective Health Care (EHC) Program provides clinician research summaries to help you get the clinical bottom line on the effectiveness of treatments. Companion patient treatment summaries help your patients explore treatment options, compare the benefits and risks of each, and prepare to discuss them with you. These include—

- Medicines for Treating Mental Health Conditions: A Review of the Research for Adults and Caregivers
- Therapies for Treatment-Resistant Depression: A Review of the Research
- Medicines for Treating Depression: A Review of the Research for Adults
- Depression After Brain Injury: A Guide for Patients and Their Caregivers
- Antipsychotic Medicines for Children and Teens: A Review of the Research for Parents and Caregivers

Resources for you include clinician research summaries, educational slide sets, podcasts, and Webcasts. You also have access to free, accredited continuing medical education/continuing education (CME/CE) activities.

To order free print copies of patient treatment summaries and consumer research summaries, call the AHRQ Publications Clearinghouse at 800-358-9295 and use code C-02.

AHRQ’s Effective Health Care Program is a leading Federal effort to compare treatments for health conditions and make findings public. The Program provides evidence-based information about the comparative benefits and risks of treatments that helps health care professionals work together with individual patients to make informed treatment decisions. For more information, visit www.effectivehealthcare.ahrq.gov or sign up for the Program’s newsletter, the EHC Inside Track.

The Revolving Door: A Report on U.S. Hospital Readmissions

The U.S. health care system suffers from a chronic malady -- the revolving door syndrome at its hospitals. It is so bad that the federal government says one in five elderly patients is back in the hospital within 30 days of leaving. Some return trips are predictable elements of a treatment plan. Others are unplanned but difficult to prevent: patients go home, new and unexpected problems arise, and they require an immediate trip back to the hospital. But many of these readmissions can and should be prevented. They are the result of a fragmented system of care that too often leaves discharged patients to their own devices, unable to follow instructions they didn’t understand, and not taking medications or getting the necessary follow-up care.

The federal government has pegged the cost of readmissions for Medicare patients alone at $26 billion annually, and says more than $17 billion of it pays for return trips that need not happen if patients get the right care. This is one reason the Centers for Medicare & Medicaid Services has identified avoidable readmissions as one of the leading problems facing the U.S. health care system and now penalizes hospitals with high rates of readmissions for their heart failure, heart attack, and pneumonia patients.

This report is being released in conjunction with the Robert Wood John Foundation’s Care About Your Care initiative, which is devoted to improving care transitions when people leave the hospital. It looks at the issue of readmissions in two ways: by the numbers and through the eyes of the people who live them.

To access the full report from February, 2013, please click here.

Source: Robert Wood Johnson Foundation
ADA Welcomes Surgeon General Endorsement of Community Water Fluoridation

US Surgeon General Regina Benjamin, MD, has officially endorsed community water fluoridation as “one of the most effective choices communities can make to prevent health problems while actually improving the oral health of their citizens.”

“Fluoridation’s effectiveness in preventing tooth decay is not limited to children, but extends throughout life, resulting in fewer and less severe cavities,” Dr. Benjamin said. “In fact, each generation born since the implementation of water fluoridation has enjoyed better dental health than the generation that preceded it.”

Every surgeon general for the past 50 years has endorsed fluoridation of community water supplies as a safe and effective weapon in the war against tooth decay. The American Dental Association (ADA) has supported water fluoridation since 1950 and “applaud(s) Dr Benjamin for making this public endorsement.”

Source: American Dental Association

Tips for Encouraging Children to Drink Water

Here are tips for encouraging children to drink fluoridated water during the day.

Make it fun: Drink from single-use bendy, silly, or colored straws. Or children can choose their favorite cups or water bottles.

Keep it portable: Water bottles that can be carried anywhere and refilled with tap water are great.

Flavor it: Children used to drinking juice, juice drinks, or pop (soda) may think water is too plain. Add a lemon, lime, or orange slice or fresh mint leaves to the water. Or add fruit like blueberries, raspberries, or strawberries.

Ice it: Serve water with ice cubes or crushed ice. Look for ice cube trays in fun shapes like dinosaurs, letters, or animals.

Make it available: Set up a station where children can get a drink of water whenever they are thirsty. It can be as simple as keeping a non-breakable water pitcher on a low counter or a chair where young children can reach it.

Model it: Young children learn by watching. Be a good role model by drinking water instead of drinks that have sugar.

Source: The National Center on Health: Brush up on Oral Health
Ohio Community Health Center Hero Award

National Health Center Week, August 11 - 17th, will be here before we know it and this year will not be successful without your Health Center’s participation! Ways your Health Center can participate include:

- **Holding a community event, such as Health Fair**
  Pick one day or several days for your Health Center’s event(s), August 11-17 is going to be THE week to shine the spotlight on your Health Center, increase community awareness, and celebrate all that your Health Center does!

- **Inviting state and federal elected officials to visit your Health Center**
  OACHC is excited to announce the continuation this year of the $250 event sponsorship when your Health Center confirms attendance by any of your state or federal legislators for your Health Center Week event.

- **Nominating staff and colleagues for the Ohio Community Health Center Hero Award**
  In honor of National Health Center Week, Ohio Community Health Center Hero Award nominations may be submitted online at www.ohiochc.org/heroaward. This is a great way to recognize outstanding leaders and advocates working for your Health Center! All nominees will be recognized with special web communications and media releases. The deadline to submit nominations is July 30, 2013. Please OACHC can provide you with postcards to place in your Health Center’s waiting room(s) and staff break room(s) to encourage Ohio Community Health Center Hero Award nomination submissions.

If you have questions about National Health Center Week ir the CHC Hero Awards or need assistance in any way please contact Julie DiRossi-King, Director of Policy and Public Affairs at jdirossi@ohiochc.org or 614.884.3101.

New HIPAA Rules In Effect

March, 2013 marks the effective date of a host of new federal privacy and security rules, including extending legal liability to business associates of healthcare providers and restoring a measure of patient control over disclosure of their records, compliance won’t be required until six months later.

The rules, most of which are amendments to the privacy and security rules under the Health Insurance Portability and Accountability Act of 1996, were drafted by HHS under authorities given by health information technology provisions of the American Recovery and Reinvestment Act of 2009.

The new rule expands HIPAA privacy and security rule coverage and direct liability for violations to business associates of HIPAA “covered entities.” Those contractors might include vendors of remote-hosted EHRs to office-based physicians or firms providing hospitals with clinical and financial data analytics. In addition to healthcare providers, HIPAA covered entities include claims clearinghouses and insurance plans.

Another major change under the rule involves the policies and technologies needed to comply with a patient consent management provision. Under the ARRA, a patient who pays out-of-pocket for treatment can ask a provider not to share a record of that treatment with the patient’s health insurance plan and providers must comply with that request.

While this provision of the law is fairly narrow—with mandatory non-disclosure covering only information exchange with the patient’s insurance carrier—a trend toward more patient-centered care is growing, Dinh Rose said. “Consumers today are becoming more aggressive, so I think we’re going to continue to see that advance as the years go on.”

For the full article, please click here.

Source: ModernHealthcare.com
Study Identifies Patients at High Risk for Hospital Readmissions

How often patients land in the hospital—and how long they stay—were better indicators of which patients would return to the hospital unnecessarily than types of illnesses, number of prescriptions and other factors, a study found.

The results, published by JAMA Internal Medicine, are among the latest in a growing body of research that seeks to identify patients at high risk for avoidable hospital stays by shifting through patient data in search of flags that predict who will make a repeat hospital visit.

Policymakers have targeted hospital readmissions as a source of potential waste. Last October, Medicare began to cut pay to hospitals with higher-than-expected readmissions within 30 days for heart attack, heart failure or pneumonia patients.

Hospitals, too, have targeted readmissions in response to Medicare's push and in a bid to lower healthcare costs under new insurance contracts, such as accountable care, that include incentives to slow health spending.

Dr. Jacques Donze, a research associate with the Brigham & Women's department of medicine who contributed to the study, said researchers sought to identify factors that could be tracked before patients leave the hospital so that clinicians might intervene with support that could prevent a repeat visit. A study already under way will use the score to identify patients to test potential interventions, such as individual coaching, home visits and pharmacist oversight of patients' medication, he said.

The analysis used data for roughly 9,200 patients who stayed at Brigham and Women's Hospital for at least 24 hours between July 1, 2009, and June 30, 2010. Patients either did not return within 30 days to any of three Partners HealthCare hospitals, including Brigham and Women's, or were readmitted within a month for what was identified as an avoidable visit.

Researchers with Brigham & Women's Hospital and the Bern University Hospital in Switzerland combed through two dozen patient characteristics that could be culled from patient records accessible during a hospital visit to look for potential risk factors.

Of those characteristics—which included factors such as age, whether patients had a caregiver upon leaving the hospital and certain laboratory results—the study identified eight that best predicted which patients would return to the hospital within a month.

Ultimately, researchers used seven of the eight factors to create a risk score for potentially avoidable readmissions. The seven factors are hemoglobin at discharge; discharge from oncology; sodium level at discharge; number of procedures during first admission; non-elective versus elective admission; number of admissions within prior year and length of the hospital stay.

Six medical conditions were examined as possible risk factors, and only congestive heart failure appeared to have any predictive value for readmissions. Congestive heart failure was eliminated from the risk score, however, because it was the weakest indicator and because the diagnosis in some cases doesn't materialize until billing data is generated after discharge.

The score will be tested in an international study, which includes seven U.S. locations, said Dr. Jacques Donze, a research associate with the Brigham & Women's department of medicine who contributed to the study.

Researchers said they believe that no prior studies have identified procedures during admission and sodium level at discharge as risk factors for readmissions. The number of hospital visits and length of stay, identified as important predictors, could be surrogates for other indicators that reflect the severity of patients' illness, the authors wrote.

To access the article please click here.

Source: ModernHealthcare.com

NACHC PCMH Accelerator Two Part Webinar Series (May 8-June 26)

Featuring 4 EHR Vendors! (NextGen, eClinicalWorks, GE Centricity, and SuccessEHS)

Learning Objectives:

- Learn from PCMH recognized health centers who used a specific vendor EHR to successfully implement and receive PCMH recognition
- Break through the challenges and barriers associated with key PCMH concepts and EHRs such as population management, care management, clinical decision support, self-care progress, referral tracking, and continuous quality improvement
- Have your questions answered by health center experts who know your EHR and have already achieved PCMH recognition

To register for the Webinar series and for more information, visit the NACHC Web site at: http://www.nachc.com/trainings
Upcoming Training Opportunities

Health Center Credentialing & Privileging—FREE
Thursday, May 23, 2:00—3:00 pm EST
This Webinar will introduce a new NACHC resource that provides insights -- or “Tips” -- from experienced health center staff about doing the work to verify credentials and grant privileges to health center staff providing patient care and services. Register here.

Who’s Leading the Leading Health Indicators? - Mental Health”
Thursday, May 23 at 12:00 pm EST
Join us as we highlight how one Tribe has been successful in using data to drive decisions and interventions for addressing youth suicide. The webinar will be led by U.S. Department of Health and Human Services Deputy Assistant Secretary for Disease Prevention and Health Promotion, Dr. Don Wright, and will include a roundtable discussion on the impact of this critical Leading Health Indicator topic. Register here.

340B Drug Discount Program Policy Issues Webinar—FREE
Wednesday, May 29, 2:00-3:00 pm EST
This webinar will provide an overview and discussion on 340B contract pharmacy rules and policies and related issues, including health center use and charges for 340B drugs for Medicaid Managed Care enrollees. Register here.

The Use of the EHR in Establishing Quality Improvement Efforts—FREE
Wednesday, May 29th, 12:00 pm EST or May 30th at 3:00 pm EST
This session will provide guidance on the importance of EHR data collection and a discussion of how this data can translate into information for quality assessment (QA) and quality improvement (QI). Register here.

Working Together to Promote Oral Health Care for Pregnant Women Webinar—FREE
Monday, June 3rd, 1:00—2:30 pm EST
The American Academy of Pediatrics (AAP) is hosting a free webinar to discuss the importance of collaboration among health professionals to ensure that the oral health needs of pregnant women are met. Register here.

Cultural Competence: The Impact of Stigma on Patients with HIV/AIDS
Thursday, June 6, 2:00-3:00 pm EST
LEARNING OBJECTIVES: Define stigma and discrimination; Discuss types of stigma and factors contributing to HIV/AIDS-related stigma and discrimination; Identify the consequences of HIV/AIDS-related stigma; Discuss at least 4 culturally responsive strategies to reduce HIV/AIDS-related stigma and discrimination. Approved for up to 1.0 Prescribed credits by the American Academy of Family Physicians (AAFP). Register here.

The Multiple Roles of Oral Health Providers: Screening and Connection to Care
Wednesday, June 12, 1:30-3:00 pm EST
This session will highlight initiatives aimed at providing care to victims of domestic violence, describe programs to train dentists to identify and intervene in cases of domestic violence, and discuss implementation of HRSA funded oral health initiatives aimed at providing dental services to victims of domestic violence by dental students and residents. Perceived dental needs among the patients will be reported along with the attitudes and behaviors among the dental team in treating this population. Register here.

Helping Your Patients Change: An Introduction to Motivational Interviewing—FREE
Tuesday, June 25, 12:30—1:30 pm EST
This webinar will discuss the theory and principals of Motivational Interviewing - the Spirit of MI - along with specific counseling behavior Do’s and Don’ts. We will also observe videotaped examples of MI sessions and analyze their content. This webinar can help you meet PCMH 1G:5. Register here.