Rural Maryland Council Health Care Committee

Executive Summary 2015-2016

Prepared by: Rural Maryland Council

December 2016

Photo courtesy of parenthelp123.org

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RMC HEALTH CARE COMMITTEE
FINAL REPORT
DECEMBER 2016

Executive Summary

The RMC Health Care Committee has been active over the years focusing on health care issues such as work force shortages, rural access to prescription medications, scope of practice regulations and the feasibility of developing a statewide telehealth consortium. Currently, the Committee has focused its attention on mental health, particularly on adolescent depression and mood disorders as well as its access through the application of telemedicine.

In March 2015, the Committee met for the first time to review its charge as well as receive background information on the Committee's previous work and the chronological development of the RMC. Discussed during that meeting were the MHCC Telemedicine Task Force recommendations, establishing priorities for committee evaluation and determining a realistic, non- duplicative agenda for the Committee to pursue. In view of the agency's limited resources related to staff and funds, it was also mentioned that RMC's role in the process might be only one of advocacy. It was further agreed that meetings would be scheduled as needed and would be a mixture of telephone conference calls and face to face deliberations depending on the presence of guest speakers.

Following that initial deliberation and subsequent suggested rankings of priorities from Committee members, it was the Committee's consensus that its principal focus would be on the application of telemedicine in addressing mental health issues in school based health centers. Although it was recognized early in the discussions that adequate reimbursement was a major factor(impediment) to many solutions, there were other contributing factors that deserved the Committee's attention. Moreover, as important as it was to develop an awareness of the telemedicine equipment available, the first most critical element was to identify that aspect of mental health upon which the Committee should focus. Therefore by discussion, review of available data and through the process of elimination, the Committee concentrated its efforts on the issue of adolescent depression.

From March 2015 to November 2016, the Committee was convened thirteen times. In most instances, when speakers were present, the option to participate by conference call was extended to recognize the geographical diversity of Committee membership and the travel distance involved. Among the early presenters was Tarik Shaheen M.D., a Psychiatrist and CEO of the Iris Telehealth Program whose Staff of Specialists are trained in Adult, Child and Consultation Psychiatry. He addressed the Committee on the types of telemental delivery models currently being practiced and issues related to adolescent depression. Additionally the Chair of the RMC Legislative Committee was invited to a subsequent meeting to acquaint the Committee with the issues that are being closely followed by his group.

At its November 2015 meeting, the Committee was presented with and accepted, the recommendations of a draft summarizing the data reviewed outlining three short term objectives to consider:

- Encourage all Primary Care physicians to include evaluations for adolescent depression in their Private office visits
- Review and revise roles of School Nurse and Counselor to assist in detecting signs of depression for possible medical attention

- Develop support for certification programs in mental health to further enhance the Advanced Degree Providers' qualifications and to assist in offsetting the recognized physician shortage in addressing and treating or referring adolescents suffering from depression

As the year 2015 concluded, Ms Shannon McMahon, Deputy Secretary, Health Care Financing, was the guest speaker at a special meeting of the Committee. Ms. McMahon provided an informative overview of the Medicaid program, its expansion to include access to telemedicine and the Department's streamlining of its application process.

As the year 2016 began, the Committee , upon receiving approval from the RMC Executive Board, launched its advocacy efforts directed at the educational components of the voids suggested by the short term objectives identified. The Committee focused on some of the major barriers confronting them. A review of data suggested an underutilization of evaluation tools by the primary care physician despite a recognition of its success when early intervention occurs. Therefore , Staff was asked to develop a list of primary care and pediatric physicians practicing in rural Maryland. Included with the individual letters to be sent to more than 400 rural Physicians encouraging their support for the program was a summary of the Committee's recommendations as well as a copy of the State promulgated evaluation tools.

As an additional professional resource, the Committee also discussed the Behavioral Health Integration In Pediatric Primary Care (BHIPP), a program supported by the Maryland Department of Health and Mental Hygiene (DHMH) and partnerships among the University of Maryland School of Medicine, the Johns Hopkins School of Public Health, and Salisbury University. BHIPP provides support to pediatric primary care providers in addressing the behavioral and developmental needs of their children. Dr. David Pruitt, a member of the committee, is the primary PI of BHIPP. At a later meeting, Dr. Pruitt and his colleagues offered a formal presentation on the BHIPP program and the potential benefits through coordination and integration of the local BHIPP, telemental health and school mental health.

Regarding the review of the roles of the front line personnel in the public school system, viz., the school nurse, counselor and teacher, the Committee became aware of the loosely integrated working relationship among the State Departments of Education, Health and Mental Hygiene and the local School Boards of Education. In fact, each County's School Board is autonomous and as a result, there are a variety of approaches to the implementation of the school based mental health programs throughout the State. Also discussed at recent Committee meetings was the role of the local Health Improvement Council and its interaction with these programs. Consequently, the Committee requested that letters be sent to the Chairs of the Local Health Improvement Councils and the School Superintendents in rural communities identifying its findings and seeking local input regarding its recommendations. There were power point presentations from Dr. Cheryl DePinto, Medical Director, Office of Population Health Improvement, DHMH; and from Health Services Specialists in the Department of Education's Student Services and Strategic Planning Branch, Ms. Alicia Mezu MSN/Ed, and Mr. Walter Sallee MPA who delineated their Departments' responsibilities and offered a better insight into those differences.

On the question of certification programs as potential approaches to better recognize advanced degree providers who have been clinically exposed to adolescent mental and behavioral disorders via their involvement in primary care activities, Dr. Karan Kverno, PhD, PMHNP-BC, Track Coordinator for the Post-graduate Psychiatric Mental Health Care nurse practitioner program at Johns Hopkins University School of Nursing and Adele Foerster, MSN, RN, CPNP-PC/AC, Chief Credentialing Officer of the Pediatric Nursing Certification Board, presented an informational program on certification options.

Dr. Kverno described the Psychiatric Nurse Program Psychiatric Mental Health Nurse Practitioner (PMHNP) certification and the available online programs for post-graduate PMHNP training. In the same Forum, Ms. Foerster outlined the criteria for certification as a Pediatric Primary Care Mental Health Specialist (PMHS). The highlights of both certificate options have been forwarded to two academic facilities on the Eastern Shore for further input and sharing with their Alumnae Associations. In post meeting discussions with the Chair, representatives from those facilities have indicated an interest in further contact with Dr. Kverno on the subject. Accordingly, in October, Dr. Kverno held a panel discussion on mental health care and advanced practice psychiatric nursing with the nursing students of Chesapeake College. Dr. Kverno, is a Committee member whose recent publications focus on the need to promote access through integrated mental health care education and rural access to it through online postgraduate nurse practitioner education.

As another example of its advocacy efforts, the Executive Director issued a report on the Health Care Committee's activities in the recent RMC Summer 2016 Newsletter which has a circulation of approximately 6,200 including all the Legislators in both Houses of government.

At the national level, a proposed legislative bill receiving attention is one being considered by Senators Hatch and Schatz. Its focus seems to be based on a concept previously discussed at an earlier meeting as a potential long range recommendation for the Committee to evaluate. Specifically the Expanding Capacity for Health Outcomes (ECHO Act) somewhat resembles a program with an identical acronym. The Extension Of Community Health Outcomes (ECHO) has its roots in New Mexico as a collaborative, university approach to community access to medical care. Its success has been replicated in several States and is spreading across many countries and medical disciplines. Perhaps the legislation, which also cites behavioral health among its provisions, will be encouraging wider application of similar delivery models through financial incentives.

At the State level, the Maryland Health Care Commission, through the enactment of Senate Bill 707 has reconvened a Rural Health Care Work Group. Among its charges, it is to develop a sustainable health care system for five counties on the Eastern Shore, which hopefully will serve as a model for the State of Maryland and rural areas across the nation. The project has funding to undertake its assignment and has behavioral health as one of the disciplines to be included in this endeavor.

Conclusions

The Committee is fully aware of the importance of health access and population health in improving the quality of life, and which is reflected in the Council's Mission Statement. Therefore, based on its deliberations to date, the presentations received and the actions initiated, the Committee recommends RMC's continued advocacy for a stronger integration of the mental health component with primary care in both the clinical and educational environments. It believes that its three short term objectives offer promising clinical and educational complements that can alleviate to some degree the current workforce shortages as well as better assist in the identification of potential behavioral disorders among the adolescents that may suggest further evaluation and early intervention.

As a financial incentive to encourage those efforts, the Committee further recommends that RMC reserve a specified share of the Prosperity Investment funds, recently authorized by the State Legislature, for health related projects that incorporate these short term objectives in their grant proposal requests as well as the application of Telehealth principles in achieving their projected outcomes.

Recognizing the limited resources of staff, the Committee recommends that the Executive Director continue to monitor support for these objectives through follow up communication/meetings with the various State agencies already contacted such as the DHMH, the Department of Education and the local Health Improvement Councils. Further, by sharing this report with representatives from other select professional organizations, such as the State Medical Society and the Maryland Nurse Associations, including Schools of Nursing, RMC can initiate discussions designed to encourage their support for the short term objectives developed.

At this point, the Committee recommends that, aside from any possible role in reviewing applications requesting grants under the Prospective Investment Fund, its future task await the outcome of the above activities before convening any future meetings.

Sincerely,

Tom

Chm

Mr. Tom McLoughlin
Health Care Committee Chair
Rural Maryland Council

Ms. Charlotte Davis
Executive Director
Rural Maryland Council

10/28/16

RMC
Rural Maryland Council

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Scott Warner, Chairman

Charlotte Davis, Executive Director

January 8, 2015

<Contact Name>
<Address>

Dear <Greeting Name>:

As you know, the Rural Maryland Council (RMC) is an independent State agency. It brings together rural leaders, government officials at all levels and representatives from the nonprofit and for profit sectors to identify and craft solutions to the challenges facing rural Maryland. Its mission is to improve quality of life while preserving the cultural heritage of Maryland's rural communities.

As Chair of its Health Care Committee, may I extend to you a most cordial invitation to join us in our discussions on identifying priorities of medical needs with a special focus on the Rural Counties in Maryland. In view of your background and interest, I believe your perspective will greatly assist in our deliberations and contribute to our goal in focusing, in a non-duplicative fashion, on the unmet needs as well as the RMC's role in calling attention to them.

The frequency of meetings will consist of monthly conversations, many of which will be by telephone in view of the geographic diversity of the Committee's membership. Recognizing the value of your time, I will not force agendas and will only convene meetings when there are specific items to present for input and consensus.

As an example, the priority reached in previous discussions centered on the *mental health component* of telemedicine. However, when the Governor reconvened the Maryland Telemedicine Task Force in mid 2013, our discussions ceased to await the outcome of that report. Consequently, with its finalization in October 2014, the initial topic for our Committee's first meeting would be a review of the MHCC's recommendations and a determination as to whether there is a continued role for RMC in this exploration. If so, what should be addressed. If not, what are the higher priorities that can be realistically addressed by the group.

I hope you will accept my invitation to become a member of our Committee. I would greatly appreciate a response at your earliest convenience and no later than February 13, 2015 so that I can make appropriate plans for an early March discussion.

Please address your responses to my attention care of rmc.mda@maryland.gov. Should you wish to contact me by telephone, I can be reached at (410) 822-5735.

Thanks for your consideration.

Sincerely,

Tom McLoughlin

Tom McLoughlin
Chair, Rural Maryland Council Health Care Committee

TM:kav

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RMC Health Care Committee Meeting
March 25, 2015
11:00 a.m. to 1:00 pm
MARBIDCO's Offices, 1410 Forest Drive, Suite 21, Annapolis, Maryland
Agenda

Invited participants: Members of the Health Care Committee
Thomas McLoughlin, Chair
Charlotte Davis, Executive Director
Kathy Vernacchio, RMC Administrative and Communications Aide

I. Welcome and Introductions

II. RMC History and Mission

III. Committee Purpose
   a. Identify Health Priorities
   b. Reach Consensus on one Topic
   c. Invite Presentations (As indicated)
   d. Analyze Alternatives
   e. Propose Solutions/Recommendations
   f. Develop Advocacy
   g. Evaluation of Efforts

IV. Maryland Telemedicine Task Force Report
   a. Summary of RMC Committee's activities
   b. Summary of MHCC Report's Conclusions

V. Open Discussion of Health Care Committee's Role
   a. Legislative
   b. Regulatory Review
   c. Community Awareness
   d. Professional Support
   e. Other

VI. Next Steps
   a. Selection of Highest Priority Topic
   b. Frequency and Type of Future Meetings
   c. Date of Next Meeting

VII. Adjournment

Minutes

Regular Meeting of the Rural Maryland Council (RMC) Health Care Committee
Wednesday, March 25, 2015, 11:00 a.m. to 1:00 p.m.
MARBIDCO, 1410 Forest Drive, Suite 21, Annapolis, Maryland 21401

Participants:

Thomas McLoughlin, RMC Health Care Committee Chair
Dr. Dianna E. Abney, M.D., Health Officer, Charles County Department of Health
Ms. Michelle Clark, Executive Director, Maryland Rural Health Assoc.
Ms. Charlotte Davis, Executive Director, Rural Maryland Council
Ms. Holly Ireland, Executive Director, Mid-Shore Mental Health Systems, Inc.
Mr. Michael Jackson, Maryland Dept of Transportation, Director, Office of Bicycle and Pedestrian Access
Dr. Karan Kverno, Ph.D., PMHCNS-BC, PMHNP-BC, Assistant Professor, PMHNP Program, Johns Hopkins University School of Nursing
Ms. Temi Oshiyoye, Director, State Office of Rural Health
Ms. Sharon Praissman, MS, CRNP-A/PMH, Clinical Director, Psychiatric Outpatient Program for Adults, Johns Hopkins University School of Nursing (by phone)
Dr. H. Neal Reynolds, M.D., Associate Professor, University of Maryland School of Medicine
Dr. P. David Sharp, Ph.D., Chair, Technology Solutions & Standards Advisory Group, Maryland Health Care Commission
Dr. Nancy M. Smith, DNP, CRNP, FNP-BC, Assistant Professor, Nursing Department, PRMC/Salisbury University
Ms. Deborah L. Wolf, MS, Director, Atlantic Health Center, Atlantic General Hospital (not present)

RMC Staff:
Charlotte Davis
Kathy Vernacchio

Chairman McLoughlin called the meeting to order at approximately 11:19 a.m.

Call to Order

The Committee meeting was called to order at 11:19 a.m.

Welcome and Introductions

The Chair welcomed all in attendance and thanked them for their commitment to participate in the Committee's deliberations He noted that some future meetings may be conducted via conference call in view of the geographic diversity of the membership. He also acknowledged

with gratitude Mr. Steve McHenry who provided his Agency's Conference Room for today's meeting.

Since this was the initial meeting of the restructured Committee, each member introduced her/himself and offered a brief summary of their professional backgrounds.

RMC History and Mission

Mr. McLoughlin first provided a brief historical review of rural development in America at the Federal level beginning with President Theodore Roosevelt's establishing the Country Living Commission in 1908 to its current status as the Department of Agriculture, including several milestones that occurred during this time interval.

He then commented on Maryland's formal involvement in 1994 when Governor Schaefer, by Executive Order, created the Council for Rural Development. A year later, the Rural Caucus and the General Assembly introduced legislation that established the RMC as a permanent and independent State Agency.

Its mission is to bring rural leaders, government officials at all levels, nonprofit and for-profit representatives together to identify and seek solutions to the challenges confronting rural populations. The specific goal is to improve life and preserve the cultural heritage in the rural areas of this State.

Committee Purpose

The Health Care Committee's purpose is to focus, in a non-duplicative fashion, on the unmet health care needs of individuals in the rural areas of the State, as perceived by the members of the Committee. The Chair outlined a suggested approach to the activities ranging from identifying priorities, analyzing alternatives, proposing recommendations and evaluating efforts. He also commented on the Agency's limited resources which necessarily requires realistic goal and objectives that can be achieved.

Although there were earlier round table discussions and surveys on Telehealth conducted jointly by the State Office of Rural Health and the Rural Maryland Council, the previous Committee focused on the Mental Health component of Telemedicine when it was convened in 2012.Of particular concern was the recognized shortage of providers in behavioral health. Its work, however, was suspended pending the outcome of a report from the MHCC's Telemedicine Task Force. With MHCC's recommendations released in October 2014, RMC has requested that the Committee resume its deliberations.

Maryland Telemedicine Task Force Report

After a brief summary of the Report's major conclusions, there was extended discussion on areas and topics for the Committee's consideration. Among the many items introduced, several centered on:

- role of Nurse Practitioners in meeting the needs
- education on the cost effectiveness of telemedicine
- partnership with other professional associations
- obstacles to recruitment and retention of practitioners
- use of telemedicine in ambulatory care, schools, health centers
- identify new stakeholder groups on value and efficiency of telehealth

It was also recognized that much of the Committee's deliberations can be identified in the Ten Telehealth Use Cases contained in the MHCC Report and distributed at the meeting by Drs. Reynolds and Sharp, copy of which is attached. Therefore, it was suggested that the Use Cases form the baseline for the Committee's developing a list of priorities. Members were asked to select from that information at least one but not more than two priorities and submit it to RMC with a brief explanation on the rationale for the choice(s) within the next two weeks. Upon receipt, the responses will be collated, summarized and sent to the members prior to the next meeting.

Next Steps

Recognizing the geographical diversity of the Committee, the next meeting will more than likely be a conference call. In order to establish a schedule for future meetings, RMC will circulate a survey to determine the time of day and day of the week that works best for the members, When the surveys are returned and the input is received, the notice for the date of the next meeting will be forwarded.

Adjournment

There being no further business to be brought to the Committee, the meeting was adjourned at 1:10 p.m.

Respectfully Submitted,

Kathleen Vernacchio

Telemedicine Task Force Recommendations

March 25, 2015

The MARYLAND HEALTH CARE COMMISSION

Background

- The Task Force was created in 2010 in response to recommendations from the Maryland Department of Health and Mental Hygiene and the Maryland State Advisory Council on Heart Disease and Stroke
- In 2011, the Task Force expanded to three advisory groups and made recommendations for advancing telehealth
  - Clinical Advisory Group
  - Finance and Business Model Advisory Group
  - Technology Solutions and Standards Advisory Group
- In 2013, State law required MHCC to reconvene the Task Force

2013/2014 Task Force

- Comprised of public and private stakeholders
  - About 90 individuals representing roughly 65 organizations
- Developed recommendations regarding:
  - Transition from the term *telemedicine* to *telehealth*
  - Telehealth use cases
  - Online telehealth provider directory

Transition from *Telemedicine* to *Telehealth*

- Current definition for *telemedicine* in Maryland law
  - *Telemedicine means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located*
- Definition for *telehealth* recommended by the Task Force
  - *Telehealth is the delivery of health education and services using telecommunications and related technologies in coordination with a health care practitioner*

Telehealth Landscape

- Telehealth technology adoption
  - 2013: ~61 percent of acute care hospitals; ~9 percent of physicians
- Even though telehealth technology and payment structures are generally in place today, claim submission for telehealth services is minimal
  - 2013: 16 practitioners submitted ~132 claims that were reimbursed by payors for services rendered via telehealth
  - Payors indicated that more practitioners may be rendering telehealth services and not using the appropriate modifier when submitting claims

Telehealth Landscape – Government Payors

- Medicare reimbursement is limited to rural areas (~4.5 percent of Maryland census tracts) and provides coverage for approximately 73 telehealth services (out of over 10,000)
- Maryland Medicaid reimbursement was previously limited to three pilot programs, recent legislation expanded reimbursement
  - 2013:
    - Only one hospital submitted two telehealth claims to Medicaid
    - Roughly 75 telemental claims were submitted to Medicaid by Federally Qualified Health Centers, mental health clinics, and physicians

Telehealth Use Cases

- The Task Force recommended use cases to accelerate telehealth diffusion in the State
  - Aim to improve patient outcomes, reduce costs, and create a sustainable change in the way care is delivered, consistent with health care reform
- Implemented in rural and/or underserved areas
- Address potential increased demand for health care services due to implementation of health care reform

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Clinical Advisory Group

Recommended telehealth use cases to enable various telehealth applications

1. Improve transitions of care between acute and post-acute settings through telehealth
2. Use telehealth to manage hospital Prevention Quality Indicators
3. Incorporate telehealth in hospital innovative care delivery models through ambulatory practice shared savings programs
4. Require value-based reimbursement models to factor in reimbursement for telehealth

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Clinical Advisory Group *Continued*

5. Use telehealth in hospital emergency departments and during transport of critically ill patients to aid in preparation for receipt of patient
6. Incorporate telehealth in public health screening and monitoring with the exchange of electronic health information
7. Deploy telehealth in schools for applications including asthma management, diabetes, childhood obesity, behavioral health, and smoking cessation
8. Use telehealth for routine and high-risk pregnancies

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Clinical Advisory Group *Continued*

9. Deploy telehealth services widely at community sites, connected to health care professionals and/or the statewide health information exchange
10. Use telehealth for remote mentoring, monitoring and proctoring of health care practitioners through telehealth for the expansion, dispersion and maintenance of skills, supervision, and education

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Funding the Telehealth Use Cases

- The Task Force proposed the General Assembly consider providing approximately $2.5 million in funding for the implementation of select telehealth use cases through pilot projects
  - Select use cases would be competitively funded through cooperative grants between the State and the recipient
- Absent funding from the General Assembly, the use of telehealth will remain stifled under existing models of care delivery where the incentives do not encourage innovation in health care delivery

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Finance and Business Model Advisory Group

- Identified key financial and business model challenges of deploying the use cases
  - Reimbursement structure
  - Remote facility and delivery site billing
  - Practitioner availability, monitoring, and care coordination; practice transformation and redesign
  - Timeframes for implementation
- Considered proposing policy solutions; concluded, at this time, statewide policy would inhibit innovation in deployment of the use cases
- Organizations need to develop solutions to mitigate implementation challenges unique to their organizations

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Technology Solutions and Standards Advisory Group

- Determined the use cases could be implemented with current and evolving telehealth technology
- Identified a barrier to telehealth diffusion is the lack of information available about practitioners rendering telehealth services and technologies utilized
  - Recommended the development of a publicly available online telehealth provider directory that includes information about telehealth services offered and technologies used
  - Made available through the MHCC's State-Designated Health Information Exchange, the Chesapeake Regional Information System for our Patients (CRISP)

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Remarks

- Telehealth provides the opportunity to enhance the patient experience by increasing access to care
- The Task Force recommendations, if implemented, are expected to improve quality of care, contain health care costs, and increase patient and provider satisfaction
- Collaboration among stakeholders is essential in implementing the use cases to foster more rapid diffusion of telehealth
- Evidence from the use cases will be compiled by MHCC to inform future telehealth policy

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Thank You!

MARYLAND The MARYLAND HEALTH CARE COMMISSION

RMC Health Care Committee

Just a friendly follow up to our initial Committee meeting on March25, 2015.

For the benefit of those members who were unable to attend our first meeting, we discussed several health issues commanding a high priority, among them, the recommendations of the MHCC Telemedicine Task Force. Specifically, we thought that the ten Telehealth Use Cases might be an appropriate base line for the group's use in identifying its top priorities from which we will attempt to reach consensus on one issue that will receive the focus of our attention.

I also highlighted the previous RMC Committee's unfinished efforts that were suspended while the Task Force study was underway. In those discussions, Telemental health was designated as the highest priority as was the dearth of psychiatrists in addressing that need.

Consequently, the committee members agreed to select from the MHCC list, preferably one, but not more than two, Use Cases for further review in determining the Committee's direction. Also requested was a brief summary on the reason for the selection in no more than two sentences. Not to be excluded from that consideration, however, is the increasing awareness of Telemedicine's vital role in Behavioral Health and the role of the psychiatrically trained Nurse Practitioner in that process.

Since each member present agreed to forward her/his thoughts within two weeks following the meeting, may I respectfully ask that you respond no later than Monday, April 13 so that we can collate the responses and send out that report for your review.

Additionally, and under separate cover, Kathy will be sending out a survey so that we can establish a set day and time for our future meetings.

Thanks for your commitment to this effort and your continued interest in serving as a member of this Committee.

Tom McLoughlin

RMC Health Care Committee
June 2, 2015
1:00 PM
Draft Agenda

1. Convene Meeting

2. Minutes of March 25, 2015

3. Review and Discussion of Priorities as Submitted

4. Committee's Role in Advocacy for Telemedicine
   A) Research –Staff/ Individuals/ Task Force/ Other Organizations
   B) Communication - Position Papers/ Speakers/ Leadership Meetings
   C) Education – Workshops/ Conferences/ Newsletters/ Other

5. Goals to be Achieved
   A) Legislative
   B) Regulatory Review
   C) Community Awareness
   D) Professional Support

6. Other Business

7. Next Meeting July 7, 2015

8. Adjournment

Minutes

Regular Meeting of the Rural Maryland Council (RMC) Health Care Committee
Tuesday, June 2, 2015, 1:00 p.m. to 2:00 p.m.
Via Conference Call

Present:

Mr. Thomas McLoughlin, RMC Health Care Committee Chair
Ms. Charlotte Davis, Executive Director, Rural Maryland Council
Dr. Karan Kverno, Ph.D., PMHCNS-BC, PMHNP-BC, Assistant Professor, PMHNP Program, Johns Hopkins University School of Nursing
Dr. Kerry Palakanis, Owner and CEO, Crisfield Clinic Family Practice
Ms. Lylie Hinh, Assistant to Dr. Palakanis, Crisfield Clinic Family Practice
Dr. David Pruitt, Director, Child and Adolescent Psychiatry and Director of Telemental Health for the Department of Psychiatry, University of Maryland School of Medicine,
Dr. H. Neal Reynolds, M.D., Associate Professor, University of Maryland School of Medicine
Ms. Sharon Praissman, MS, CRNP-A/PMH, Clinical Director, Psychiatric Outpatient Program for Adults, Johns Hopkins University School of Nursing
Dr. Nancy M. Smith, DNP, CRNP, FNP-BC, Assistant Professor, Nursing Department, PRMC/Salisbury University
Ms. Deborah L. Wolf, MS, Director, Atlantic Health Center, Atlantic General Hospital

RMC Staff:
Kathy Vernacchio

Call to Order

The Committee meeting was called to order at 1:15 p.m.

Welcome and Introductions

The Chair welcomed the participants and thanked everyone who was able to join the call.

Minutes

The minutes of the March 25, 2015 meeting were previously distributed to all Committee members. The Chair asked if there were any questions on the content, comments, or corrections. There being none and upon motion properly made and seconded, it was voted to accept the minutes as submitted.

Review and Discussion of Priorities

At the March 25, 2015 meeting, members were asked to select one but not more than two priorities from MHCC's Task Force recommendations and submit that information to the RMC for discussion at today's meeting.

Approximately eight members forwarded their suggestions totaling ten priority items. Four responses identified school-based programs, community sites received two votes, and the monitoring, proctoring and mentoring of health care practitioners received two votes. Other comments considered as high priority were the use of telehealth for prevention quality indicators, and its use in emergency rooms.

During the discussion that ensued, much of the focus was on the need for school and community center based programs. Many of the comments related to the importance of psychiatric medicine in telehealth as well as the role of the psychiatrically trained nurse practitioner in addressing the issue of behavioral health especially in the rural communities.

Committee members also included comments on their experiences with current tele-behavioral health initiatives underway and efforts in collaborating with other organizations in the field.

Committee's Role in Advocacy for Telemedicine

Based on the discussion under the previous agenda item, it was suggested that the Committee might benefit from a guest speaker being invited to a future meeting. Members who attended a Mid-Atlantic Telehealth Resource Center (MATRC) Summit meeting in March indicated that the topic of telepsychiatry was not only on that formal program but was also represented among the exhibits at the site. Consequently, it was the Committee's consensus that a representative from one of the exhibitors in that forum be approached for a presentation on telemental health delivery models at an upcoming meeting.

Next Meeting

RMC will attempt to secure a guest speaker for the next meeting tentatively scheduled for Tuesday, July 7, 2015 at 1:00 p.m. Its format will be determined by the availability of the members for a face-to-face meeting or conference call.

Adjournment

There being no further business to be brought forward, the meeting was adjourned at approximately 2:12 p.m.

Respectfully Submitted,

Kathleen Vernacchio

RMC Health Care Committee Meeting
July 7, 2015
1:30 p.m. to 3:00 pm
Maryland Department of Agriculture
50 Harry S. Truman Parkway, Annapolis, Maryland 21401
Agenda

Invited participants: Tarik K. Shaheen, M.D., Child Psychiatrist and Founder, Iris Telehealth
Members of the Health Care Committee
Thomas McLoughlin, Chair
Charlotte Davis, Executive Director
Kathy Vernacchio, RMC Administrative and Communications Aide

I. Convene Meeting

II. Minutes of June 2, 2015

III. Tarik Shaheen, MD Presentation

IV. Open Discussion

V. RMC White Paper

VI. Other Business

VII. Adjournment

Next Meeting Scheduled for August 4, 2015, Location to be determined

Minutes

Regular Meeting of the Rural Maryland Council (RMC) Health Care Committee
Tuesday, July 7, 2015, 1:30 p.m. to 3:00 p.m.
Maryland Department of Agriculture
50 Harry S. Truman Parkway, Annapolis, Maryland 21401

Present:

Mr. Thomas McLoughlin, RMC Health Care Committee Chair
Ms. Michelle Clark, Executive Director, Maryland Rural Health Association
Ms. Charlotte Davis, Executive Director, Rural Maryland Council
Mr. Michael Franklin, FACHE, President and CEO, Atlantic General Hospital
Ms. Roxanne Hale, Director, Office of Primary Care Access, Health Systems and Infrastructure Administration, Maryland Department of Health and Mental Hygiene
Ms. Holly Ireland, Executive Director, Mid-Shore Mental Health Systems, Inc.
Mr. John Kornak, Director of Telehealth, University of Maryland Medical Center
Dr. Karan Kverno, Ph.D., PMHCNS-BC, PMHNP-BC, Assistant Professor, PMHNP Program, Johns Hopkins University School of Nursing
Ms. Sharon Praissman, MS, CRNP-A/PMH, Clinical Director, Psychiatric Outpatient Program for Adults, Johns Hopkins University School of Nursing
Dr. David Pruitt, Director, Child and Adolescent Psychiatry and Director of Telemental Health for the Department of Psychiatry, University of Maryland School of Medicine,
Dr. H. Neal Reynolds, M.D., Associate Professor, University of Maryland School of Medicine
Dr. P. David Sharp, Ph.D., Chair, Technology Solutions & Standards Advisory Group, Maryland Health Care Commission
Dr. Nancy M. Smith, DNP, CRNP, FNP-BC, Assistant Professor, Nursing Department, PRMC/Salisbury University
Ms. Teresa Zent, J.D., Attorney

RMC Staff:
Kathy Vernacchio

Call to Order

The Committee meeting was called to order at 1:41 p.m.

Welcome and Introductions

The Chair welcomed the participants and thanked the members for their attendance and continued interest in the committee's activities. He introduced Dr. Tarik Shaheen, Child Psychiatrist and Founder of Iris Telehealth and provided a brief introduction of his background. At the Chair's request, each member introduced him/herself to Dr. Shaheen and offered a brief summary of their involvement in the health field.

Tarik Shaheen M.D. Presentation

Dr. Shaheen focused his comments on the health care needs for telementalhealth , particularly in rural areas. He discussed the impact of technology, organizational strategy, operational planning and patient sensitivity in developing and sustaining a successful program. He also touched on potential barriers encountered such as but not limited to reimbursement, clinical and administrative acceptance, frequency of regulatory changes, and the perception that it is not a cost effective solution.
He concluded his remarks reflecting on the rapid growth in telemedicine, its increasing recognition as a critical clinical tool for improving access to health care and its importance to patients, especially in rural communities.

Open Discussion

During the discussion that followed, Dr. Shaheen responded to comments/questions related to advocacy roles, telehealth curriculum in medical schools, adequacy of reimbursement for mental health, telehealth's applicability to both urban and rural areas and many other clinical, operational and policy development issues.
The Chair concluded the meeting by thanking Dr. Shaheen for his presentation, the enlightening information he shared , and his candid observations based on his practice experience. The Chair also requested that the members reflect on today's presentation and relate it to Ms. Davis' White Paper which will be discussed at the next meeting in greater detail as the committee attempts to contemplate a meaningful role for the RMC in moving the conversation of telepsychiatry forward.

Minutes

The minutes of the June 2, 2015 meeting were previously distributed to all Committee members. The Chair asked if there were any questions on the content, comments, or corrections. There being no modifications noted, and upon motion properly made and seconded, the minutes were accepted as submitted.

Next Meeting

The next meeting is scheduled for Tuesday, August 4, 2015. Based on the responses received to the Chair's request a determination will be made as to the type of meeting (face to face vs. conference call).

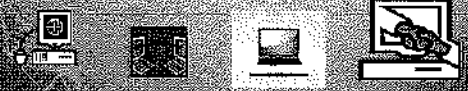
Adjournment

There being no further business to be brought forward, the meeting was adjourned at approximately 3:00 p.m.

Respectfully Submitted,
Kathleen Vernacchio

TELEPSYCHIATRY

NETWORK INITIATIVE



BACKGROUND

- 3 Year Grant- Health Resources and Services Administration and Maryland Department of Health and Mental Hygiene
- Launched December 2008- 7 MD Counties

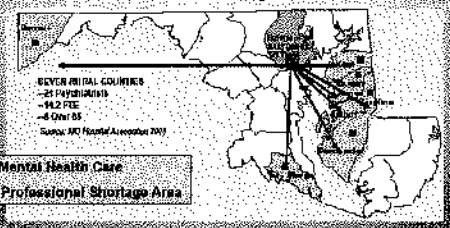
Partners

- ✓Mid Shore Mental Health Systems, Inc.
- ✓University of Maryland School of Medicine Department of Psychiatry
- ✓Garrett County Core Service Agency
- ✓St. Mary's County Department of Human Services

Seven Rural Counties

Caroline, Dorchester, Kent, Talbot
Queen Anne's, St Mary's and Garrett

Professional Shortages



Sites

- **Caroline:** Caroline County Mental Health Clinic *(General)*
- **Talbot and Queen Anne's**: Corsica River Mental Health Clinic *(General)*
- **Dorchester:** Wellness Center Mace's Lane Middle School *(Child and Adolescent)*
- **Garrett:** Garrett County Health Department *(Child and Adolescent)*
- **Kent:** A.F. Whitsitt Center *(Co-occurring)*
- **St. Mary's:** Pathways, Inc *(General)*

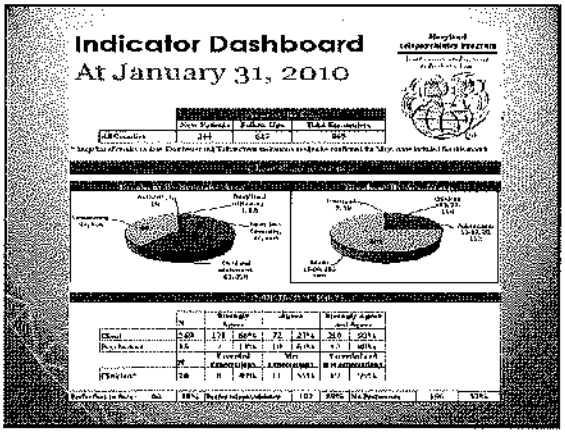
★ **Priority Populations**: **Child/Adolescent, Geriatric, Co-Occurring Substance Abuse, Deaf/Hard of Hearing**

Operational Framework/ Outcomes

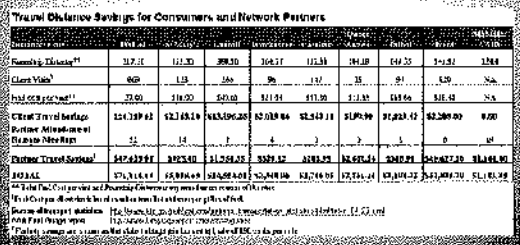
- **Services Launched December 2008**
- **Routine 2 hour weekly slots**
- **Client Services**
  - 244 Unduplicated Clients
  - 869 Total Sessions
  - Appointment rate 72%, Utilization 73%
- **Client Satisfaction**
  - 98% Client Satisfaction
  - *Client Preference:* 53% None, 29% prefer Telepsychiatry, 18% Face to Face

Indicator Dashboard

At January 31, 2010



Travel Cost Savings



Summary Findings

Consumers/ Community: Overall Increases Access and Choice

- **Reduces Appointment Wait Times**
- **Early intervention and treatment**
- **Access to Specialist Providers**
- **Continuity of care and Reduced ER visits**
- **Cost savings $71,814 ($24,159 Consumer)**
- **82% similar/ prefer to a face to face**
- **Leverage**

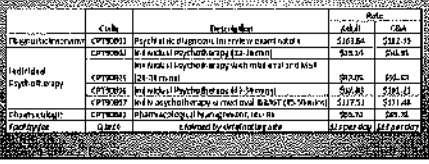
Providers: Increases clinical capacity

- **Connected to Academic Centers.**
- **Meetings, Training, Group Therapy.**

Sustainability Milestone

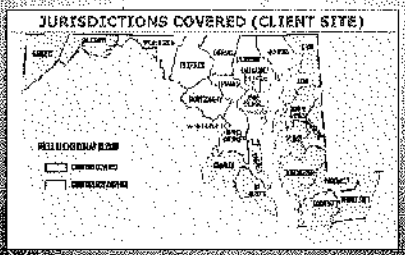
Passage of regulations COMAR 10.21.30

- **Telepsychiatry reimbursement through Medicaid**
- **Approved by State in August became effective September 2010**
- **Billing to become effective with CMS/ federal approval**



STIPULATIONS

- **Clinical and Provider Sites: OMHCs, Hospitals, FQHCs**
- **Technical Specifications: Bandwidth, Encryption, Size**



- **Patient site – anywhere in the State of Maryland**

OUTLOOK

- Sustainability (funding and business plans)
- Growth
- Leverage
- Clearinghouse
- Training-Building the Provider Network

RMC Health Care Committee
August 4, 2015
1:00 PM
Draft Agenda

1. Convene Meeting
2. Minutes of July 7, 2015
3. RMC White Paper
4. Open Discussion Dr. Shaheen's Presentation
5. Future Topics for Committee Review
6. Other Business
7. Next Meeting September 1, 2015
8. Adjournment

Minutes
Regular Meeting of the Rural Maryland Council (RMC) Health Care Committee
Tuesday, August 4, 2015, 1:30 p.m. to 3:00 p.m.
Conference Call

Present:
Mr. Thomas McLoughlin, RMC Health Care Committee Chair
Ms. Charlotte Davis, Executive Director, Rural Maryland Council
Ms. Roxanne Hale, Director, Office of Primary Care Access, Health Systems and Infrastructure Administration, Maryland Department of Health and Mental Hygiene
Ms. Holly Ireland, Executive Director, Mid-Shore Mental Health Systems, Inc.
Mr. John Kornak, Director of Telehealth, University of Maryland Medical Center
Dr. David Pruitt, Director, Child and Adolescent Psychiatry and Director of Telemental Health for the Department of Psychiatry, University of Maryland School of Medicine,
Dr. H. Neal Reynolds, M.D., Associate Professor, University of Maryland School of Medicine
Dr. P. David Sharp, Ph.D., Chair, Technology Solutions & Standards Advisory Group, Maryland Health Care Commission
Dr. Diana Abney, Health Officer, Charles County Department of Health
Dr. Kerry Palakanis, CRNP, CEO, Crisfield Clinic Family Practice
Mr. Josh Hastings, RMC Legislative Chair
Dr. Nancy M. Smith, DNP, CRNP, FNP-BC, Assistant Professor, Nursing Department, PRMC/Salisbury University

1.Convene Meeting

The meeting was convened at approximately 1:05 pm.

2. Minutes of July 7, 2015

The Chair apologized for the delay in forwarding the minutes of the July 7th meeting minutes to committee members. It was mentioned that the minutes will be sent shortly for review and action at the next regular meeting.

3. RMC White Paper

The RMC Executive Director presented the draft RMC white paper for discussion. Also the Chair of the RMC Legislative Committee summarized its activities during the past session and outlined its responsibilities, including the process observed in developing its list of legislative priorities and creating a bill tracking sheet. During the discussion that followed, there were questions related to the possibility of Rural Maryland Prosperity Investment Fund revenue for Fiscal Year 2017, the review process involved in the grants awarded by the Maryland Agricultural Education and Rural Development Assistance Fund and the experience of the RMC with its partners, the Maryland Rural Health Association and the Department of Health and Mental Hygiene in conducting the Round Table discussions on Telemedicine.

4. Open Discussion Dr. Shaheen's Presentation

Several observations were offered regarding the preceding discussion and a review of Dr. Tarik Shaheen's remarks at the July 7th meeting. Among them were the feasibility of hosting three pilot telemedicine sites to identify mechanisms to make telemedicine more functional, Medicaid payment issues, the challenges raised regarding certification and reciprocity and the matter of coverage for behavioral health by private insurers. It was suggested that speakers on the various topics mentioned be invited to future meetings of the committee.

5. Future Topics for Committee Review

It was reported that the Center for Remote Health has recently released its compilation of the telehealth laws for each of the 50 states. However, members have not yet been able to review the material. Among the topics suggested for committee review were the need for a reasonable reimbursement program, increased focus on school based delivery demonstrating its cost effectiveness, the feasibility of creating a nonprofit Telemedicine organization and the possibility of developing a coalition that is focused on expanding access to behavioral health via telemedicine with potential membership broadened to include non health related organizations such as local community foundations and businesses. Also mentioned was a strengthening of the working relationship with the Mid-Atlantic Telehealth Resource Center.

6. Other Business

Ms. Davis reported that a workshop on the future of Teletheraphy has been assembled by Delegate Kirill Reznik. Its first meeting occurred on July 27th for a brief overview of the need and activities to date. Its next meeting is scheduled for August 31st.

After further discussion, Committee members were asked to reflect on the subject matter of today's meeting and to submit their comments and specific recommendations to the Chair for more detailed consideration at future meetings.

7. Next Meeting

In view of the proximity of the next meeting date to the Labor Day Weekend, there was discussion as to whether the next meeting on Tuesday September 1st should be canceled. After discussion, it was concluded that a decision will be made and communicated to the members no later than a week before the scheduled meeting.

8. Adjournment

There being no further business to be brought to the committee, the meeting was adjourned at approximately 2:55 pm.

One of the Rural Maryland Council's major goals is to enhance rural policy development and coordination by regularly bringing stakeholders together to identify challenges common to rural areas and, by consensus, to develop, implement and monitor public and fiscal policy, programmatic or regulatory solutions. With a small staff, the RMC uses working committees to develop policy expertise across rural concerns and to engage already committed and knowledgeable rural advocates. Working Committees identify a specific challenge facing rural areas across the state or region, research the problem to get an overall understanding of it, and then, by consensus, develop proposed solutions. Solutions usually include developing or modifying state legislation, regulations, budget appropriations or programs. Committees bring recommendations to the full RMC Executive Board for approval and implementation. Working Committees also continue to monitor the results and evaluate the effectiveness of the solution, and to suggest changes over time, when necessary. Ultimately, the committees empower the RMC to speak on behalf of rural Marylanders with one voice on important issues.

The Health Care Working Committee has been active in the past, focusing on health work force shortage issues. A separate Telehealth Working Committee was created in 2009 as a result of a Rural Health Roundtable discussion which investigated the need for a statewide telehealth consortium. The committee developed a survey of telehealth providers and receivers in Maryland implemented by the Upper Shore Regional Council and funded by a Maryland Agricultural Education and Rural Development Assistance Fund (MAERDAF) grant award.

In developing future policy and program recommendations, it is helpful to consider the strengths of the Rural Maryland Council.

The ability to bring forward state resources including:

- MAERDAF grants to rural-serving nonprofit organizations which include those that provide health care programs
- Rural Maryland Prosperity Investment Fund (RMPIF) grants
    - Grants for infrastructure, entrepreneurship, regional councils and health care programs and projects
- Agency connections
    - Departments of Agriculture, Business and Economic Development, Health and Mental Hygiene, and Natural Resources participate in RMC functions
- Maryland Agriculture and Resource-Based Industry Development Corporation (MARBIDCO)
- Regional council support
    - Regional councils serve a three-county area and focus on regional economic development and planning. Health care entities are often the largest employer in many rural communities.

The ability to advocate at the different levels of government:

- We partner with other agencies and organizations including: Department of Health and Mental Hygiene, Maryland Association of Counties, Maryland Municipal League, Maryland Chamber of Commerce, Maryland Rural Health Association and others
- Legislative experience and a record of achievement:
    - Successfully advocated for reauthorizing legislation RMPIF in 2014 to extend sunset date and include health care under the Fund's area of focus
    - Offer oral and written testimony before legislative bodies as well joint testimony with the Maryland Rural Health Association

The ability to organize events and meetings to educate and promote issues:

- Organized telemedicine roundtables
- Organized town hall meetings to discuss rural youth engagement
- Organized community development organizations into regional coalitions to assess needs and capacity issues

The ability to reach out directly into communities:

- Participate in direct outreach into communities through participating in local community events
- Coordinate with federal, state, local elected officials and appointed officials as well as private for-profit and non-profit organizations

Rural Maryland Council
50 Harry Truman Parkway
Annapolis, Maryland 21401
Charlotte Davis, Executive Director
charlotte.davis@maryland.gov

RMC Health Care Committee Meeting
October 6, 2015
1:00 p.m. to 3:00 pm
Anne Arundel County Health Department
Lower Level, Conference Room A
3 Harry S. Truman Parkway, Annapolis, Maryland 21401
Agenda

Invited participants: Members of the Health Care Committee
Thomas McLoughlin, Chair
Kathy Vernacchio, RMC Administrative and Communications Aide

1. Convene Meeting

2. Action on Minutes
   a) July 7, 2015
   b) August 4, 2015

3. Telehealth Program Updates

4. Michael Lore, Chief of Staff
   Senator Lee's Office

5. Draft Adolescent Depression

6. Open Discussion Evaluation

7. Other Business

8. Next Meeting

9. Adjournment

Next Meeting Scheduled for November 3, 2015, Location to be determined

Minutes
Regular Meeting of the Rural Maryland Council (RMC) Health Care Committee
Tuesday, October 6, 2015, 1:00 p.m. to 3:00 p.m.
Anne Arundel County Health Department
3 Harry S. Truman Parkway, Annapolis, Maryland

Present:
Mr. Thomas McLoughlin, RMC Health Care Committee Chair
Dr. Diana Abney, Health Officer, Charles County Department of Health
Ms. Michelle Green Clark, Executive Director, Maryland Rural Health Association
Dr. Karan Kverno, Ph.D., PMHCNS-BC, PMHNP-BC, Assistant Professor, PMHNP Program, Johns Hopkins University School of Nursing
Ms. Roxanne Hale, Director, Office of Primary Care Access, Health Systems and Infrastructure Administration, Maryland Department of Health and Mental Hygiene
Ms. Temi Oshiyoye, Director, State Office of Rural Health, Maryland Department of Health and Mental Hygiene
Dr. David Pruitt, Director, Child and Adolescent Psychiatry and Director of Telemental Health for the Department of Psychiatry, University of Maryland School of Medicine,
Dr. H. Neal Reynolds, M.D., Associate Professor, University of Maryland School of Medicine
Dr. P. David Sharp, Ph.D., Chair, Technology Solutions & Standards Advisory Group, Maryland Health Care Commission

Guest Speaker:
Mr. Michael W. Lore, Esq., Chief of Staff, Senator Susan C. Lee, The Senate of Maryland

RMC Staff: Kathy Vernacchio

1. Convene Meeting

The meeting was convened at approximately 1:20 p.m.

2. Action on Minutes

The minutes of both the July 7, 2015 and August 4, 2015 meetings were previously distributed to all Committee members. The Chair asked if there were any questions on the content, comments, or corrections. There being none and upon motion properly made and seconded, it was voted to accept the minutes as submitted.

3. Mr. Michael Lore Presentation

The Chair asked Dr. Reynolds to introduce the guest speaker, Michael Lore, Chief of Staff for Senator Susan C. Lee. In his introduction, Dr. Reynolds provided a historical background regarding telehealth advocacy and legislation in Maryland over the past five or six years. He also mentioned the efforts surrounding the passage of the 2014 Medicaid Telehealth Reimbursement Bill sponsored by Delegate Susan Lee and Senator Catherine Pugh.

Mr. Lore indicated that he hoped to benefit from the experiences of the Committee members present and that the office of Senator Lee intends to increase its working relationship with the Maryland Department of Health and Mental Hygiene (DHMH) and the Rural Maryland Council. He mentioned that 14 other states have legislation supporting telehealth and telemental health and commented on topics such as access, regulation and the role of the legislature regarding those regulations.

In discussing the 2014 Bill to encompass all reimbursements, it was pointed out that an amendment was introduced with the intent to limit reimbursements due to State budgetary considerations. While the current language indicates that the DHMH may authorize coverage, the next legislative session might include strengthening that statement. Mr. Lore said Senator Pugh, Senator Lee and Delegate Resnick are interested in working on this subject prior to and during the 2016 Legislative Session.

4. Open Discussion Evaluation

Several observations were made regarding the presentation. Deep cuts in State budgets were a major source of concern and changing the language of the Bill might not be addressing the core issue which is the fiscal challenge. One of the possibilities advanced was working with DHMH in identifying funding through existing programs. There was extended discussion regarding the global budgeting and healthy population programs and their potential impact on generating income and creating incentives for hospitals to develop and support telehealth models in the community environment. In focusing on cost savings as a major strategy in revising legislation, organizations such as the American Telemedicine Association may provide data on cost savings and/or best practices realized through the adoption of telemedicine by neighboring states.

Other considerations discussed were:

Legislative changes in reimbursement that would incentivize the adoption of telehealth delivery models such as “gain sharing” among primary care practices that exist in the hospital’s service area by partnering with practitioners already delivering care in the community.

Legislative changes in regulation that would provide motivation for adoption of telemedicine. Declining numbers of physicians in some medical professions should initiate a closer focus on revising regulations to better accommodate the training and clinical qualifications of other advanced degree health care practitioners such as the nurse practitioner.

School based and Community Center programs in primary care are closely related especially in the areas of mental health and substance abuse. Presenting options for the integration of both in the same environment using telehealth would provide motivation to adopt this health care delivery model.

In concluding the discussion, several members of the committee agreed to follow up with the suggestions offered and will report back at the next meeting.

5. Draft Adolescent Depression

In view of the previous discussion, this agenda item was tabled for a future meeting

7. Other Business

There was a brief discussion on a more flexible interpretation on the option of conference calls when guest speakers are involved and traveling to Annapolis for a presentation. While the consensus preferred physical presence, it was recognized that every member from time to time encounters conflicts in schedules. Therefore, the committee suggested that exceptions be made when a member has been unsuccessful in resolving it. However it was also agreed that a guest speaker will not be invited unless there is at least 60% Committee attendance at the meeting site.

8. Next Meeting

The next meeting is scheduled for November 3, 2015.

The December meeting is scheduled for Tuesday, December 1, 2015. The Guest Speaker is Ms. Shannon McMahon, Deputy Secretary, Health Care Financing for the Maryland Department of Health and Mental Hygiene.

9. Adjournment

There being no further business to be brought to the committee, the meeting was adjourned at approximately 3:15 pm.

DRAFT FOR DISCUSSION ONLY

ADOLESCENT DEPRESSION

N.B. The following information is not intended to be a thoroughly researched study on the impact of depression among adolescents. Rather its purpose is to stimulate productive discussion by focusing on the major profiles associated with the disease. Through that approach, it is hoped that a realistic course of preventive action can be identified and developed to lessen its influence over the lives of the youth in this country.

October 2015

According to a report published by Healthy People 2020, Depression is the most common disorder identified in mental illness. It is the leading cause of disability in the work force, is responsible for more than 60% of all suicides each year and contributes to a shortened life span. Currently, suicide is the 3rd leading cause of death for adolescents in both the 10-14 and 15-19 age groups in this country. In fact, some projections suggest it could become a leading cause of death by 2020, second only to Heart Disease.

Major depression is defined as experiencing a depressed mood or loss of interest or pleasure in daily activities including such issues as sleep, eating, energy, concentration and self-worth for at least a two week interval. Among its causes are anxiety, phobias, stress, and chronic diseases. Despite its devastating impact, the literature indicates it is very treatable. In a statement issued by the Depression and Bipolar Support Alliance, it is estimated that up to 80% who are treated for depression show improvement in their symptoms within four to six weeks.

Offsetting that success rate is the fact that more than half of the adult population (18 & older) do not actively seek or receive the proper treatment. In the recently released 2014 survey conducted by Substance Abuse and Mental Health Services Administration (SAMHSA), the major reason for not receiving any mental care cited by approximately half of all adults was the cost associated with it. Another significant segment (25%) believed the problem could be managed without treatment.

In attempting to analyze the impact of depression on adolescents (Ages 12-17), it was measured by their ability to do chores at home, do well at school or work, get along with family and have a social life. In 2013, the number of adolescents with a major depression episode (MDE) within the past 12 months was 2.6 million (10.7%) which included almost 360,000 who had a co-occurring substance abuse disorder. That number increased to 2.8 million due primarily to the increase in

MDE incidents. The most common response from nearly 50% of those receiving care, whether it was in specialty mental health services (inpatient or outpatient care within the year) or in an educational setting was “feeling depressed” with 29% acknowledging thoughts and/or attempts at suicide. However, there were significantly broader differences from the educational setting when responding to prioritizing perceived problems at school (22.4% vs. 13.0%) and with friends (17.7% vs. 4.5%).

Regarding the co-occurring conditions (MDE & SU) among youths in this age category there was an increase in using illicit drugs within the past year as opposed to those who did not experience MDE during that interval. Nearly33% of the MDE youths acknowledged illicit drug use versus 15% in the non MDE group. In both categories, the dominant drug of choice was marijuana.

Among the 12-17 age group, females seem to be receiving more care in outpatient and educational settings than their male counterparts. However, those resources are the most frequently utilized by both genders.

At the national level, the principal resource in more than 90% of the youths seeking assistance was the Family Physician with counselors being contacted in at least 50% of the episodes. According to the 2012-2013 data less than 10% of the contacts involved a mental health nurse or other non-physician health care provider.

Studies further cite the lack of evaluation for depression in office visits with the primary care physician. One such study stated that only 25% of the physicians included the evaluation despite the recognition by 75% of the respondents that it is a treatable condition. Another complication highlighted by Communities Healing Adolescent Depression and Suicide (CHADS), a Missouri based organization, suggests that approximately 80% of all youths with mental illness have not been identified and, therefore, are not receiving any mental health service.

At the State level, the National Alliance for Mental Illness (NAMI) in a State Advisory Report published in 2010 indicated that Maryland’s public mental health

system provided services to only 19% of its adult residents who live with serious mental illnesses. Moreover, a 2015 report by Mental Health in America (formerly the National Mental Health Association) pointed out that Maryland ranked 33rd among the states where children needed but did not receive mental health services. In another SAMSHA publication entitled Behavioral Health Barometer for Maryland 2014, it was stated that the percentage of adolescents with MDE was similar to the national average for2012-2013. During that same interval, however, it suggested that 62% within that age group did not receive treatment for depression.

From a review of the Mental Health Workforce Availability Chart included in the 2015 MHA report, Maryland's ratio of population per mental health worker was ranked 21st (666:1) and was better than the national average (790:1)as well as its neighboring states excepting Delaware. On the other hand, there is increasing concern regarding the shortages of psychiatrists as services for mental health increase. A recent study initiated by the Mental Health Association of Maryland highlighted that finding. Among Its results indicated that only 14% of the 1,154 psychiatrists identified under health reform were accepting new patients and available for appointments within 45 days.

In 2008, a Maryland Physician Workforce Study was jointly sponsored by the Maryland State Medical Society and the Maryland Hospital Association. Among its observations was a 41% projected increase in total allied health professionals (AHP) between 2007 and 2015 with only a 14% increase in primary care physicians. It also compared Maryland's utilization of the AHP as a percentage of primary care providers (37%) which was somewhat higher than the national average (24%). At this point, however, the data are not yet available to determine the accuracy of that forecast.

Nationally, the President Elect of the American Psychiatric Association estimated that the country will need another 30,000 child psychiatrists to augment the current 8,000 in practice to meet the mental health provisions included in the Affordable Care Act. However, the Kaiser Health News reported that lower pay, reimbursement difficulties and paperwork requirements are discouraging more

medical students from considering this aspect of practice, which is one of the lower paying specialties in the medical profession.

At the National level, there are more than 200,000 Nurse Practitioners, over 50% of whom identify their specialty as family care with approximately 4% focused on psychiatric/mental care. According to the Maryland Association of Nurse Practitioners, there are 3,500 NP's involved in the State's health care activities with 1,000 focused on family care and less than 100 indicating psychiatric/mental health as their field of specialization, a percentage similar to the nation's average. The nursing profession whether in the clinical or educational setting can and should be encouraged to assume a broader role in this process consistent with their training and qualifications.

There are many more dimensions to this very complex and increasingly dominant component of mental health that have not been mentioned. Finance, transportation, insurance, patient and public perception, as well as facilities and equipment are only some of the essential factors that must be a part of a meaningful discussion on the topic. In many instances, however, that approach has a tendency to delay and, might even dissuade, short term objectives from being implemented.

Therefore, as examples, three short term objectives for further discussion might be:

- Encourage all Primary physicians to include an evaluation for depression in their Private office visits
- Review and revise roles of School Nurse and Counselor to assist in detecting signs of depression for possible medical attention
- Develop support for certification programs in mental health to further enhance ADP's qualifications and offset the recognized physician shortage in addressing and treating or referring adolescents suffering from depression

None of the above represents novel concepts. However there does not appear to be any evidence to date that suggests these items are receiving the attention they deserve. Perhaps that moment has arrived.

RMC Health Care Committee Meeting
November 3, 2015
1:00 p.m. to 3:00 pm
Via Conference Call

Agenda

Call-in Information:
Toll-free dial-in number: 1-877-658-7465
Conference Code: 5962756099

Invited participants: Members of the Health Care Committee
Thomas McLoughlin, Chair
Charlotte Davis, RMC Executive Director
Kathy Vernacchio, RMC Administrative and Communications Aide

1. Convene Meeting

2. Action on Minutes

3. Telehealth Program Updates
   Maryland Hospital Association
   Med Chi Society
   Department Health and Mental Hygiene
   Mid Atlantic Telemedicine Resource Center
   Care First Blue Cross Blue Shield

4. Draft Adolescent Depression (Previously Distributed)

5. Open Discussion

6. Other Business
   Video conferencing for future meetings

7. Next Meeting December 1, 2015

8. Adjournment

RMC Health Care Committee Meeting
Tuesday, November 3, 2015
Via Conference Call
Minutes

Participants:

Mr. Thomas McLoughlin, RMC Health Care Committee Chair
Dr. Diana Abney, Health Officer, Charles County Department of Health
Dr. Karan Kverno, Ph.D., PMHCNS-BC, PMHNP-BC, Assistant Professor, PMHNP Program, Johns Hopkins University School of Nursing
Ms. Roxanne Hale, Director, Office of Primary Care Access, Health Systems and Infrastructure Administration, Maryland Department of Health and Mental Hygiene
Mr. John Kornak, Director, Telehealth, University of Maryland Medical Center
Dr. Kerry Palakanis, Owner and CEO, Crisfield Clinic Family Practice
Ms. Sharon Praissman, MS, CRNP-A/PMH, Clinical Director, Psychiatric Outpatient Program for Adults, Johns Hopkins University School of Nursing
Dr. David Pruitt, Director, Child and Adolescent Psychiatry and Director of Telemental Health for the Department of Psychiatry, University of Maryland School of Medicine,
Dr. H. Neal Reynolds, M.D., Associate Professor, University of Maryland School of Medicine
Dr. P. David Sharp, Ph.D., Chair, Technology Solutions & Standards Advisory Group, Maryland Health Care Commission
Ms. Lara Wilson, Executive Director, Maryland Rural Health Association
Attorney Teresa Zent, J.D.

RMC Staff:
Charlotte Davis, Executive Director
Kathy Vernacchio, Administrative Assistant

1. Convene Meeting

The meeting was convened at approximately 1:05 p.m.

2. Action on Minutes

The minutes of the October 6, 2015 meeting were previously distributed to all Committee members. The Chair asked if there were any questions on the content, comments, or corrections. There being none and upon motion properly made and seconded, it was voted to accept the minutes as submitted.

3. Telehealth Program Updates

Based on last month's discussion, additional perspectives were sought on the question of funding for telemedicine projects for primary/mental health. Among the examples identified were ECHO and ACT, programs jointly funded by government and nonprofit foundations as well as state programs designed to encourage preceptor involvement in medical education such as Georgia and one currently being discussed in Maryland. Also mentioned was Care First's offer to provide $3,000,000 in grants over one to three years for telemedicine projects that involve interactive video conferencing or remote patient

monitoring. However, that window of opportunity closes on November 23, 2015. On the other hand, while there is a recognition of need, it may be premature to anticipate participation in such funding from the new approach to hospital reimbursement in this State at this time. There followed extended discussion on the significant challenges represented by inadequate reimbursement for services. Consequently, it was suggested that the subject could be raised for further discussion with Deputy Secretary McMahon in the December meeting.

4. Adolescent Depression Draft Paper

The Chair summarized the draft material on Adolescent Depression previously distributed to the Committee. Highlighted were the following proposed, short-term objectives:

- Encourage all primary physicians to include an evaluation for depression in their private office visits.
- Review and revise roles of School Nurse and Counselor to assist in detecting signs of depression for possible medical attention.
- Develop certification programs in mental health to further enhance ADP's qualifications and offset the recognized physician shortage in addressing and treating or referring adolescents suffering from depression.

In the discussion that followed, it was also mentioned that the draft was shared with the MATRC and its concept outlined in an informal discussion with a State official. Some programs and pilot studies that are currently exploring telemental health as well as school-based delivery were identified. Also mentioned were the loan repayment programs and their potential impact on practitioner recruitment in rural areas, especially nurse practitioners.

The members present accepted the short term objectives of the draft as the principal focus of its deliberations over the next twelve months and offered input on the areas to be included in the draft. Among them were the investigation of the role of telemedicine in this process and available technologies for education and remote patient monitoring, the recognition of anxiety in view of its similarity with depression, and the linkage of primary care with the schools.

In concluding the discussion, it was suggested that the committee consider as its goal the establishment of a model for the first telemental health program for school-based populations in the area. To advance this discussion to the next step in accomplishing this goal, the members were asked to submit their thoughts and suggestions so that they can be assembled and brought to the next regular meeting for further discussion and development.

6. Other Business

The Committee discussed the feasibility of video conferencing for future meetings as proposed and offered by John Kornak to provide remote access to these discussions .His offer was graciously accepted with appreciation and he will be working with RMC Staff to establish the necessary arrangements for future meetings. It was mentioned that the mechanism is designed to recognize the travel distances involved for all members but with the hope that it will be used appropriately when a request is made for the physical presence of committee members.

6. Next Meeting

The next meeting was originally scheduled for Tuesday, December 1, 2015. However, guest speaker, Shannon McMahon, Deputy Secretary for Health Care Financing, Maryland Department of Health and Mental Hygiene, had a change in her schedule. The RMC Staff will generate a Doodle Poll to determine member availability for another date.

7. Adjournment

There being no further business to be brought to the committee, the meeting was adjourned at approximately 2:41 pm.

RMC Health Care Committee Meeting
November 30, 2015
Maryland Department of Agriculture, 50 Harry S Truman Parkway, Annapolis
Minutes

Participants:

Mr. Thomas McLoughlin, RMC Health Care Committee Chair
Ms. Roxanne Hale, Director, Office of Primary Care Access, Health Systems and Infrastructure Administration, Maryland Department of Health and Mental Hygiene
Mr. John Kornak, Director, Telehealth, University of Maryland Medical Center
Dr. Kerry Palakanis, Owner and CEO, Crisfield Clinic Family Practice
Ms. Sharon Praissman, MS, CRNP-A/PMH, Clinical Director, Psychiatric Outpatient Program for Adults, Johns Hopkins University School of Nursing
Dr. David Pruitt, Director, Child and Adolescent Psychiatry and Director of Telemental Health for the Department of Psychiatry, University of Maryland School of Medicine,
Dr. H. Neal Reynolds, M.D., Associate Professor, University of Maryland School of Medicine
Nancy Smith
Anita Browning, MidAtlantic Telehealth Resource Center
Bob White, University of Maryland
Donna Gugel, DHMH
Shannon McMahon, DHMH
Temi Oshiyoye, DHMH
Teresa Zent, J.D.
The Honorable Addie Eckardt
Michael Lore, Senator Susan Lee's office

RMC Staff:
Charlotte Davis, Executive Director
Kathy Vernacchio, Administrative Assistant

1. Convene Meeting

The meeting was convened at approximately 3:20 p.m.

2. Continuing Discussion on Committee activities

In view of the anticipated discussion with Deputy Secretary Shannon McMahon, there was no formal agenda for today's meeting. Consequently, the Committee members reviewed the three main focus topics as accepted at the last meeting:

- Encourage all primary physicians to include an evaluation for depression in their private office visits.
- Review and revise roles of School Nurse and Counselor to assist in detecting signs of depression for possible medical attention.
- Develop certification programs in mental health to further enhance ADP's qualifications and offset the recognized physician shortage in addressing and treating or referring adolescents suffering from depression.

Among the Committee members suggestions were including mood disorders and substance abuse in addition to depression; examining the role of primary care physicians in aligning with the Behavioral Health Integration into Pediatric Primary Care Program (BHIPP) in view of the provider shortage; and increasing coordination with school based primary care activities. Also mentioned was the diabetes management legislation that was introduced during the 2015 Session and which is expected to be reintroduced in 2016. There was extended discussion on the school delivery systems as well as an assessment of potential delivery options including a focus on the need to strengthen communications between the patient-centered home delivery model and the schools. The Committee recommended that more information be sought related to the interaction between the Maryland School-Based Nurses Association and the local management boards within the counties.

3. Dr. Shannon McMahon, Deputy Secretary, Health Care Financing, Maryland Department of Health and Mental Hygiene

Dr. McMahon was introduced and welcomed upon her arrival. Her presentation provided an overview of the Medicaid program which encompasses over 23% of all Maryland residents with approximately 55,000 providers currently enrolled and projected statewide Medicaid expenditures exceeding $10 billion in FY 2015.

Dr. McMahon discussed the State's activities In 2014, commenting on Medicaid's expansion to include statewide access to telemedicine using a hub and spoke model as well as nurse practitioners and midwives as eligible providers. She also mentioned that three existing programs – the Telemental Health Program, the Rural Access Telemedicine Program, and the Cardiovascular Disease and Stroke Program – have been combined and expanded.

Among the requirements for participation in the telemedicine program, providers must be enrolled as a Medicaid provider and complete the telemedicine provider addendum. The addendum requires applicants to demonstrate three primary things: 1) ability to bill Medicaid for services, 2) service delivery model is an appropriate and safe use of telemedicine, and 3) beneficial for the patient. She added that the Department during the current year has received 36 addenda and approved 32, the majority of which represent mental health projects.

Since the Department's principal focus is incremental, its major effort is directed at identifying gaps in existing coverage before addressing additional service delivery modalities. Therefore, the program does not currently cover store-and-forward or remote patient monitoring.

The Department is presently updating regulations to include methadone clinics and community-based substance abuse (SUD) programs as originating sites as early as Spring 2016. Also being updated is the

Telemedicine Manual to clarify that the scope of services for distant site providers may expand beyond consultation codes. Additionally, the Department will be streamlining its application process.

After the formal presentation, Committee members raised questions related to reimbursement, the absence of school-based health sites as possible originators of telemedicine, potential conflicts of interpretation between "originating" and "distant" sites, and store-and-forward issues when providers are not eligible for reimbursement.

4. Adjournment

Following the extensive discussion and recognizing the many demands on her schedule, Dr. McMahon was thanked for accepting the Committee's invitation, providing the Committee with a better insight regarding the Department's activities and her sensitivity to the needs of the rural communities. With no other business to be brought to the Committee's attention, the meeting was adjourned at approximately 5:00 pm.

Next Meeting: January 5, 2016

Telehealth Overview
Rural Maryland Council

November 30, 2015

Shannon M. McMahon, MPA
Deputy Secretary, Health Care Financing
Maryland Department of Health and Mental Hygiene
Shannon.McMahon@Maryland.gov

Telehealth in the News

NPR: Morning Edition Telemedicine Feature

Maryland Medicaid: Facts at a Glance

- As of January 2015, Medicaid covers 23% of all Maryland residents
- As of January 2015, Medicaid or MCHP covers 39% of all Maryland children
- In 2014, Medicaid paid for 73% of all nursing facility days in the state
- There are currently 55,000 providers enrolled in Maryland Medicaid
- In federal fiscal year 2014, Medicaid reimbursed services in the amount of $8.9 billion Statewide, including funding of DDA, MHA, and MSDE Medicaid services
- The projected Statewide Medicaid spending in FY 2015 exceeds $10 billion

Telehealth Background

- Following the passage of SB 198/HB 802 of 2014, the Department significantly expanded coverage of telehealth services.
- Three existing programs— the Telemental Health Program, the Rural Access Telemedicine Program, and the Cardiovascular Disease and Stroke Program – have been combined and expanded.
- Telehealth services are now offered on a statewide basis and coverage is not restricted by health condition or geographic region.

Telehealth – Service Model

- Telehealth in Maryland employs a "hub-and-spoke" model.
- The "hub", or "distant site", is the location of the medical specialist, who provides consultation services to the "spoke", or "originating site", where both provider and participant are located.
- Communication between the originating and distant sites involves real-time interaction via a secure, two-way audio and video telecommunication system.
- This service model was determined to be the most practical to improve access to consulting providers.

Telehealth – Service Model

- Program-approved originating site providers must have agreements with Program-approved consulting providers to deliver telemedicine services.
- Providers are paid fee-for-service; rate is the same as in-person specialty consultations.
- Medicaid reimburses approved providers for medically necessary services that can reasonably be delivered using technology-assisted communication.

Eligible Providers

- Provider eligibility is not limited to consultants and specialists.
- Physicians, Nurse Practitioners, and Nurse Midwives—all of whom may be considered primary care providers (see: COMAR 10.09.49.07 and COMAR 10.09.66.05)—are eligible to participate in the Program.
- Regulations aim to *enhance* access to specialty and/or subspecialty consultation services
- Nothing precludes participation for primary care providers

Provider Addendum

- In order to participate in the telemedicine program, providers must:
  - Be enrolled as a Medicaid provider.
  - Complete the Telemedicine Provider Addendum.
- The Addendum is the Department's tool to ensure that all proposed telemedicine arrangements meet the Program's logistic, clinical, and regulatory criteria.
- The Addendum requires applicants to demonstrate three primary things:
  (1) that they are able to bill Medicaid for services;
  (2) that their service delivery model is an appropriate and safe use of telemedicine; and
  (3) that their service delivery model is beneficial for the patient.

Originating Sites

- Free-standing renal dialysis centers
- Federally Qualified Health Centers
- Hospitals, including emergency departments*
- Local health departments
- Nursing facilities
- Physicians
- Nurse practitioners
- Nurse midwives

*The Program will approve Maryland hospitals as originating sites only if a specialist is not available to provide timely consultation and diagnostic evaluation.

Distant Site Providers

- Physicians
- Nurse practitioners
- Nurse midwives
- Psychiatric nurse practitioners

Participant Eligibility

1. Participants must be enrolled in the Medicaid;
2. Participants must be present at the originating site at the time the telemedicine service is rendered; and
3. Participants must consent to telemedicine services unless there is an emergency that prevents obtaining consent.

Covered Services

- Originating site
  - Medically necessary office or other outpatient services rendered by an approved originating site provider that are distinct from the telemedicine services provided by a consulting provider; and
  - An approved telemedicine transaction fee; or
  - If the originating site is a hospital, the appropriate revenue code; and
  - If the originating site is an out-of-state hospital, a telemedicine transaction fee.
- Distant site
  - Medically necessary consultation services rendered by an approved consulting provider that can reasonably be delivered using technology-assisted communication.

Telehealth Provider Participation

- The Department has received 36 addenda – 30 telemental health and 6 somatic telemedicine addenda to date
- Out of the 36 addenda submitted, 32 have been approved:
  - All 30 telemental health addenda; and
  - 2 out of 6 somatic telemedicine addenda

Telehealth Approved Technology

- SB 198/HB 802 of 2014, delegates discretionary power to the Department to make decisions related to coverage and reimbursement for services that are delivered through "store-and-forward technology" and "remote patient monitoring" service delivery models, based on budget availability.
  - Presently, the Department does not cover store-and-forward or remote patient monitoring delivery models.
  - In addition to fiscal feasibility, the Department must consider concerns related to patient confidentiality, quality assurance, and administrative oversight—particularly as related to remote (or, "home") patient monitoring.
- The Department favors taking an incremental approach before implementing additional service delivery modalities.
- The Program's telemedicine technology requirements were developed in collaboration with the Maryland Health Care Commission's Telemedicine Task Force.

Next Steps

- In late October, DHMH submitted an amendment to the telehealth regulations that will allow substance use disorder treatment providers to participate as originating sites.
  - If approved the Telehealth Program will include methadone clinics and community-based SUD programs as originating sites as early as Spring 2016.
- We are actively working to improve the Medicaid Telehealth Program for participating providers including:
  1. Telemedicine Manual: The Department will update the Telemedicine Manual to clarify that the scope of services for distant site providers may expand beyond consultation codes.
  2. Provider enrollment: It has also come to our attention that some providers view that the telehealth addendum process as burdensome. Due to these concerns, we are working to streamline the application process within the next month.

RMC Health Care Committee Meeting
January 5, 2016
1:00 p.m. to 3:00 pm
Via Conference Call

Agenda

Call-in Information:
Toll-free dial-in number: 1-877-658-7465
Conference Code: 5962756099

Invited participants: Members of the Health Care Committee
Thomas McLoughlin, Chair
Charlotte Davis, RMC Executive Director
Kathy Vernacchio, RMC Administrative and Communications Aide

1. Convene Meeting
2. Action on Minutes
3. Short-Term goals as identified earlier
    - Encourage all primary physicians to include an evaluation for depression in their private office visits
    - Review and revise roles of school nurse and counselor to assist in detecting signs of depression for possible medical attention
    - Develop certification programs in mental health to further enhance ADPS's qualifications and offset the recognized physician shortage in addressing and treating or referring adolescents suffering from depression
4. Barriers to each goal
5. Solutions for each goal
6. Open Discussion
7. Other Business
8. Next Meeting February 2, 2015
9. Adjournment

RMC Health Care Committee
January 5, 2016
Via conference call
Meeting Minutes

Participants:
Tom McLoughlin, Justine Springer (on behalf of David Sharpe), Lara Wilson, Roxanne Hale, Karen Kverno, Holly Ireland, Michael Franklin, Dr. Diana Abney, Charlotte Davis

1. Convene Meeting
The meeting convened at approximately 1:10 pm.

2.Action on Minutes
The minutes from the November 3 and 30, 2016 meetings were previously distributed to all Committee members. The Chair asked if there were any questions on the content, comments, or corrections. There being none and upon motion properly made and seconded, it was voted to accept the minutes as submitted.

3.Short Term Goals
Committee members continued the discussion from the previous meeting to identify a major barrier to each of the three short-term goals as well as potential strategies to overcome each one.

I Encouraging primary care physicians to include screening for depression or mood disorder
There was discussion regarding the role of the primary care in assuming responsibility for mental health care, a medical discipline for which they are not adequately trained and without sufficient specialists to whom referrals can be made. Some possibilities mentioned were referral to programs such as Behavioral Health Integrated in Pediatric Primary Care (BHIPP) that enables telehealth consultation for pediatricians to support interventions in the primary care setting. Also mentioned was the expansion of the Mental Health Urgent Care Center concept that could involve social workers from the Maryland School of Social Work with primary care providers as part of the crisis response team.

There was extended discussion on the absence of standardized screening practices, despite current Medicaid guidelines requiring the inclusion of depression screening and substance abuse disorder at age 11. In view of the recent implementation of these requirements, it was suggested that the Committee consider a communication to all physicians specifying the regulation and identifying some referral programs. Since access to specialty care is an issue, especially in rural communities, the Committee agreed to review that proposed communication after further information was made available regarding the guidelines and recommendations as well as a list of possible resources. A report will be developed for review at the next meeting.

II. Review and revision of the role of the School Nurse and Counsellor .
During the discussion it was reported that there are approximately 70-72 school based health centers for 1500 schools throughout the Maryland school system. Since each county, as an autonomous entity, can make its own determination, there are a variety of administrative approaches to mental health issues. Responsibility may be assumed by the local board of education, the local county health center, or an independent contractor providing the service.These different approaches would suggest a lack of

effective communication and/or coordination thereby impeding a unified approach to addressing the issue.

After further comments on the topic, it was suggested that an invitation be extended to a representative from the Maryland State Department of Education (MSDE) to discuss school based health centers in general and mental health issues in particular.

III.Develop certification programs in mental health.
There were three barriers identified and discussed. viz., geographic, faculty shortage and workforce shortages.The growth of on-line courses allowing students to remain within their communities without leaving their families and practices has effectively minimized the concern related to access to university based programs. There were also concerns expressed regarding the Faculty shortage and its impact on limiting student enrollment as well as the economic disparities between mental health workers in the private and public sectors. Additionally, the topic of scope of practice particularly as it related to the Advance Degreed Providers was a subject discussed at length. After further deliberation, the topic remained open for future development and recommendations.

4.Other Business
The Committee briefly discussed the 2016 Issues papers, published by the Department of Legislative Services and referred to a link which was previously sent to Committee members. The Chair called attention to two summaries, both of which were the topics of conversation at previous meetings, "Medicaid Population and Expenditure Trends" and "Implementation of an All-payer Model Contract". As the Maryland General Assembly convenes for the annual Legislative Session, these documents are helpful discussion points.

The meeting adjourned at approximately 2:40 pm.

5.Next Meeting
February 2, 2016.

6.Adjournament
There being no further business to be brought to the Committee, the meeting was adjourned at approximately 2:40 PM.

Health Care Committee

The RMC Health Care Committee has been active over the years focusing on health care issues such as, work force shortages, rural access to prescription medications, scope of practice regulations and the feasibility of developing a statewide telehealth consortium. Currently, the Committee has focused its attention on mental health and its access through the application of telemedicine, particularly, adolescent depression and mood disorders. In the course of these discussions, the Committee has reviewed data indicating that:

- According to a report published by Healthy People 2020, depression is the most common disorder identified in mental illness. It is the leading cause of disability in the work force, is responsible for more than 60% of all suicides each year and contributes to a shortened life span. Currently, suicide is the 3rd leading cause of death for adolescents in both the 10-14 and 15-19 age groups in this country.
- In 2013, the number of adolescents with a major depression episode (MDE) within the past 12 months was 2.6 million (10.7%) which included almost 360,000 who had a co-occurring substance abuse disorder. That number increased to 2.8 million due primarily to the increase in MDE incidents.
- Some studies cite the lack of evaluation for depression in office visits with the primary care physician. One such study stated that only 25% of the physicians surveyed included it despite the recognition by 75% of the respondents that it is a treatable condition.
- From a review of the Mental Health Workforce Availability Chart included in the 2015 MHA report, Maryland's ratio of population per mental health worker was ranked 21st (666:1) and was better than the national average (790:1)as well as its neighboring states excepting Delaware. On the other hand, there is increasing concern regarding the shortages of psychiatrists as services for mental health increase. A recent study initiated by the Mental Health Association of Maryland highlighted that finding. Among Its results indicated that only 14% of the 1,154 psychiatrists identified under health reform were accepting new patients and available for appointments within 45 days.
- Nationally, the President Elect of the American Psychiatric Association estimated that the country will need another 30,000 child psychiatrists to augment the current 8,000 in practice to meet the mental health provisions included in the Affordable Care Act. However, the Kaiser Health News reported that lower pay, reimbursement difficulties and paperwork requirements are discouraging more medical students from considering this aspect of practice, which is one of the lower paying specialties in the medical profession.

Based on these findings, the Committee has accepted the following short-term goals in focusing on its future deliberations:

- Encourage all Primary physicians to include an evaluation for depression in their Private office visits
- Review and revise roles of School Nurse and Counselor to assist in detecting signs of depression for possible medical attention
- Develop certification programs in mental health to further enhance ADP's qualifications and offset the recognized physician shortage in addressing and treating or referring adolescents suffering from depression.

For more information, visit the RMC's website at: rural.maryland.gov
50 Harry S. Truman Parkway, Annapolis, Maryland 21401
(410) 841-5772
Charlotte Davis, Executive Director: charlotte.davis@maryland.gov

Chaired by Tom McLoughlin, a former Hospital CEO, and RMC Executive Committee member, the Committee's membership consists of:

Dr. Dianna E. Abney, M.D.
Health Officer, Charles County Department of Health

Mr. Michael A. Franklin, FACHE
President and CEO, Atlantic General Hospital

Ms. Roxanne Hale, MHA,
Director, Office of Primary Care Access, Health Systems and Infrastructure Administration
Maryland Department of Health and Mental Hygiene

Ms. Holly Ireland
Executive Director
Mid-Shore Mental Health Systems, Inc.

Mr. John Kornak
Director, Telehealth
University of Maryland Medical Center

Dr. Karan Kverno, Ph.D.,
Assistant Professor, PMHNP Program, Johns Hopkins University School of Nursing

Ms. Temi Oshiyoye
Director
State Office of Rural Health, Maryland Department of Health and Mental Hygiene

Dr. Kerry C. Palakanis, CRNP
CEO
Crisfield Clinic Family Practice

Ms. Sharon Praissman, MS, CRNP-A/PMH
Clinical Director,
Psychiatric Outpatient Program for Adults
Johns Hopkins University School of Nursing

Dr. David B. Pruitt, M.D.
Director, Child and Adolescent Psychiatry
University of Maryland School of Medicine

Dr. H. Neal Reynolds, M.D.
Associate Professor
University of Maryland School of Medicine

Dr. P. David Sharp, Ph.D.
Maryland Health Care Commission

Dr. Nancy M. Smith, DNP, CRNP, FNP-BC
Assistant Professor, Nursing Department
PRMC/Salisbury University

Ms. Lara D. Wilson
Executive Director
Maryland Rural Health Assoc.

Ms. Jennifer Witten
Government Relations Director
Maryland Hospital Association

Ms. Deborah L. Wolf, MS
Director
Atlantic Health Center, Atlantic General Hospital

Ms. Teresa Zent, J.D.
Attorney

One of the Rural Maryland Council's major goals is to enhance rural policy development and coordination by regularly bringing stakeholders together to identify challenges common to rural areas and, by consensus, to develop, implement and monitor public and fiscal policy, programmatic or regulatory solutions. With a small staff, the RMC uses working committees to develop policy expertise across rural concerns and to engage already committed and knowledgeable rural advocates. Committees identify a specific challenge facing rural areas across the state or region, research the problem to get an overall understanding of it, and then, by consensus, develop proposed solutions. Solutions usually include developing or modifying state legislation, regulations, budget appropriations or programs. Committees bring recommendations to the full RMC Executive Board for approval and implementation. Committees also continue to monitor the results and evaluate the effectiveness of the solution, and to suggest changes over time, when necessary. Ultimately, the committees empower the RMC to speak on behalf of rural Marylanders with one voice on important issues.

For more information, visit the RMC's website at: rural.maryland.gov
50 Harry S. Truman Parkway, Annapolis, Maryland 21401
(410) 841-5772
Charlotte Davis, Executive Director: charlotte.davis@maryland.gov

RMC Health Care Committee Meeting
March 1, 2016
1:00 pm to 3:00 pm
Via Conference Call
Agenda

Call-in Information:
Toll-free dial-in number: 1-877-658-7465
Conference Code: 5962756099

Invited participants: Members of the RMC Health Care Committee
Tom McLoughlin, Chair
Charlotte Davis, Executive Director
Meredith Donaho, RMC Administrative and Communications Aide

I. Welcome and Introductions — Charlotte Davis

II. Review and Adoption of the January 5, 2016 meeting minutes

III. Review and discussion of 2016 Legislation

- HB713/SB494 - State Department of Education - Community-Partnered School Behavioral Health Services Programs - Reporting System and Report (School Behavioral Health Accountability Act)
- HB1103 - Health Care Practitioners - Use of Teletherapy
- HB1494/SB411 - Income Tax - Credit for Physician Preceptors in Areas With Health Care Workforce Shortages
- SB217 - State Board of Physicians - Distribution of Fees by Comptroller - Loan Assistance Repayment for Physicians and Physician Assistants
- HB886/SB242 - Maryland Medical Assistance Program - Telemedicine – Modifications
- SB393/HB490 - Maryland Nurse Practice Act - Peer Review and Advisory Committees and Penalties
- HB998/SB1020 – State Board of Physicians – Authority to Adopt Regulations – Physician Licensing Reciprocity

IV. Review and discussion of draft letter to physicians on mental health screenings

V. April Guest Speakers and development of potential questions

a. Dr. Cheryl DePinto, DHMH

b. Mr. Walter Sallee, MSDE

c. Dr. Nicole Gloff, UM School of Medicine, BHIPP

VI. Schedule Next Meeting

VII. Adjourn

RMC Health Care Committee
March 1, 2016
Via Conference Call
Meeting Minutes

Participants:
Roxanne Hale
Michael Franklin
Karen Kverno
Dr. David Pruitt
Justine Springer
Lara Wilson

RMC Staff:
Charlotte Davis, Executive Director
Meredith Donaho, Administrative and Communications Assistant

Welcome and Introduction The meeting was called to order at approximately 1:05 pm. In view of the Chair's excused absence Ms. Davis welcomed the group, facilitated introductions and convened the meeting.

January 5, 2016 Meeting Minutes. Upon motion properly made and seconded, it was voted to accept the minutes as distributed.

Review of Proposed 2016 Legislation The following bills were reviewed and discussed in detail:

- HB713/SB494 – State Department of Education – Community-Partnered School Behavioral Health Services Programs. No position was recommended at this time.
- HB1103 – Health Care Practitioners – Use of Teletherapy. No position was recommended at this time.
- HB1491/SB411 – Income Tax – Credit for Physician Preceptors in Health Care Shortage Areas. The Committee recommended letter of support with comments as discussed.
- SB217 – State Board of Physicians – Loan Assistance Repayment Physicians and Physician Assistants. No position was recommended at this time but continue to monitor its progress.
- HB886/SB242 – Maryland Medical Assistance Program – Telemedicine. No position was recommended at this time.
- SB393/HB490 – Maryland Nurse Practice Act – Peer Review and Advisory Committees. Karen Kverno mentioned she was meeting with the Executive Director of the Board of Nurses to discuss the bill. MHRA has no position. No position recommended at this time based on a need for more information.
- HB998/SB1020 – State Board of Physicians – Authority to Adopt Regulations - Physician Licensing Reciprocity. There was concern that the licensing could impact rural border areas where physicians work in 1 or 2 states and may help ease the process.No position recommended at this time but continue to monitor its progress.
- Other Bills: No other bills were mentioned or called to be included on the list.

Draft Letter regarding Mental Health Screenings. There was extended discussion on the proposed correspondence to physicians. Some suggestions included attaching an evidence-based screening form/white paper on adolescent depression, as well as a clearer explanation of its purpose and potential

sources of mailing lists for primary care physicians. Based on the input received, the letter will be revised and reviewed at the next meeting.

April Meeting's Guest Speakers The Committee was asked for input on potential questions to prepare for the April meeting and to create more robust conversation in that forum. Among the topics mentioned was a focus on school-based health center policies among different jurisdictions and its impact on a standard delivery of care.

Other Business There was discussion regarding the DHMH Spring Cycle Loan Assistance Repayment Program. Opened on March 1st, the program already has 5 applicants. It was suggested that information on the program be communicated to eligible young physicians and physician assistants.

Adjourment The meeting adjourned at approximately 2:00 pm.

Next meeting: April 5, 2016, 1pm

RMC Health Care Committee Meeting
April 5, 2016
1:00 pm to 3:00 pm
Maryland Department of Agriculture, 50 Harry S Truman Parkway, Annapolis
Agenda

Invited participants: Members of the RMC Health Care Committee
Tom McLoughlin, Chair
Charlotte Davis, Executive Director
Meredith Donaho, RMC Administrative and Communications Aide

I. Welcome and Introductions — Tom McLoughlin

II. Review and Adoption of the March 1, 2016 meeting minutes

III. Featured Guest Speaker

a. Dr. Cheryl DePinto, Medical Director, Office of Population Health Improvement, Maryland Department of Health and Mental Hygiene

IV. Review and discussion of one-page committee description

V. Med-Chi

VI. Other Issues

VII. Adjourn

Next Meeting: May 3, 2016, 1:00 pm to 3:00 pm

RMC Health Care Committee
April 5, 2016, 1pm- 3pm,
Via Conference Call
Meeting Minutes

Participants:
Tom McLoughlin, Justine Springer, Lara Wilson, Karen Kverno, Holly Ireland, Michael Franklin, Meredith Donaho, Charlotte Davis, Dr. David Pruitt, Kerry Palakanis, Lori Weddell, Neal Reynolds
Guest Speaker: Dr. Cheryl De Pinto, MD, MPH, DHMH

Convene Meeting
The meeting convened at approximately 1:05 pm.

Dr. De Pinto's Presentation – Maryland School Health Services Program Overview
In view of the last minute change to a conference call, Dr. De Pinto's power point presentation was emailed to all Committee members earlier in the day prior to the meeting. Among the topics included were an overview of school health services in Maryland, definitions of school health, framework, intra/inter-agency collaborations, School Based Health Centers (SBHC), staffing models and major activities.
Following her presentation, several questions addressed by De. De Pinto related to the coordination of student information between schools and providers; needed care when it does not exist in the community; parental consent in SBHC; and barriers in obtaining approval for telehealth services.

On behalf of the Committee, the Chair thanked Dr. De Pinto for her extremely informative presentation and excused her from the balance of the meeting.

Meeting Minutes Review
The minutes from the January 5th meeting were reviewed. In the absence of questions, comments or corrections, and upon motion properly made and seconded, the minutes were accepted as distributed.

Letter to Physicians
The Healthy Kids/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program letter to physicians was updated. It was reported that a list of physicians has been obtained from the Board of Physicians and has identified 3,724 physicians involved in rural, general practices. Work is continuing on the letter and will be reviewed at the next meeting.

MedChi
The Chair requested committee input regarding the feasibility of approaching MedChi as a strategic partner to determine that agency's interest in assisting the Committee in furthering its objectives. Based on the feedback received, the issue will be further addressed at the next meeting.

Other Issues
A review of the Pediatric Board Nurse Certification Program was discussed, including the Pediatric Mental Health Specialist Certification Program. It was mentioned that this mechanism might address an aspect of the committee's third short term objective related to the expansion of the role of providers in the field as well as the shortages of psychiatrists in rural areas. After further discussion, it was the consensus to further explore its potential applicability.

Ms.Holly Ireland advised that a Behavioral Health Integration Work Group Training will be offered in the Fall and asked the Committee to share the training with colleagues. She mentioned that the training will involve screenings for substance use disorders in pediatric evaluations. The RMC will share this information with its membership in an upcoming newsletter.

Next Meeting & Adjournment

The next meeting ,May 3, 2016, tentatively, will include a presentation from Dr. Gloff, a colleague of Dr. Pruitt.

There being no further business to be brought to the Committee, the meeting was adjourned at approximately 3:00 PM.

CHANGING
Maryland
for the Better

Maryland School Health Services Program Overview

Cheryl De Pinto, MD, MPH
Department of Health and Mental Hygiene

Rural Maryland Council
April 5, 2016

Chapter 405 Article 77 of the 1969 Laws of Maryland

85. School Health Program.

Each county board of education **WITH THE ASSISTANCE OF THE COUNTY HEALTH DEPARTMENT** ***shall provide adequate school health services, instruction in health education, and healthful school environment. The State Department of Education and the State Health Department shall develop jointly public standards and guidelines for school health programs and offer assistance to county boards of education and health departments in their implementation.***

The 1969 law was part of a general overhaul to the Education statute

Definitions

- **School Health:**
  All the strategies, activities, and services offered by, in, or in association with schools that are designed to promote students' physical, emotional, and social development make up a school's health program.
  (www.ASHA.org)

- **Coordinated School Health:**
  When a school works with students, their families, and their community to provide these strategies, activities, and services in a coordinated, planned way, then the term coordinated school health program applies.
  (www.ASHA.org)

Annotated Code of Maryland

Education Article § 7-401
School Health Program

- a) Duty of county board.- With the assistance of the county health department, each county board shall provide:
  - 1) Adequate school health services;
  - 2) Instruction in health education, including the importance of physical activity in maintaining good health; and
  - 3) A healthful school environment.

- b) Development of public standards and guidelines.- The Department of Education and the Department of Health and Mental Hygiene jointly shall:
  - 1) Develop public standards and guidelines for school health programs; and
  - 2) Offer assistance to the county boards and county health departments in their implementation.

[An. Code 1957, art. 77, § 85; 1978, ch. 22, § 2; 2005, ch. 312.]

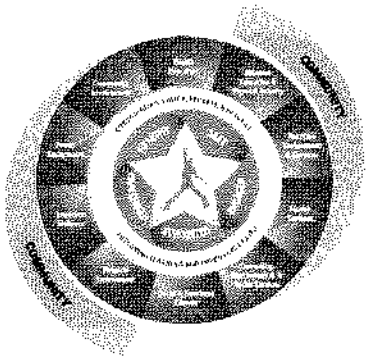
Select Important Laws Pertaining to School Health Services

- Americans with Disabilities Act of 1990 (Public Law 101-336) US Department of Labor
- Blood-borne Pathogens Standards (29 CFR –1910.1030)
- Communicable Disease Control (COMAR 13A.05.05.07E)
- FERPA (Family Education Records Privacy Act) (20U.S.C. §1232g)
- Section 504, Rehabilitation Act 1973, 29 U.S.C. 791 et seq.
- Individuals with Disabilities Education Act (20 U.S.C. § 1400 et seq.)
- Immunization Compliance (COMAR 10.06.04)
- Medicaid Reimbursement/Schools (COMAR 10.09.50)
- Medication Administration (COMAR 13A.05.05.08F)
- Medication Technicians (COMAR 10.39.01.01-.09)
- Nurse Practice Act (Annotated Code of Maryland, Health Occupations Article, Title 8,COMAR 10.27)
- School Health Services Program Reviews (Onsites) (COMAR 13A.05.05.14)
- Vision and Hearing Screening (Education Article, Section 7-404, Annotated Code of Maryland and COMAR 13A.05.05.07-3a) see Hearing

Intra/Inter-Agency Collaborations

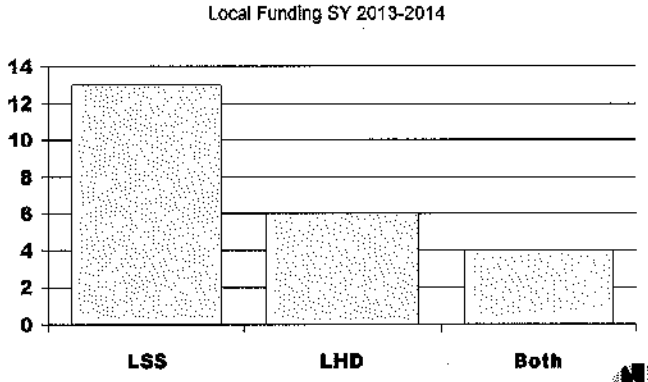
- **DHMH**
  - FHA-CMCH; Health Promotion
    - Health Services
    - Health Education
    - Family Involvement
    - Nutrition and PA
    - Staff Wellness
    - Environment
  - CHA-IDEHA-CD;STD;TB; Env. Health
  - MA
    - School Health Services
  - MHA
    - Counseling/psychological svs
- **MSDE**
  - Student Services
    - School Health Services
    - Counseling/psychological svs
  - Early Childhood
  - Instruction
    - Health Education
    - Physical Education
- **MSDE (con't)**
  - Physical Facilities
  - Transportation
  - Nutrition
  - Rehabilitation
  - Special Education
  - Family Involvement
- **Local collaborations**
  - Health
  - Education
  - Local school health councils
  - Community
  - Parents
  - Local equivalents of state programs
  - Local Health Improvement Coalitions

School Framework Health Framework
Whole School, Whole Community, Whole Child

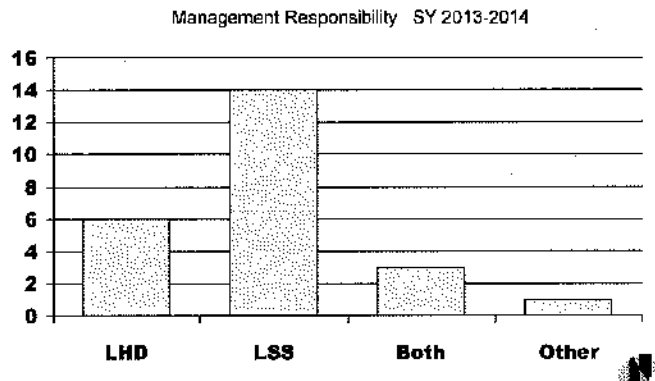


Source: http://www.ascd.org/programs/learning-and-health/wscc-model.aspx

School Health Services Programs



School Health Services Programs



Major Activities: State Level

- Guidelines
- Site Reviews/certification
- School Health Services Supervisors Meetings
- Training
- Technical Assistance
- Liaison functions
- Statistics/data/monitoring

School Health Services Programs: Staffing Models

- RN in every school
- RN or LPN in every School
- RN for every 1-4 schools (paraprofessional at every school)
- Nursing Supervision (LHD or LSS) in every Jurisdiction

School Based Health Centers (SBHC)

- SBHCs are:
  - An optional expansion of the SHS program
  - Present to meet identified (i.e., needs assessment) needs
  - Operate as an "add on" to SHS programs (e.g., governed by laws and standards of health care delivery
    - MA billing requirements
    - Confidentiality
    - Etc.
  - Approved by MSDE and DHMH to operate
  - Funding is often blended

School Based Health Centers (SBHC)

- Overview of Status:
  - 85 SBHCs
  - 13 jurisdictions
  - 17 different sponsoring organizations
    - FQHC
    - LHD
    - General Clinics (hospital affiliated)
  - 5 approved telehealth sites
    - Does not include school mental health programs using telehealth

SBHC Application/Approval Process

- MSDE –Review of application and schedules site visit
- MSDE +/- DHMH site visit and general program approval based on required elements
- DHMH Medicaid approval
  - Provider type
  - Provider credentials
- Final MSDE approval

School Based Health Centers: Staffing

- A primary care provider, such as a pediatrician, nurse practitioner, or physician assistant
- A registered nurse (RN or BSN) and/or a licensed practical nurse (LPN)
- A medical office assistant (MOA) or medical assistant (MA)
- A billing or clerical staff member
- A mental health provider, such as a psychiatrist, psychologist, social worker, or other therapist
- A substance abuse counselor
- A dentist and/or dental hygienist
- A health educator
- A nutritionist or registered dietitian

Questions?

Contacts:

Cheryl De Pinto, MD, MPH
cheryl.depinto@maryland.gov

Alicia Mezu, MSN/Ed, BSN, BS, RN
alicia.mezu@maryland.gov

MARYLAND STATE DEPARTMENT OF EDUCATION
PREPARING WORLD CLASS STUDENTS

MSDE Home

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  - Career and College Readiness
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      - Bullying Prevention
      - HIV/AIDS Prevention
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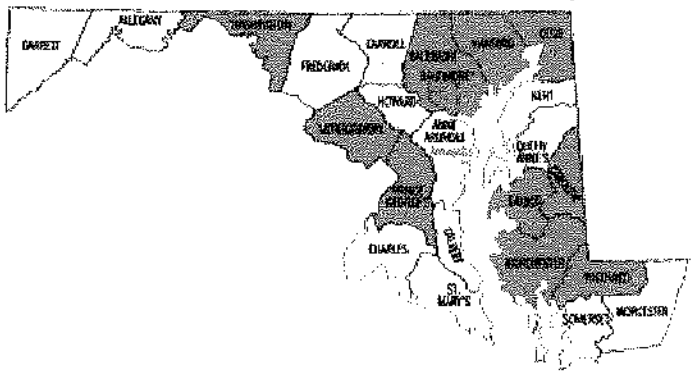
      - Inhalant Abuse
      - Maryland Safe and Supportive Schools Grant
      - Positive Behavioral Interventions and Supports

Divisions

Divisions > Student, Family, and School Support > Student Services and Alternative Programs > School-Based Health Centers

School-Based Health Centers

School-Based Health Centers in Maryland



What are School-Based Health Centers (SBHCs) or School-Based Wellness Centers?

SBHCs are health centers, located in a school or on a school campus, which provide onsite comprehensive preventive and primary health services. Services may also include mental health, oral health, ancillary, and supportive services. You might think of a SBHC as "doctor's office in a school". SBHCs may be staffed by one or more of the following health professionals:

- A primary care provider, such as a pediatrician, nurse practitioner, or physician assistant
- A registered nurse (RN or BSN) and/or a licensed practical nurse (LPN)
- A medical office assistant (MOA) or medical assistant (MA)
- A billing or clerical staff member
- A mental health provider, such as a psychiatrist, psychologist, social worker, or other therapist
- A substance abuse counselor
- A dentist and/or dental hygienist
- A health educator
- A nutritionist or registered dietitian

In Focus

Maryland SBHC Application

SBHC Standards
- SBHC Standards

SBHC Administrative Meetings
- SBHC Administrative Meetings

SBHC Policy Advisory Council
- SBHC Policy Advisory Council

SBHC Survey
- SBHC Survey

Related Websites
- Center for Adolescent Health & the Law
- Center for Health & Health Care in Schools
- Center for School Mental Health at U. of MD.
- Code of MD Regulations
- Healthy People 2020
- MD Assembly on School-Based Health Care
- MD Dept. of Health & Mental Hygiene
- National Assembly on School-Based Health Care

- Pupil Personnel and School Social Workers
- Safe and Drug-Free Schools
- School-Based Health Centers
  - docs
  - SBHC Policy Advisory Council
  - SBHC Survey
  - School-Based Health Centers
- School Counseling
- School Health Services
- School Mental Health
- School Psychological Services
- Self-Injury
- Student Enrollment Issues
- Suicide Prevention
- Surveys
- Teen Pregnancy
- Emergency Planning and School Safety
- Family Support Branch

How many are there?
As of July 2013, there were 70 SBHCs in Maryland, with more being planned. Some SBHCs serve more than one school, sharing staff between neighboring schools. Maryland's SBHCs are located in elementary, middle, high, K-8 and special schools.

Where are they located?

There are SBHCs in 13 of Maryland's 24 jurisdictions.

Local County	Number of SBHCs
Baltimore City	16
Baltimore County	18
Caroline County	9
Cecil County	4
Dorchester County	1
Frederick County	5
Harford County:	12
Montgomery County	4
Prince George's County	1
Talbot County	4
Washington County	2
Wicomico County	1
Total SBHC Programs (FY16)	**77**

How can I locate a specific SBHC in Maryland?
Click here for a contact list for Maryland SBHCs.

What is the relationship between SBHCs and school nurses/school health services programs?

In school year 2007-2008, all 1,455 public schools in Maryland had school health services, usually staffed by a registered nurse. Some large or rural schools have a full-time nurse, but most schools share a part-time nurse with one or more other schools. School nurses provide acute care for injuries and illnesses, care for chronic health conditions under the supervision of a physician, conduct screening for health problems, and maintain up-to-date health and immunization records. School nurses do not diagnose or treat illness; they refer children for appropriate medical care.

In school year 2007-2008, SBHCs served 72 of the 1455 public schools. (There were 61 SBHCs in Maryland, but some serve more than one school.) SBHCs employ a primary care provider (a pediatrician, nurse practitioner, or physician assistant) who works cooperatively with the school nurse to screen, diagnose, treat, and refer children for medical conditions. School nurses often serve as the first contact for health issues in a school. They evaluate the problem at hand

and either provide care or refer the student to the appropriate provider of care, which may be a SBHC nurse practitioner, a mental health provider, or the child's own doctor.

What is the relationship between SBHCs and the health care community/doctors?

SBHCs provide care while children are in school, and help prevent them from missing school due to illness. They do not provide round-the-clock care or emergency coverage. All children should have a primary care provider in the community who oversees their care. SBHCs help make sure they have a doctor by helping parents to locate a convenient pediatrician and secure health insurance coverage.

If all children should have their own doctor, why do we need SBHCs?

In 2004, 1 out of every 11 Maryland children under age 18 had no health insurance and 1 out of every 4 Maryland children under age 18 lived in poverty (*Kids Count,* Annie E. Casey Foundation Maryland data profile). Uninsured and poor children have less access to health care and often have more chronic health problems than other children.

SBHCs were started in Maryland in 1985 to increase children's access to health care. They have proven effective in diagnosing and treating illness, managing chronic health conditions, and increasing school attendance for children at risk of missing school due to health issues. In some parts of the United States, where SBHCs have been studied, an increase in student achievement has been noted in schools with SBHCs.

SBHCs are good for all children, though, not just the poor and the uninsured. Modern parents are busy working and taking care of other children, and it can be expensive and inconvenient to take a child to the doctor for a minor health concern. Many rural Maryland counties have few pediatricians or other child health professionals, so services provided in schools are especially important. In recent years, chronic conditions have increased in children, such as asthma, diabetes, and obesity, which benefit from daily monitoring and treatment in the school setting.

Contact Information

Maryland State Department of Education
200 West Baltimore Street
Baltimore, MD 21201
Phone: 410-767-0353 or 410-767-0278
Fax: 410-333-8148
Email:sbhcentprog.msde@maryland.gov

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RMC Health Care Committee Meeting
May 3, 2016
1:00 pm to 3:00 pm
Maryland Department of Agriculture, 50 Harry S Truman Parkway, Annapolis
Agenda

Invited participants: Members of the RMC Health Care Committee
Tom McLoughlin, Chair
Charlotte Davis, Executive Director
Meredith Donaho, RMC Administrative and Communications Aide

I. Welcome and Introductions — Tom McLoughlin

II. Review and Adoption of the April 5, 2016 meeting minutes

III. Featured Guest Speakers

a. Lillian Adele Foerster, MSN, RN, CPNP-PC/AC
Chief Credentialing Officer
Pediatric Nursing Certification Board
b. Karan Kverno, PhD, PMHNP-BC, PMHCNS-BC | ASSISTANT PROFESSOR
Track Coordinator, Post-graduate PMHNP Program
Acute and Chronic Care
Johns Hopkins School of Nursing

IV. Review and discussion of mailing to physicians

V. Update of school-based mental health care conversation

VI. Other Issues

VII. Adjourn

Next Meeting: June 7, 2016, 1:00 pm to 3:00 pm

RMC Health Care Committee Meeting
May 3, 2016
Maryland Department of Agriculture, Annapolis
Minutes

Participants: Tom McLoughlin, Justine Springer, Temi Oshiyoye, Deborah Wolf, Dr. Diana Abney, Adele Foerster, Karan Kverno and Charlotte Davis

The meeting convened at approximately 1:16 pm.

Chairman McLoughlin called the meeting to order and welcomed participants.

Minutes
The minutes from the April 5, 2016 meeting were presented for review. There being no comments, questions or corrections and upon motion properly made and seconded, the minutes were unanimously accepted as distributed.

Review and Discussion of Mailing to Physicians and Update of School-Based Mental Health Care Conversation
The Chair reviewed the Committee's progress to date on these two short term goals and commented on the need for further refinement.

Regarding the letter to the physicians, it was reported that Staff is finalizing the database for rural Family Practice and Pediatric physicians. The revised draft letter was distributed to Committee members for additional comment. Its purpose and the attachments to be affixed are intended to serve as an educational process to expand the utilization of the evaluation tool in assessing the adolescent patient. Following discussion, no additional revisions were suggested.

Regarding school-based mental health care activity, DHMH representatives have been invited to address the Committee. Last meeting, Dr. De Pinto, Medical Director Office of Population Health Improvement, discussed her responsibilities and identified other groups involved in the process. Staff is continuing efforts to secure additional speakers from the State Department of Education as well as identify contact points in the groups mentioned by Dr. De Pinto.

Featured Guest Speakers
Ms. Adele Foerster, Chief Credentialing Officer with the Pediatric Nursing Certification Board (PNCB) presented a power point program on her agency's certification program and the role of the non-physician advanced practitioner in efforts to address the shortage of primary care and mental health professionals in the State.

Dr. Karan Kverno, Director, , Post-Graduate PMHNP Program at Johns Hopkins School of Nursing and a Committee member, discussed the PMHNP-BC program. In her power point presentation, she highlighted the American Association of Colleges of Nursing guidelines for baccalaureate and graduate-degree nursing programs as well as recruitment issues in rural areas.

After the formal presentations, there was extended discussion on the two programs and their distinctions. The PNCP certification program seemed to address the advanced degree practitioner who has developed skills based on work experience whereas the University setting to be the course for the practitioner who is seeking to add a core specialty. Also discussed was the role of regulation as was the

feasibility of a pilot project for training/or certifying advanced degree providers in mental health. It is difficult to get practitioners to move into rural areas. One pilot could identify individuals who are interested in getting the additional credentials. Among the suggestions advanced were to contact the Maryland Board of Nursing and the Nurse Practitioners Association of Maryland for their input on this issue. In closing the discussion it was suggested that an RMC representative consider attendance at the upcoming Maryland Assembly of School-Based Health Care Centers Annual Conference.

There being no further business to be brought to the Committee's attention, the meeting was adjourned at approximately 2:41 pm.

Next Meeting: Tuesday June 7, 2016, 1:00 pm – 3:00 pm

RMC
Rural Maryland Council

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Email: rmc.mda@maryland.gov
Website: www.rural.maryland.gov

Doris Mason, Chair *Charlotte Davis, Executive Director*

May 27, 2016

Letters Sent to Local Health Improvement Coalitions (LHICs)

<Contact Name>
<Address>

Dear <Greeting Name>:

On behalf of the Rural Maryland Council, we extend our deep appreciation for your organization's continued service in providing and promoting quality, affordable health care services in your communities. Aware of your vital role in this process, we wish to call your attention to one of our Health Care Committee's current activities (copy attached).

The Health Care Committee has recently sent letters addressed to rural-serving pediatric and general family physicians regarding the Healthy Kids/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. As you will note from the attachment, the evaluation tools for assessing the adolescent with behavioral issues seem to be underutilized, despite the increasing number of young people suffering from mood disorders, including drug and alcohol abuse. Consequently, the Council is conveying its support for preventative assessments and targeted interventions for early detection, diagnosis and treatment of the adolescent patient and encouraging the physicians' continued active participation in the program. We understand that referrals might often be an issue and we would welcome your input on the topic as well as any suggestions you might offer regarding the needs of health care providers in the rural communities.

As most of you may know, the RMC is an independent State agency established by an act of the State Legislature in 1994. It brings together rural community leaders, government officials at all levels and representatives from the non-profit and profit sectors to identify and craft solutions to the challenges facing rural Maryland. It provides a venue to cross traditional boundaries, share information and address in a more holistic manner the special needs and opportunities in rural Maryland. Its mission is to improve the quality of life while preserving the cultural heritage of Maryland's rural communities. Regardless of your location, we recognize that urban, suburban and rural jurisdictions often face the same challenges such as in the case of teenage depression and mental health.

If the Council can be of any assistance, please contact Charlotte Davis at (410) 841-5774 or e-mail at charlotte.davis@maryland.gov.

Sincerely,

Tom

Tom McLoughlin
Chair, Health Care Committee
Rural Maryland Council

Charlotte Davis
Executive Director
Rural Maryland Council

RMC
Rural Maryland Council

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Email: rmc.mda@maryland.gov
Website: www.rural.maryland.gov

Doris Mason, Chair

Charlotte Davis, Executive Director

June 24, 2016

Letters Sent to School Superintendents

<Contact Name>
<Address>

Dear <Greeting Name>:

First and foremost, and on behalf of the Rural Maryland Council, please accept our gratitude for your continued service providing and promoting quality education in our rural communities. Aware of your major role in the process as well as the importance of health as a contributing factor to its successful achievement, may we call to your attention one of our Health Care Committee's current activities.

During its deliberations, the Committee focused on the issue of behavioral disorders, including depression and substance abuse among adolescents and youth. It recognized that preventive assessments and early interventions are critical in successfully treating the youth. However, it seemed that despite the increasing numbers of young people suffering from mood disorders, the available evaluation tools seemed to be underutilized. Consequently, RMC has forwarded a letter to rural-serving physicians regarding its support for the Healthy Kids/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and to encourage the physicians' active participation in the program. Understanding that referrals might often be an issue, we welcome your input/ suggestions regarding your experiences in addressing these concerns.

As most of you know, the RMC provides a venue for citizens, members of agriculture and natural resource-based industries, health care facilities, educational institutions, economic and community development organizations, for-profit and nonprofit corporations, and government agencies to cross traditional boundaries, share information, and address in a more holistic way the special needs and opportunities in Rural Maryland. Its vision is the ultimate realization that citizens living in rural communities have access to affordable, quality health care services and treatment.

If the Council can be of any assistance, or if you have any questions about the Health Care Committee, please contact Charlotte Davis at (410) 841-5774 or e-mail at charlotte.davis@maryland.gov.

Sincerely,

Tom McLoughlin
Chair, Health Care Committee
Rural Maryland Council

Charlotte Davis
Executive Director
Rural Maryland Council

RMC
Rural Maryland Council

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Office: 410-841-5774 • TTY: 800-735-2258
Email: rmc.mda@maryland.gov
Website: rural.maryland.gov

Doris Mason, Chair
Charlotte Davis, Executive Director

June 23, 2016

Letters sent to Rural-Serving Physicians

<Contact Name>
<Address>

Dear <Greeting Name>:

First and foremost, please accept our gratitude for your continued service as a health care provider in promoting quality and affordable health care services for rural communities and participating in the Healthy Kids/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Its mission is to provide access to quality health care for Medical Assistance children, teens and young adults under 21 years of age. EPSDT is defined in the Code of Federal Regulations, §441.50-441.62.

Among its vital services is providing assessments that identify the early signs of depression and substance abuse among adolescents and youth. As you know, there is an epidemic of heroin and opioid usage nationwide and Maryland, especially its rural communities, is no exception. Therefore, preventative assessments and targeted interventions are critical in providing early detection, diagnosis and treatment to the increasing number of adolescents and young adults suffering from mood disorders, including drug and alcohol abuse.

The Rural Maryland Council (RMC) is sensitive to the issues, recognizes the complexities involved and at the moment, through one of its Committees, is attempting to address them. We believe that one approach to that goal is by encouraging your active participation in the EPSDT program. You can learn more about the program at https://mmcp.dhmh.maryland.gov/epsdt/Pages/Home.aspx.

RMC is an independent State agency established by act of the State Legislature in 1994. It brings together rural community leaders, government officials at all levels and representatives from the non-profit and profit sectors to identify and craft solutions to the challenges facing rural Maryland. It provides a venue to cross traditional boundaries, share information and address in a more holistic manner the special needs and opportunities in rural Maryland. Its mission is to improve the quality of life while preserving the cultural heritage of Maryland's rural communities.

If you have any questions regarding our role in supporting the Healthy Kids/EPSDT program, please do not hesitate to contact me at (410) 841-5774 or at charlotte.davis@maryland.gov

Sincerely,

Tom McLoughlin
Chair, Health Care Committee
Rural Maryland Council

Charlotte Davis
Executive Director
Rural Maryland Council

Section 3 Healthy Kids/EPSDT Screening Components

A. HEALTH AND DEVELOPMENTAL HISTORY

Comprehensive Health History

Comprehensive health and family histories are key components of effective screening for high risk factors, as well as important tools for obtaining relevant health information and identifying health conditions that have a genetic component. At the initial Healthy Kids visit, obtain a complete medical, family, psychosocial, perinatal, immunization and developmental history. At each subsequent well child visit, update and document the child/family's health history. A standardized set of questions can improve the provider's ability to identify children/teens at risk of having significant health problems. The Maryland Healthy Kids Program provides the *Medical/Family History* Questionnaire for this purpose available in both English and Spanish languages (Refer to Section 7, Appendix I, for the *English* and *Spanish* versions). The parent, guardian, or patient may complete this form prior to review by the provider. Update the medical, family, and psychosocial histories annually.

In general, a comprehensive health history includes:

- Personal medical and mental health history: chronic and acute illnesses, allergies, surgeries, injuries, and nutritional conditions and concerns, (i.e., failure to thrive, anorexia/bulimia, etc.),
- Perinatal history: prenatal care, birth history, conditions and concerns in the neonatal period, etc.,
- Developmental history: attainment of developmental milestones, learning disorders/educational concerns,
- Family medical and mental health history: health of the immediate and extended family (through the first generation of grandparents, aunts, uncles, etc.) including chronic and acute illnesses (physical and mental), hereditary disorders, disabilities, family violence and substance abuse,
- Psychosocial history: family constellation (number of members and who is living in household) and family relationships and functioning or dynamics (any boyfriend/girlfriend of single parent, parental separation/divorce, foster care or adoption), housing, financial needs, assessment of support systems, exposure to family and community violence,
- Immunization history: record of previous immunizations and assessment of current immunization status,
- Adolescent history: menarche, sexual activity, substance abuse, mental health problems and current status, social functioning and academic concerns.

Developmental Surveillance and Screening

Developmental surveillance is a longitudinal, continuous, and cumulative process of recognizing children who may be at risk of developmental delays. Developmental surveillance involves eliciting parents' concerns, obtaining a developmental history, making accurate and informed observations of the child, identifying the presence of risk and protective factors, and documenting the process and findings. **Developmental surveillance should be performed at all Healthy Kids preventive care visits.**

In contrast, *developmental screening* is the administration of a brief standardized, validated tool to aid the identification of children at risk of a developmental disorder. Periodic developmental screening of all children in addition to ongoing developmental surveillance can significantly increase the identification of children with developmental delays.

Based on the 2006 policy statement of the American Academy of Pediatrics (AAP), it is now **required** that general developmental screening be performed for all children at the 9-, 18-, and 24-30 month Healthy Kids preventive care visits, and whenever a concern is identified through developmental surveillance.[1] If the child is not seen at these recommended ages, screening should be conducted at the next preventive care visit. The AAP also **recommends** screening specifically for autism at the 18- and 24-month visits using a standardized tool.[2]

Both developmental surveillance and screening should address the following areas, as age-appropriate: 1) speech and language development 2) gross and fine motor development, 3) self-help and self-care skills, 4) social development, 5) cognitive development, and 6) presence of learning disabilities.

[1] AAP. (2006). Identifying Infants and Young Children with Developmental Disorders in the Medical Home: an Algorithm for Developmental Surveillance and Screening. *Pediatrics*, 118(1), 405 - 420 Retrieved on 08/08/14, from http://pediatrics.aappublications.org/content/118/1/405.full.

[2] AAP. (2007). Identification and Evaluation of Children with Autism Spectrum Disorders. *Pediatrics*, 120 (5),1183-1215. Retrieved on 08/08/14 *from* http://pediatrics.aappublications.org/content/120/5/1183.full.html.

Developmental Screening Tools

Healthy Kids recommends the following standardized, validated developmental screening tools for use in general developmental screening at the intervals noted above:

- *The Ages and Stages Questionnaire* (ASQ)[3]
- *Parents' Evaluation of Developmental Status* (PEDS)[4]

An additional list of standardized, validated general *Developmental Screening Tools* has been approved for use in the Healthy Kids Program to screen children through age of 5 (refer to Section 3, Addendum).

Results of the developmental surveillance and screening, and the screening tool used, should be documented in the medical record. Children identified as being at risk for developmental delays should have documented counseling and referral for additional evaluation services. (Refer to Section 3, Addendum - *Additional Evaluation and Intervention for Developmental Disorders*). Refer to *Section 6* of this Manual for coding and documentation guidelines.

Screening for Autism Spectrum Disorders (ASDs)

Autism Spectrum Disorders (ASDs) are neuro-developmental conditions characterized by:

- Impairments in social interaction,
- Impairments in communication,
- Restricted repetitive and stereotyped patterns of behavior, interests, and activities.

The Centers for Disease Control and Prevention (CDC) estimated that autism affects 1 in every 68 children aged 8 years old. The rates are higher among males, among families where another sibling has ASD, and among children with certain medical conditions (including Fragile X syndrome, fetal alcohol syndrome). The exact cause of ASDs is unknown.[5]

Early identification and early intervention services are critical to optimizing educational and functional outcomes for children with ASDs. Since 2007, the AAP recommended that primary care providers (PCPs), in addition to conducting general developmental

[3] See the ASQ website: *http://agesandstages.com/*

[4] See the PEDS website: *www.pedstest.com*

[5] CDC (2014). Prevalence of Autism Spectrum Disorder Among Children Aged 8 Years - Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2010. *CDC Surveillance Summaries*. 63(SS02), 1-21. Retrieved on 08/18/2014, from *http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6302a1.htm?s_cid=ss6302a1_w*

surveillance and screening, should perform autism-specific surveillance during all well child visits.[6] Autism-specific surveillance includes:

- Ascertaining family history of ASDs, especially among older siblings,
- Eliciting parent concerns, particularly about communication, social reciprocity, and pretend play skills,
- Assessing the child's behavior and attainment of communication and social-emotional milestones.

Red flags that warrant immediate referral include:

- No babbling or pointing or other gesture by 12 months,
- No single word by 16 months,
- No 2-word spontaneous phrases (not echolalic) by 24 months,
- Loss of language or social skills at any age,
- Failed results of an autism-specific screen of any child using a structured, standardized instrument at 18 and 24 months of age.

In addition to **requiring** general developmental screening, the MD Healthy Kids Program **recommends** autism-specific surveillance at all visits and requires structured autism-specific screening at 18 and 24-30 month well child visits. The MD Healthy Kids Program recommends the *Modified Checklist for Autism in Toddlers-Revised, with Follow up* (MCHAT-R/F) screening instrument.[7]

As with general developmental surveillance and screening, children with findings of concern on autism-specific surveillance or screening should be simultaneously referred for medical evaluation and to the *Maryland Infants & Toddlers Program* at **1-800-535-0182** for possible early intervention services.

[6] AAP. (2007). Identification and Evaluation of Children with Autism Spectrum Disorders. *Pediatrics*, 120 (5), 1183-1215. Retrieved on 08/08/14 *from* *http://pediatrics.aappublications.org/content/120/5/1183.full.html*.

[7] The MCAT-R/F screening instrument can be accessed and freely downloaded at http://*www2.gsu.edu/~psydlr/M-CHAT/Official_M-CHAT_Website.html*

The following organizations provide resources for information about general developmental screening, autism-specific screening, and early intervention:

- *AAP National Center for Medical Home Implementation*[8]
- *CDC "Learn the Signs. Act Early" campaign*[9]

Mental Health Assessment

The mental health assessment provides an overall view of the child's personality, behavior, social interactions, affect and temperament. It is the responsibility of the PCP to conduct a mental health assessment on each Healthy Kids visit, beginning at 3 years of age, to identify risks associated with behavioral or emotional problems.

The Healthy Kids Program, in collaboration with the Mental Hygiene Administration, has developed age-specific *Mental Health Questionnaires* available in English and Spanish languages (Refer to Section 7, Appendix II, for the *English* and *Spanish* versions) to assist providers in assessing for mental health problems.

Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP) is a free service for PCPs caring for patients with mental health needs from infancy through the transition to young-adulthood. It provides support to PCP through four main components: telephone consultation, continuing education, resource and referral networking and social work co-location. For more information, refer to B-HIPP website at *www.mdbhipp.org* at or call **855-632-4477**.

Bright Futures in Practice, a series of publications from the Maternal and Child Health Bureau and the National Center for Education in Maternal & Child Health, provides additional information regarding mental health assessment for children and adolescents. Information regarding mental health assessment can be found on the ***Bright Futures*** website at *http://brightfutures.aap.org*.

Document the result of the mental health assessment in the medical record. In some cases, when a mental health problem is identified, the primary care provider can counsel the patient and note this in the record. However, when specialty mental health services are needed, refer directly to the **Maryland Public Behavioral System** by contacting **1-800-888-1965 (consumers and providers).** Access additional mental health information and resources online at: *maryland.valueoptions.com/services*. Document the referral in the medical record.

[8] See *http://www.medicalhomeinfo.org/*

[9] See *http://www.cdc.gov/ncbddd/actearly/hcp/index.html*

Depression in Children

Depression is often overlooked and considered to be "mood swings" that are a normal part of childhood. This is unfortunate, because the early diagnosis and treatment of depressive disorders is paramount in the healthy development of the child. Depression is occurring earlier on the developmental continuum than in the past. Children/adolescents and their parents are less likely to identify symptoms of depression. Often the PCP is in a better position to trend the behavior and suggest that the child/adolescent should see a mental health professional.

Risk Factors for Depression:

- Family history of depression,
- A parent who experienced depression at an early age,
- Teen cigarette smoking,
- Stress,
- A loss of a parent or loved one by death or divorce or other loss,
- Attention, conduct, or learning disorder,
- Chronic illness, such as diabetes,
- Abuse or neglect,
- Other trauma, including natural disasters.

Signs That May Be Associated with Depression in Children and Adolescents:

- Frequent vague, non-specific physical complaints such as headaches, muscle aches, stomachaches or tiredness,
- Frequent absences from school or change in school performance,
- Talk of or efforts to run away,
- Outbursts of shouting, complaining, unexplained irritability or crying,
- Being bored,
- Lack of interest in playing with friends,
- Alcohol or substance abuse,
- Social isolation, poor communication,
- Fear of death,
- Extreme sensitivity to rejection or failure,
- Increased irritability, anger, or hostility,
- Reckless behavior,
- Difficulty with relationships,

- Change in sleep patterns.

Depressed children have an increased risk of suicidal ideation and gestures. Early diagnosis and treatment, accurate evaluation of suicidal ideation, and limiting access to lethal agents, including firearms and medications, may hold the greatest suicide prevention value.

Attention Deficit Hyperactive Disorder (ADHD)

ADHD is a disorder characterized by behavior and attention difficulties exhibited in multiple settings. It begins in childhood and is identified by specific attention, hyperactivity and impulsiveness criteria found in the *American Psychiatric Association's Diagnostic and Statistical Manual (DSMIVR).*[10]

A clinician with skills and knowledge in the area of mental health, developmental or behavioral pediatrics must perform the ADHD evaluation. A provider who specializes in developmental or behavioral pediatrics can become a specialty mental health provider through Maryland Medical Assistance by registering with the *Community Mental Health Unit* at the **DHMH Office of Health Care Quality**. To print the *Community Mental Health Program Application*, follow the link *http://dhmh.maryland.gov/ohcq/MH/docs/MH_Forms/mh_app.pdf*. For more information, contact the **Community Mental Health Unit at 877-402-8220/410-402-8060** or visit their webpage at: *http://dhmh.maryland.gov/ohcq/MH/default.aspx*.

The overall approach to diagnosing a child with ADHD involves the following:

- A comprehensive interview with the child's adult caregiver,
- A mental status examination of the child,
- A medical evaluation for general health and neurological status,
- A cognitive assessment of ability and achievement,
- Use of ADHD-focused parent and teacher rating scales,
- School reports and other adjunctive evaluations separate from the school reports such as speech, language assessment, etc.

A child diagnosed with ADHD without any accompanying emotional disorders can receive care from a PCP for management of medications. However, medication is only one component in the comprehensive treatment of ADHD. Adjunctive services can significantly improve a child's response. Teaching and reinforcing organizational skills and social skills are adjunctive interventions that can significantly improve outcomes. In addition, ongoing contact and follow-up with the parents of a child with ADHD on medication is a critical component of the medication management.

[10] Diagnostic and Statistical Manual of Mental Disorders.(2013). 5th edition. Arlington, VA., *American Psychiatric Association.*

A number of psychiatric conditions frequently occur with ADHD, i.e., mood disorder, conduct disorder, oppositional defiant disorder and bipolar disorder. ADHD is classified as a specialty mental health disorder, possibly requiring multiple therapeutic approaches (Refer to Section V, *Public Mental Health System*). If the child's behavior changes significantly, reevaluation is necessary through a mental health referral by contacting **Maryland Public Mental Health System** at **1-800-888-1965** (consumers and providers). Access additional mental health information and resources online at: *maryland.valueoptions.com/services.*

For more information about ADHD, refer to the *AAP Clinical Practices Guidelines for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents.*[11]

Child Abuse Assessment

Provider awareness of the physical and behavioral indicators of child abuse, neglect or mental injury is critical to identification of mistreatment in children. Child abuse tends to be repetitive and usually escalates over time. In many cases, the abuse is the result of unrealistic caretaker expectations and the abuser is not intending to hurt the child. This is particularly true with shaken baby syndrome. Multiple socioeconomic or physical factors may place children at greater risk for child abuse. It is important to be aware of the child and parent risk factors that predispose children to abuse and neglect.

Child Risk Factors for Abuse:

- Separation from parents at birth due to prematurity or illness,
- Difficult temperaments,
- Developmental disabilities,
- Congenital anomalies or chronic medical conditions,
- Foster care,
- Behavior problems,
- Younger than 3 years of age.

[11] See AAP. (2011). ADHD: Clinical Practice Guidelines for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics*. 128(5), 1007-1022. Retrieved on 10/31/20014, from *http://pediatrics.aappublications.org/content/128/5/1007.full.pdf*

Parent Risk Factors for Child Abuse:

- Adolescent/young parents,
- Single parent with few support systems,
- Parental history of abuse,
- Unwanted pregnancy,
- Poverty or changes in socioeconomic status,
- Social stressors,
- Parental history of substance abuse,
- Parental history of mental illness/developmental delay,
- Parent with poor impulse control,
- Domestic violence.

Behavioral Indicators for Possible Abuse:

- Extremes in child behavior,
- Substance abuse by child,
- School problems,
- Depression,
- Frequent runaway activity,
- Suicide attempts,
- Poor social interactions,
- Sudden changes in daily routines.

The *SEEK Questionnaire* (Refer to Section 7, Appendix II, for the *English* and *Spanish* versions) is designed to assist providers to identify and address potential risks for abuse and neglect for children younger than 3 years of age.

Child abuse and neglect is a serious problem that requires the involvement of professionals in the community for the purpose of prevention, identification and treatment. The medical history is integral to the evaluation. The provider should obtain sufficient information to complete the physical and decide if local protective services or police are needed. When suspicions of inflicted injury occur, interview the parent and child separately. Past medical history, the child's social situation and the parent's response to the event are necessary components of the history. Not all child abuse occurs in high-risk families. Although the incidence is higher in high-risk families, the provider should thoroughly evaluate every child with a suspicious injury.

Red Flags that Signal Possible Abuse:

- Inconsistent history,
- No explanation for injury/bruises,
- Delay in seeking care,
- Incident inconsistent with child's developmental level,
- Severe injury not witnessed or corroborated,
- Scene of injury not consistent with history,
- High risk social situation,
- Previous suspicious and/or multiple injuries,
- Blaming of injury on sibling.

In Maryland, Subtitle 7 of the Maryland Family Law Code Annotated requires professionals, including health practitioners, police officers, educators and social workers, to report suspected child abuse or face possible professional sanctions.[12] The law requires that anyone who suspects a child has been, or is being, mistreated must report the matter to the *Department of Social Services* (Refer to Section 8) or the police. Any person who, in good faith, makes a report of abuse or neglect is immune from civil liability or criminal penalty.

Bullying and Cyber-bullying

Bullying including cyber-bullying is of increasing concern in the pediatric population. Health care providers should:

- Ask children and adolescents about their experiences, if any, regarding bullying and cyber bullying,
- Provide information in their offices for families to educate them on this topic,
- Encourage parents to work with schools to promote awareness, prevention, and appropriate intervention.

For more information on youth violence including bullying and dating violence, review *2009 AAP Policy on the Role of Pediatrician in Youth Violence Prevention*.[13] A specific assessment tool measuring bullying victimization is the *Victimization Scale* (refer to Section 7, Appendix II for the *English* and *Spanish* versions of the tool). For other

[12] 2010 Maryland Code Family Law Title 5 - Children Subtitle 7 - Child Abuse and Neglect Section 5-704

[13] See AAP. (2009). Role of Pediatrician in Youth Violence Prevention. Pediatrics. 124(1), 393-402. Retrieved on 06/03/2015, from *http://pediatrics.aappublications.org/content/124/1/393.full*

assessment tools, see *Measuring Bullying Victimization, Perpetration, and Bystander Experiences: A Compendium of Assessment Tools*, published by the Centers for Disease Control and Prevention (CDC) in 2011.[14]

Alcohol and Substance Use Disorder Assessment

Performing an assessment or screening for substance use is critical, because of the increased number of adolescents and young adults using drugs and alcohol.[15] [16] Primary care providers play an important role in identifying those who abuse substances. Completion of at least an assessment for substance use at every well child visit is required annually starting at 12 years of age. Screening for substance use should be performed by using a standardized tool such as *CRAFFT* (Refer to Section 7, Appendix II, for the *English* and *Spanish* language versions of the tool).[17] For availability of CRAFFT in other languages, refer to the *Center for Adolescent Substance Abuse Research* website *at http://www.ceasar-boston.org/*.

[14] See CDC (2011).Measuring Bullying Victimization, Perpetration, and Bystander Experiences: A Compendium of Assessment Tools. Retrieved on 06/03/2015, from *http://www.cdc.gov/violenceprevention/pdf/bullycompendium-a.pdf*

[15]See AAP (2005). Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention, Identification, and Management of Use. *Pediatrics*.115(3), 816–821. Reaffirmed March 2013. Retrieved on 08/18/2014, from *http://pediatrics.aappublications.org/content/115/3/816.full*.

[17] AAP (2011). Policy Statement: Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians. *Pediatrics*. 128 (5), 1330 -1340. Retrieved on 08/18/2014, from *http://pediatrics.aappublications.org/content/128/5/e1330.full?sid=f5722c8f-0064-40c2-927f-da32a3a674ef*

The Psychiatric Mental Health Nurse Practitioner

Karan Kverno, PhD, PMHNP-BC

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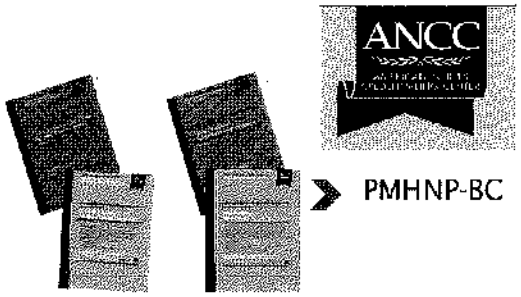

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Scope of Practice

Scope: defines psychiatric mental health nursing, the levels of practice based on educational preparation, and current clinical practice activities and sites.

Standards: authoritative statements that describe the responsibilities for which its practitioners are accountable.

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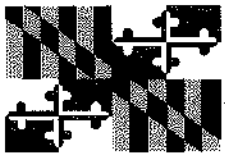
Maryland



- National: PMHNP-BC
- State: CRNP-PMH

MD Bill HB 999/SB 723: Full practice authority. New NPs require mentor for 18 months.

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EDUCATIONAL PREPARATION

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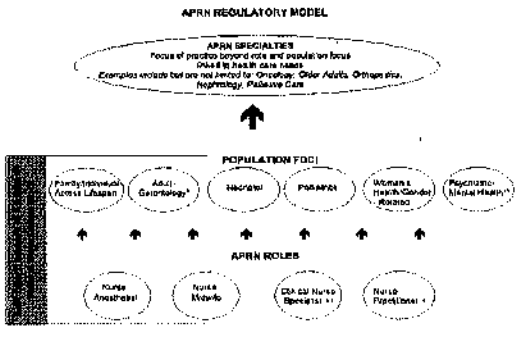

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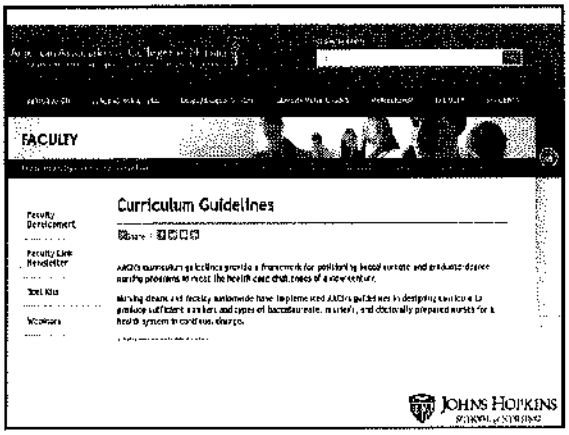

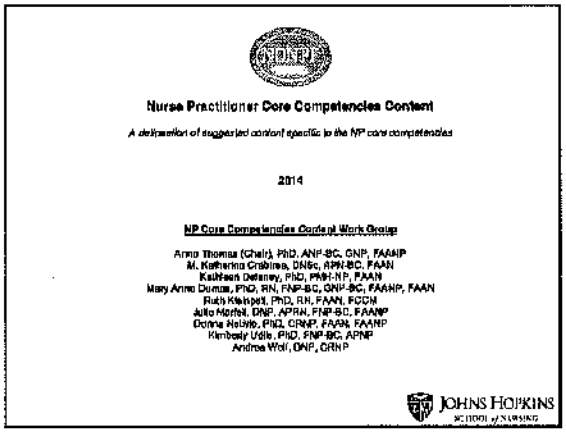

PMHNP Competencies

National Organization of Nurse Practitioner Faculties

- PMHNP competencies with suggested curricular content

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WORKFORCE

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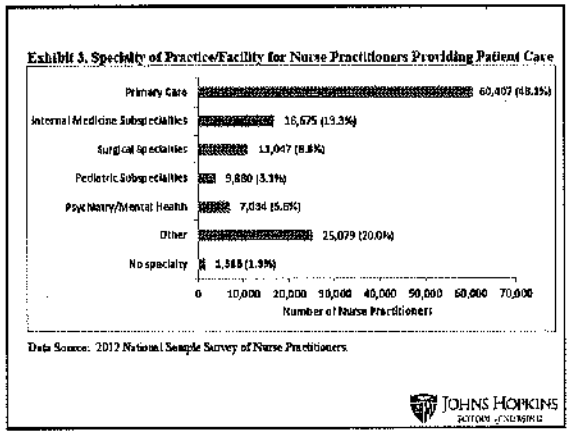

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Workforce

- 1,500 certified PMHNPs in the U.S.
  (ANCC, 2014)
- 50% of NPs work in primary care
  (DHHS, 2014)
- PCNPs are more likely than PCMDs to be practicing in rural areas.
  (Buerhaus et al., 2015)

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PMHNP Education Available to Rural NPs

- 15 online post-graduate PMHNP certificate programs
  - 6 entirely online with local clinical
  - 4 emphasized rural; 3 emphasized integrated care
- Cost
  - Range: 10,440 to 30,498
  - Ave: 17,644

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References

- ANCC. (2014). 2013 *Role Delineation Study: Psychiatric-mental health nursing national survey results.* Silver Spring, MD: ANCC.
- Buerhaus, P. I., DesRoches, C. M., Dittus, R., Donelan, K. (2015). Practice characteristics of primary care nurse practitioners and physicians. *Nursing Outlook*, 63, 144-153. http://dx.doi.org/10.1016/j.outlook.2014.08.008
- U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. (2014). *Highlights From the 2012 National Sample Survey of Nurse Practitioners.* Rockville, Maryland: U.S. Department of Health and Human Services.

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BRIEF REPORT

Expanding rural access to mental health care through online postgraduate nurse practitioner education

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Nurse practitioners; mental health; rural; distance education.

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Abstract

Background and purpose: Workforce shortages in mental health care are especially relevant to rural communities. People often turn to their primary care providers for mental healthcare services, yet primary care providers indicate that more education is needed to fill this role. Rural primary care nurse practitioners (NPs) are ideal candidates for educational enhancement. Online programs allow NPs to continue living and working in their communities while developing the competencies to provide comprehensive and integrated mental healthcare services. This article presents a review of current online postgraduate psychiatric mental health NP (PMHNP) options.

Methods: Website descriptions of online PMHNP programs were located using keywords: PMHNP or psychiatric nurse practitioner, postgraduate or post-master's, and distance or online.

Conclusions: Across the United States, 15 online postgraduate certificate programs were located that are designed for primary care NPs seeking additional PMHNP specialization.

Implications for practice: For rural primary care NPs who are ready, willing, and able, a postgraduate PMHNP specialty certificate can be obtained online in as few as three to four semesters. The expected outcome is a cadre of dually credentialed NPs capable of functioning in an integrated role and of increasing rural access to comprehensive mental healthcare services.

Introduction

In the United States, the 12-month prevalence of any diagnosable mental, behavioral, or emotional disorder is approximately 18.6% for adults (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013) and 13%–20% for children (Centers for Disease Control and Prevention [CDC], 2013). The gap between the needs for mental health care and the provision of mental health services is a major concern in the United States. The 2012 National Survey on Drug Use and Health (SAMHSA, 2013) and the National Comorbidity Survey-Adolescent (Costello, He, Sampson, Kessler, & Merikangas, 2014) indicate that, within a given year, fewer than half of the adults and youth with diagnosable mental disorders receive treatment. Approximately 30% of the U.S. population live in mental health professional shortage areas (mental health HPSAs) where access to care is difficult (Population Health Institute, 2016).

Rural workforce shortages

Across all geographic designations, rural areas have proportionately fewer mental and behavioral health providers than urban areas (U.S. Department of Health and Human Services, Health Resources and Services Administration, 2010). Access to mental health care is one of the top four priorities identified by the Rural Healthy People 2020 survey (Ferdinand, Madkins, McMaughan, & Schulze, 2015). Ninety percent of the rural and very rural hospital chief executive officer (CEO) respondents in a national rural mental health workforce needs assessment survey reported that people needing mental health services frequently wait over 1 month or travel more than 20 miles to reach a mental healthcare provider, and that people living in "very rural" areas often have to drive more than 60 miles. Many of the respondents reported absolutely no mental health services (15%) or mental health professionals (26%) in their area (Thomas, MacDowell, & Glasser, 2012).

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Recruitment and retention of mental healthcare practitioners into rural areas is challenging. Financial incentives such as scholarships and loan repayment increase initial recruitment to rural areas; however, a lack of continued financial incentives, professional isolation, distance to and unavailability of advanced and continuous medical education programs, and unfamiliarity with the rural lifestyle are among the barriers to retention (Campbell, McAllister, & Eley, 2012; Watanabe-Galloway, Madison, Watkins, Nguyen, & Chen, 2015; Weinhold & Gurtner, 2014). Because people who have a rural background and have served rural communities are more likely to stay there, retention efforts may be more successful when practitioners are recruited from where they live (Sharp, Bond, Cheek, & Wolff, 2015).

Rationale for integrated care

The comorbidity rate of persons with mental, substance use, and medical conditions is high and creates substantial personal and societal burdens (Druss & Walker, 2011). National and international policy, practice, and research organizations advocate the systematic integration of mental health, substance use, and primary care services to reduce the treatment gap for mental and behavioral disorders (SAMHSA-Health Resources and Services Administration [HRSA], n.d.; World Health Organization [WHO], 2013). Levels of healthcare integration can range from collaboration between healthcare providers in different practices to fully merged healthcare systems where patients receive all services in the same location by a team that effectively functions together. The rationale for integrated mental health care includes improved outcomes and cost-effectiveness (e.g., Croze, 2015; Druss & Walker, 2011). The benefits of integration may be especially relevant to rural-dwelling people, whose sociocultural attitudes and expectations may include stoicism, self-reliance, and stigmatizing views of mental illness that reduce the likelihood of them seeking out separate mental health services (Ferdinand et al., 2015).

How nurses can help

Primary care providers play an especially important role in providing mental health care to rural populations (Druss & Walker, 2011; Xierali et al., 2013). Primary care nurse practitioners (NPs) make up the great majority (86.5%) of the NP workforce (American Association of Nurse Practitioners [AANP], 2015) and are more likely to practice in rural counties and primary care shortage areas compared to primary care physicians (Buerhaus, DesRoches, Dittus, & Donelan, 2015). Of 1583 NPs from southern U.S. states who responded to a workforce survey, 72% practiced in shortage areas and 47% worked in rural areas (Kippenbrock, Lo, Odell, & Buron, 2015). Primary care NPs in rural areas are already caring for patients with mental health needs and are therefore ideal candidates for educational initiatives.

In their "blueprint" for the development of the mental healthcare workforce, Hanrahan, Delaney, and Stuart (2012) proposed the development of strategies to expand access to advanced practice registered nurse (APRN) psychiatric mental health education. One alternative to trying to move the mental healthcare workforce into rural areas is to build on the existing strengths of the rural APRN workforce. The purpose of this review was to search for and describe options for postgraduate online specialty training in mental health care. Because distance programs are particularly feasible for reaching rural areas, we only looked at programs that are offered all or mostly online.

Methods

We searched the internet for online graduate PMHNP certificate programs using the following keywords: PMHNP or psychiatric nurse practitioner, postgraduate or post-master's, and online or distance. We then examined the website program descriptions for the admission requirements (NP credential or Master of Science in Nursing [MSN]), extent of online availability, the curriculum requirements, the number of credits, cost, and whether rural nursing or integrated care was explicitly mentioned in the website literature. Where the information was not clear on the website, we called the admissions or program office to gather the information. Programs that required more than two visits to campus per semester (i.e., hybrid or block format) were not included in the final review.

Results

The list and descriptions of postgraduate online PMHNP programs is shown in Table 1. A total of 15 online postgraduate PMHNP certificate programs were found. The majority of programs are designed for MSN or credentialed APRN entry and use a gap analysis process to determine the required plan of study. Three schools only offer programs to NPs who are seeking a second NP specialty in mental health care (JHU, NKU, UM-Flint). In the NP-entry programs, the core NP courses, including the three Ps (physical assessment, pathophysiology, and pharmacology) are required as pre-requisites, and the programs can be completed in 13–23 credits over three to four semesters.

Six of the postgraduate PMHNP programs are offered entirely online and nine require no more than two brief campus visits per year or one visit per semester. Most of the programs offer a mostly asynchronous learning

Table 1 Postgraduate PMHNP programs

University	Types of students	Online/onsite	Semester credits	Tuition (out-of-state)	Emphasis	Website
Drexel University	MSN or NP	Online with one onsite visit each semester; weekly synchronous class	24–34 credits; 1 year	$887/credit; $21,288–$30,158	General	http://drexel.edu/cnhp/academics/post-masters/Certificate-Nurse-Practitioner-Psychiatric-Mental-Health/
Eastern Kentucky University (EKU)	MSN or NP	Entirely online	22–31 credits; 4 semesters	$625/credit; $13,750–$19,375	Rural	http://onlinenursingprograms.eku.edu/psychiatric-mental-health-nurse-practitioner-certificate-post-msn
Husson University	MSN or NP	Online with a 1-week/1-year onsite requirement	Approximately 26 credits for NPs (phone inquiry); 2 years	$547/credit; $14,222	Rural	http://www.husson.edu/content/829/curriculum/http-www-husson-edu-content-829-curriculum
Johns Hopkins University (JHU)	NP	Entirely online	13–14 credits; three semesters	$1509/credit; $19,617–$21,126	Integrated role	http://nursing.jhu.edu/academics/programs/post-degree/psychiatric/
Northern Kentucky University (NKU)	NP (ANP or FNP)	Entirely online	21 credits; four semesters	$597/credit; $12,537	General	http://healthprofessions.nku.edu/departments/advancednursing/programs/postgrad/certificate/fampsych.html
Ohio State University (OSU)	Certified APRNs	Online with two onsite visits per year	34 specialty credits, plus other cores if needed; four semesters or more	$850.5/credit; $28,917	Integrated role	http://nursing.osu.edu/sections/academic-programs/masters-program-overview/graduate-specialties-introduction/adult-psychiatric-mental-health-nurse-practitioner.html
St. Louis University (SLU)	MSN or NP	Online with two onsite visits during program	18–24 credits are typical for NPs; three to four semesters (phone inquiry)	$1050/credit; $18,900–$25,200	General	http://www.slu.edu/nursing/majors-and-degrees/post-masters-nurse-practitioner-certificate-(post-msn-np-certificate)
University of Cincinnati (UCC)	MSN or NP	Online with 2-day onsite visit first semester	17–20 credits for NPs; four semesters	$739/credit; $12,563–$14,780	Integrated role	http://nursing.uc.edu/academic_programs/post-master_s_certificate/psych-mental-health.html
University of Michigan - Flint (UM-Flint)	NP	Entirely online	20 credits minimum; four semesters	$795.5/credit; $15,910 minimum	General	http://www.umflint.edu/graduateprograms/nursing-certificate

(Continued)

Table 1 continued

University	Types of students	Online/onsite	Semester credits	Tuition (out-of-state)	Emphasis	Website
University of Nebraska Medical Center (UNMC)	MSN or NP	Entirely online	20 credits for NPs; three or four semesters	$933.25/credit; $18,665–$32,663	Rural	http://www.unmc.edu/nursing/programs/postmasters-pmc/postmasters-options/psychiatric-mental-health-np-pmc.html
University of South Carolina (USC)	MSN or NP	Online with two onsite visits during clinical practicums	18 credits for NPs; three or more semesters	$625/credit; $11,250	General	http://www.sc.edu/study/colleges_schools/nursing/academic_programs/graduate_programs/certificate_programs/psychiatric_mental_health_nurse_practitioner.php
University of Southern Alabama (USA)	MSN or NP	Online with onsite campus orientation	24 credits for NPs; four semesters	$892/credit; $21,408	General	http://www.southalabama.edu/colleges/con/msn/fampsynp.html
University of Virginia (UVA)	MSN or NP	Online or onsite; all classes synchronous	23 credits for certified NPs; four semesters	$1326/credit; $30,498	Rural	http://www.nursing.virginia.edu/programs/pmhpost/
Washburn University (WU)	ANP or FNP	Entirely online	20–23 credit hours; 4 semesters	$522/credit; $10,440–$12,006	General	http://www.washburn.edu/academics/college-schools/nursing/grad/pmhnp/program-overview.html
Wilkes University	MSN or NP	Online with 3-day onsite residency for health assessment course; onsite visit for other clinical courses is up to faculty	24–27 credits; 18 months or more	$625/credit; $15,000–$16,875	General	http://www.wilkes.edu/academics/graduate-programs/masters-programs/nursing/nursing-ms/psychiatric-mental-health-nurse-practitioner/index.aspx

Note. The data were available on school websites or verified by phone as of February 10, 2016. Approximated tuition is based on published cost/credit for nonresidents. State schools may offer programs to residents at a substantially lower cost. Tuition does not include a variety of required fees. Programs not included were those that are primarily hybrid programs that require more than two campus visits per semester or face-to-face courses on campus.

environment with the exception of UVA that combines its face-to-face and online cohorts.

The range of credits for students seeking a second NP specialty was 13–34. Programs with mixed MSN and NP students did not all specify how many credits would be required for the credentialed NPs. Where it was not clear, we called the admissions or program office to inquire. Assuming that most NPs entering a postgraduate certificate program have taken the core NP courses, the lowest credit option was used in the calculation of program cost. The cost ranged from $10,440 (Washburn) to $30,498 (UVA), with an average cost across programs of $17,644. On their websites, four programs emphasized rural health care (EKU, Husson, UNMC, UVA) and three emphasized an integrated role (JHU, OSU, UCC) for dually credentialed APRNs.

Discussion

Across the United States, we found 15 online postgraduate PMHNP programs that are available to NPs seeking an additional specialty. These programs bring the education and training to the student in his or her geographic area with minimal necessity to travel to the educational institution. With online education, rural NPs do not need to quit their jobs or relocate, increasing the potential for retention in their own communities. Increasing the number of PMH-NPs who can provide comprehensive and integrated mental healthcare services in rural areas will improve availability and access. Developing a cadre of dually credentialed NPs who can function in an integrated role additionally increases the availability of preceptors and educators who will enhance the capacity of the mental healthcare system.

Although this study only focused on online programs, there are rural states and universities that offer onsite dual or postgraduate programs with a focus on integrated care for rural populations (e.g., Hulme, Houfek, Fiandt, Barron, & Muhlbauer, 2015). For nurses that live in nearby areas, these are excellent options. In addition, there are hybrid or block-design programs that offer much of their education online. There may also be online options that were not identified through our search strategies. Although 15 distance programs may not be enough to solve the problem of access to mental health care in rural areas, it is a promising start.

Future challenges for rural mental health programs include finding practicing primary care NPs, currently working in mental health HPSAs who are ready, willing, and able to make a commitment to the provision of mental healthcare services in their communities. This process involves tracking mental health workforce needs, developing university-based mental healthcare system relationships in workforce shortage areas, and collaborating to find scholarships, loan repayment programs, and other funding sources to encourage primary care NPs to develop dual competencies and certification. The average cost of the online postgraduate programs was $17,664. This amount of money may present a barrier to many otherwise interested NPs. Other challenges include establishing partnerships with appropriate training sites and providers that will make available the clinical opportunities for the development of the psychiatric mental health competencies (Population-focused Competencies Task Force, National Organization of Nurse Practitioner Faculties, 2013). Outcome measures of importance include pass rates on the American Nurses Credentialing Center (ANCC) PMHNP certification exam, practice location and setting after PMHNP certification, delivery of integrated mental healthcare services, and availability and desire to share mental health competencies with fellow colleagues or future students.

Conclusions

Rural Healthy People 2020 identifies APRNs as having "great potential to be a solution to the shortage of mental health workers in rural areas" (Ferdinand et al., 2015, p. 63). Online PMHNP programs could achieve this goal in a relatively short time period given that the addition of a PMHNP specialty can take as few as three semesters. Postgraduate programs can be taken before, during, or after a DNP program. Online programs play an important role in providing access to NPs in rural areas and therefore greater access to comprehensive mental health care. Outcome assessment will help us determine whether bringing mental healthcare education to NPs working in rural areas and mental health HPSAs through distance education is a sustainable approach to workforce development. For now, there is a need and value in these programs. NPs with dual competency and certification in mental and physical health care can function in an integrated role, treating the whole person.

Acknowledgments

Karan Kverno is the primary author. She developed the concepts, collected and analyzed most of the data, and wrote most of the manuscript. Kate Kozeniewski helped with data collection and analysis and edited and contributed to the manuscript.

References

American Association of Nurse Practitioners. (2015). *NP facts*. Retrieved from https://www.aanp.org/all-about-nps/np-fact-sheet

Buerhaus, P. I., DesRoches, C. M., Dittus, R., & Donelan, K. (2015). Practice characteristics of primary care nurse practitioners and physicians. *Nursing Outlook, 63*(2), 144–153.

Campbell, N., McAllister, L., & Eley, D. (2012). The influence of motivation in recruitment and retention of rural and remote allied health professionals: A literature review. *Rural and Remote Health*, 12(1900), 1–15. Retrieved from http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=1900

Centers for Disease Control and Prevention (CDC). (2013). *Mental health surveillance among children—United States, 2005–2011*. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm

Costello, E. J., He, J. P., Sampson, N. A., Kessler, R. C., & Merikangas, K. R. (2014). Services for adolescents with psychiatric disorders: 12-month data from the national comorbidity survey-adolescent. *Psychiatric Services (Washington, D.C.)*, 65(3), 359–366. doi:10.1176/appi.ps.201100518

Croze, C. (2015). *Healthcare integration in the era of the Affordable Care Act*. Washington, DC: Association for Behavioral Health and Wellness. Retrieved from http://www.integration.samhsa.gov/integrated-care-models/Healthcare_Integration_In_the_Era_of_ACA.pdf

Druss, B. G., & Walker, E. R. (2011). *Mental disorders and medical comorbidity* (Research Synthesis Report No. 21). Princeton, NJ: Robert Wood Johnson Foundation. Retrieved from http://www.integration.samhsa.gov/workforce/mental_disorders_and_medical_comorbidity.pdf

Ferdinand, A. O., Madkins, J., McMaughan, D., & Schulze, A. (2015). Mental health and mental disorders: A rural challenge. In J. N. Bolin, G. Bellamy, A. O. Ferdinand, B. Kash, & J. W. Helduser (Eds.), *Rural healthy people 2020: A companion document to Healthy People 2020* (Vol. 1, pp. 55–72). College Station, TX: Texas A&M University Health Science Center, School of Public Health, & Southwest Rural Health Research Center. Retrieved from: http://sph.tamhsc.edu/srhrc/rhp2020.html

Hanrahan, N. P., Delaney, K. R., & Stuart, G. W. (2012). Blueprint for development of the advanced practice psychiatric nurse workforce. *Nursing Outlook*, 60(2), 91–104. doi: 10.1016/j.outlook.2011.04.007

Hulme, P. A., Houfek, J. F., Flandt, K., Barron, C., & Muhlbauer, S. (2015). Educating integrated family/psychiatric-mental health nurse practitioners: Program development and evaluation. *Journal of Nursing Education*, 54(9), 493–499. doi:10.3928/01484834-20150814-03

Kippenbrock, T., Lo, W.-J., Odell, E., & Buron, B. (2015). Southern states: NPs made an impact in rural and healthcare shortage areas. *Journal of the American Association of Nurse Practitioners*, 27(12), 707–713. doi:10.1002/2327-6924.12243

Population Health Institute. (2016). *Mental health providers, 2016 County Health Rankings*. University of Wisconsin and Robert Wood Johnson Foundation. Retrieved from http://www.countyhealthrankings.org/measure/mental-health-providers

Population-focused Competencies Task Force, National Organization of Nurse Practitioner Faculties. (2013). *Population focused nurse practitioner competencies*. Retrieved from https://c.ymcdn.com/sites/www.nonpf.org/resource/resmgr/Competencies/CompilationPopFocusComps2013.pdf

Sharp, D., Bond, M., Check, K., & Wolff, H. (2015). *Quality of life impacts the recruitment and retention of rural health care providers*. National Rural Health Association Policy Brief. Retrieved from http://www.ruralhealthweb.org/go/left/policy-and-advocacy/policy-documents-and-statements/official-nrha-policy-positions

Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). *Results from the 2012 national survey on drug use and health: Mental health findings* (HHS Publication No. (SMA) 13-4805). Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA)–Health Resources and Services Administration (HRSA). SAMHSA-HRSA Center for Integrated Health Solutions. Retrieved from http://www.integration.samhsa.gov

Thomas, D., MacDowell, M., & Glasser, M. (2012). Rural mental health workforce needs assessment—A national survey. *Rural Remote Health*, 12, 2176. Retrieved from http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=2176

U.S. Department of Health and Human Services, Health Resources and Services Administration. (2010). *Distribution of U.S. health care providers residing in rural and urban areas*. National Center for Health Workforce Analysis. Retrieved from http://bhw.hrsa.gov/healthworkforce/supplydemand/nchwafactsheet.pdf

Watanabe-Galloway, S., Madison, L., Watkins, K. L., Nguyen, A. T., & Chen, L. (2015). Recruitment and retention of mental health care providers in rural Nebraska: Perceptions of providers and administrators. *Rural and Remote Health*, 15, 3392. Retrieved from http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=3392

Weinhold, I., & Gurtner, S. (2014). Understanding shortages of sufficient health care in rural areas. *Health Policy*, 118(2), 201–214. doi:10.1016/j.healthpol.2014.07.018

World Health Organization (WHO). (2013). *Mental health action plan 2013–2020*. Geneva, Switzerland: WHO Press. Retrieved from http://www.who.int/mental_health/action_plan_2013/en/

Xierali, I. M., Tong, S. T., Petterson, S. M., Puffer, J. C., Phillips, R. L., Jr, & Bazemore, A. W. (2013). Family physicians are essential for mental health care delivery. *Journal of the American Board of Family Medicine*, 26(2), 114–115. doi:10.3122/jabfm.2013.02.120219

Pediatric Primary Care Mental Health Specialists

Strengthening Access to Care

Adele Foerster, MSN, RN, CPNP-PC/AC
Chief Credentialing Officer, Pediatric Nursing Certification Board

About Adele

- Retired Army Nurse Corps Officer
- Pediatric nurse or nurse practitioner since 1977
- Oversight for all PNCB exam & CE content development, processes, and accreditation
- As needed (PRN) PNP practice at Holy Cross Emergency Department

About PNCB

- Largest certification board for pediatric nursing
- Established in 1975 by AAP and NAPNAP
- 42,000+ actively certified RNs and APRNs
- 5 certifications offered
  - 16K CPNP - nurse practitioner / required in 46 states
    - Primary care or acute care or dual
  - 4K+ CPEN - emergency - RN / voluntary
  - 23K CPN - general - RN / voluntary
  - 315 PMHS - BMH specialty - APRN / voluntary
    - launched 2011, candidates increasing each year
    - 9 PMHSs in Maryland, 1 testing in May

You know the numbers...

- 17.1 million young people have or had a diagnosable psychiatric disorder. [1]
- How many youth not getting treatment? [1]
  - 40% with ADHD
  - 80% with anxiety
  - 60% with depression
- One-third of all US outpatient pediatric mental health concerns seen by PCPs only. [2]

[1] [illegible], Child Mind Institute, 2015.
[2] [illegible] - AAP, November 2015

Evolving to meet the need

- IOM Future of Nursing:
  - *Nurses should practice to the full extent of their education and training.*
- NONPF NP Competencies:
  - PNP: *Conducts age appropriate comprehensive advanced physical, mental and developmental assessment across pediatric age groups ... Provides the full spectrum of health care services.*
  - FNP: *Provides the full spectrum of health care services across the life span ... developmental and behavioral screening, physical exam and mental health evaluations.*
- APRN Consensus Model:
  - *In addition, specialties can provide depth in one's practice within the established population foci... New specialties emerge based on health needs of the population.*
- PNCB Needs Assessment Survey
  - "Would you like national validation of specialty expertise?"

What is the PMHS credential?

- *Pediatric Primary Care Mental Health Specialist*
- Developed after role delineation study of APRNs
  - Which disorders and tasks? How often? What tools, medications, and collaboration?
- Builds upon APRN DBMH role/competencies to provide advanced assessment, evaluation, diagnosis, and treatment of common behavioral and mental health problems in children and adolescents.
  - Above but not in place of foundational certification of PNP, FNP, PMHNP, or PMHCNS
- Secure national specialty board exam
- Validates added expertise self-acquired within the scope of foundational role
- Communicates expertise to families, community, and other healthcare roles
- Renews every 3 years: 45 contact hours in specialty (15 – peds psychopharm)

What exactly is the role?

- May see all BMH, or may see BMH along with other primary care concerns.
- Early identification, intervention, and collaboration of care for BMH concerns typically seen in primary care.
- Assessment, diagnosis, and management of BMH concerns. When needed, PMHSs also help patients and their families manage these concerns until specialized care is available.
- For complex disorders, therapeutic services include early recognition, intervention, and active monitoring as well as appropriate referral.
- Evidence-based health care services uses BMH screening tools, brief psychotherapeutic interventions, and psychopharmacology.
- Plays a role in collaboration and coordination of care with other professionals in medical and educational settings.
- Usually bills with PC codes; some isolated success with MH codes.

What it isn't

- Does not expand the licensed role beyond foundational education/certification/licensure scope
- Does not include talk therapy/counseling unless the PMHS also has that education and license
- Does not extend to severe disorders (e.g., schizophrenia) unless practitioner is also a PMHNP or PMHCNS
- Not inpatient or psychiatry setting unless the PMHS is an APRN managing BMH within primary care scope or a PMHNP or PMHCNS
- Is not intended to replace other roles providing this specialty care

What knowledge does it test?

- 150 questions / 2.5 hours
- All questions rely on DSM information reference DSM-5

Mental Health Assessment and Promotion	(40%) = 60 test questions
Diagnostic Decision Making	(27%) = 34 test questions
Management	(30%) = 37 test questions
Professional Issues	(3%) = 4 test questions

What knowledge does it test?

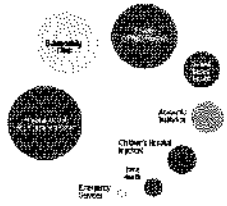
Diagnosed	Managed	Co-Managed	Referred

• ADHD
• Elimination Disorders
  - Enuresis
  - Encopresis
• Mood Disorders
• Disruptive Disorders
  - Aggressive/Irritability
  - Oppositional Behavior
• Anxiety Disorders
• Relational Problems – Parent/Child/Sibling
• Depressive Disorder NEC
	• ADHD
	• Elimination Disorders
	  - Enuresis
	  - Encopresis
	• Depressive Disorder, Mild
	• Aggressive/Irritability
	• Oppositional Defiant Disorder
	• Relational Problems – Parent/Child/Sibling
	• Generalized Anxiety Disorder
		• ADHD
		• Autism Spectrum Disorder
		• Oppositional Defiant Disorder
		• Conduct Disorder
		• Aggressive/Irritability
		• Relational Problems – Parent/Child/Sibling
		• Generalized Anxiety Disorder
			• Substance-related Disorders
			  - Hyperactivity
			  - Withdrawal
			  - Intoxication
			• Sleep/Wake Disorders
			  - Obstructive Sleep Apnea Hypopnea
			• Major Depressive Disorders
			  - Moderate
			  - Severe
			• Bipolar and Related Disorders
			  - Bipolar I Disorder with Psychotic Features
			• Feeding and Eating Disorders
			  - Anorexia Nervosa
			  - Bulimia Nervosa
			  - Binge Eating Disorder
			• Gobolo Syndrome
			• Tic Disorders
			• Specific Learning Disorder

Profile of successful testers

- A minimum of 1,000 hours of APRN primary care BMH clinical practice experience within the past 2-3 years
- Earned APRN continuing education / contact hours in pediatric behavioral mental health
- Earned APRN pediatric psychopharmacology contact hours
- Have prescriptive privileges in their state that include Schedule II medications such as stimulants

Major practice settings



A sampling of unique settings:

- Pain
- Endocrine
- Neurology
- Non-profit
- Military
- Community mental health center
- Mobile community health bus
- Psychiatric practices

What does a PMHS often see?

PMHS: benefits to patients

Care is

- Timely
- Usually in a familiar setting
- Cost-appropriate
- Coordinated
- Managed over time for continuity and improved outcomes

How PMHSs Improve Access to Care

Potential Barriers

- Newer credential as yet unfamiliar to insurance carriers and employers
- Medicaid reimbursement for pediatric BMH codes to only nurse practitioners who have the Psych MH certification: PMHNP
  - North Carolina
  - Kentucky
  - Maryland
- Employers not allowing APRNs to practice to the fullest extent of their education and training
- States not allowing APRNs to prescribe Schedule II medications

Rural PMHS Success Story #1

- Route to PMHS: PNP
- Rural Maryland solo nurse practitioner practices in an area with a 3- to 5-month waiting list to see a psychiatrist
- Issues commonly seen: depression, anxiety, ADHD, and ODD
- Concentrates solely on these concerns
- Works under a non-profit tax ID number
- Collaborates with a case management organization, mental health clinics, and a therapist in the community

"I help the community access specialty care more quickly and easily."

Rural PMHS Success Story #2

- Route to PMHS: FNP + mental health CNS
- Large rural Pennsylvania practice
- Evaluates and treats: depression, anxiety, ADHD, Asperger's, tic disorders
- Initiates treatment for: new onset bipolar/psychotic disorders and autism
- Provides pharmacotherapy and brief psychosocial interventions

"PMHS communicates my unique expertise as a primary care provider with added expertise in the evaluation and treatment of mental health disorders, as well as more comprehensive health promotion."

Parting thoughts

Viewing the patient as a whole, both physically and mentally, is the very essence of our nursing paradigm.

Innovation is born of crisis

- What creative models of integrative care can help rural Maryland?
- Consider how PNPs and PMHSs can support your telemedicine initiative.
- How can PNCB support your goals?
- Any questions?

RMC Health Care Committee Meeting
June 7, 2016
1:00 pm to 3:00 pm
Maryland Department of Agriculture, 50 Harry S Truman Parkway, Annapolis
Agenda

Invited participants: Members of the RMC Health Care Committee
Tom McLoughlin, Chair
Charlotte Davis, Executive Director
Meredith Donaho, RMC Administrative and Communications Aide

I. Welcome and Introductions — Tom McLoughlin

II. Review and Adoption of the May 3, 2016 meeting minutes

III. Featured Guest Speakers

a. Dr. Nicole Gloff, Assistant Professor, University Maryland School of Medicine
b. Kelly Coble, LCSW-C
Instructor, Division of Child and Adolescent Psychiatry
Program Director, Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP)
University of Maryland School of Medicine

IV. Review of proposed Health Care portion of the Rural Maryland Prosperity Investment Fund

V. Update of school-based mental health care conversation and recent Maryland Assembly of School-Based Health Care Centers Annual Conference

VI. Other Issues

VII. Adjourn

Next Meeting: September 6, 2016, 1:00 pm to 3:00 pm

RMC Health Care Committee Meeting
June 7, 2016
Maryland Department of Agriculture, Annapolis
Minutes

Participants: Tom McLoughlin, Charlotte Davis, John Kornak, Temi Oshiyoye, Roxanne Hale, Justine Springer, Karen Kverno, Jennifer Witten, Meredith Donaho

Guest Speakers: Dr. David Pruitt, Dr. Nicole Gloff, Kelly Coble

The meeting convened at approximately 1:10 pm.

Chairman McLoughlin called the meeting to order and welcomed participants.

I Action on Minutes
The minutes from the May 3, 2016 meeting were presented for review. There being no comments, questions or corrections and upon motion properly made and seconded, the minutes were unanimously accepted as distributed.

II Behavioral Health Integration in Pediatric Primary Care (BHIPP) Presentation
Dr. Pruitt introduced his colleagues who provided an overview of current resources available to meet the needs of rural children and adolescents in need of treatment for mental health.
In their presentations, Dr. Gloff, and Ms. Coble advised that the program is a telehealth service accessible by telephone or video conferencing to support the efforts of primary care providers in assessing and managing the mental health needs of their patients from infancy through the transition to young adulthood. It is a consulting service for primary care physicians consisting of four main components including phone consultation, continuing education, resource & referral networking, and social work co-location. Its consultants connect primary care providers with appropriate resources in the community or provide general education on topics such as trauma and adverse experiences, substance abuse, developmental delays, behavioral and learning difficulties. It was also mentioned that BHIPP is a collaboration effort among the University of Maryland School of Medicine, Johns Hopkins Bloomberg School of Public Health, and Salisbury University.

After their presentations and following a question and answer session, Dr. Gloff and Ms. Coble were thanked and excused from the balance of the meeting.

III RMPIF – Rural Health Care Organizations
A copy of the guidelines and overview portion for rural health care organizations for RMPIF was distributed to the Committee. Charlotte Davis asked for the Committee to review and provide their suggestions and feedback. No suggestions or changes were provided.

IV Other Updates
The Chair reported that the letters to the rural primary care physicians reviewed by the Committee at its last meeting will be sent within the next two weeks. Staff has acquired a database of names and is currently preparing the mailings. The letters will encourage increased utilization of the Healthy Kids/EPSDT program as well as provide information on the Committee's short term objectives related to adolescent depression. Additionally, similar letters will be sent to rural School Superintendents plus the Chairs of the Local Health Improvement Councils for their information and input.

The Chair also called attention to activities at the Federal level that referenced a topic previously discussed briefly as a potential long range topic. In an article, copy of which was previously distributed, it mentioned that the Senate was discussing the use of technology enabled collaborative learning and capacity building models to improve HHS programs. The proposed legislation being discussed is entitled “Expanding Capacity for Health Outcomes Act (ECHO Act)” and sponsored by Senators Hatch and Schatz. It might be appropriate for the Committee to monitor that legislative process before considering any long-term commitment at this time.

V Adjourn There being no further business to be brought to the Committee's attention, the meeting was adjourned at approximately 2:35 pm.

Next Meeting: Tuesday, September 6, 1pm-3pm, Location: Maryland Department of Agriculture, Conference Room 110.

UNIVERSITY of MARYLAND SCHOOL OF MEDICINE

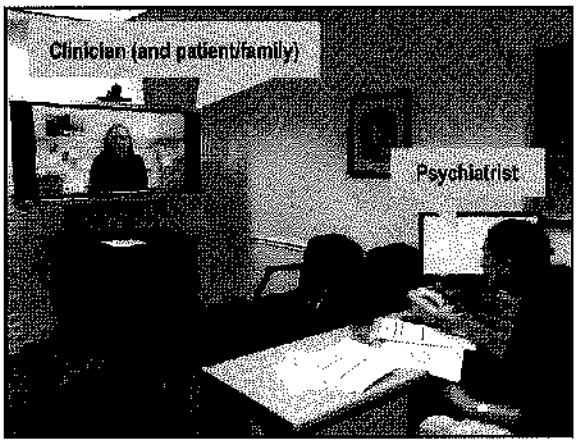
Increasing Access to Care: Telemental Health at the University of Maryland

Nicole Gloff, M.D. and Kelly Coble, LCSW-C

June 7, 2016

What is Telemental Health?

- The use of video teleconferencing to deliver mental healthcare or education at a distance
  - Interactions using live audio/video
  - i.e. a counselor and a student consulting with a psychiatrist in real time



Why telemental health?

- Improves ***access to care***
  - Timely access to locally unavailable services
  - Spared burden/cost of transportation
  - Addresses workforce shortages
- Convenience
- Cost
- Patients like it!
  - High satisfaction ratings
  - Some prefer TMH – youth, anxiety, ASD
- Multidisciplinary team can be in multiple settings and come together at once
  - Collaboration better than in-person

Exceptions: Safety concerns, patient refusal

Confidentiality and Privacy

- Important issue in TMH
  - Transmission of video/audio data
  - Audio/visual privacy at patient and provider site
- Technology
  - Systems and data storage must be in compliance with HIPAA

What is the evidence?

- Services delivered through TMH are <u>feasible</u>, <u>acceptable</u>, have been delivered across developmental status, and to youth with varied disorders
- Early work suggests that <u>outcomes are comparable</u> to services delivered in-person

What is the evidence?

- Satisfaction
  - High patient satisfaction ratings
- Rapport/Therapeutic alliance
  - High satisfaction suggests that a solid therapeutic alliance develops
- Safety
  - *Traditional outpatient model* – on-site staff assist with safety issues, SOPs
  - *Home-based* – Safety plan, high risk patients may be inappropriate, patient location must be known

Elford et al., 2001; Greenberg et al., 2006; Luxton et al., 2012; Myers et al., 2007, 2008

UNIVERSITY of MARYLAND SCHOOL OF MEDICINE

Sites of Service and Providing Care

Primary Care

- PCPs more often becoming default mental health providers
- Consultative and collaborative models support PCPs in building skills to provide metal healthcare to children
  - Increases the pool of mental health expertise
- High levels of satisfaction
- Promise for integration into the pediatric medical home model of care

American Academy of Pediatrics, 2002; Bird et al., 2001; Duffett et al., 2007; Connor et al., 2006 2010; Greenberg et al., 2006; Myers et al., 2008

Background and Significance

- Gap between the *need* for and the *availability* of child and adolescent mental health services
- Lack of access to mental health care for children and adolescents is particularly evident in rural or remote communities where access to evidence-based mental health treatments is limited, with some areas having no access at all

Burns et al., 1995; Essau, 2005; Merikangas et al., 2010; Wu et al., 2001; Birk, Dempsey, & Hartley, 2003; Connor et al., 2006.

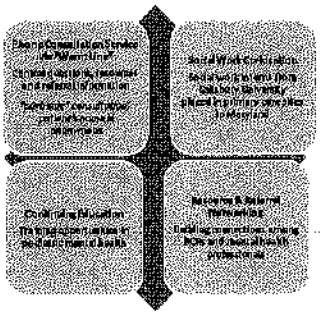
MD BHIPP

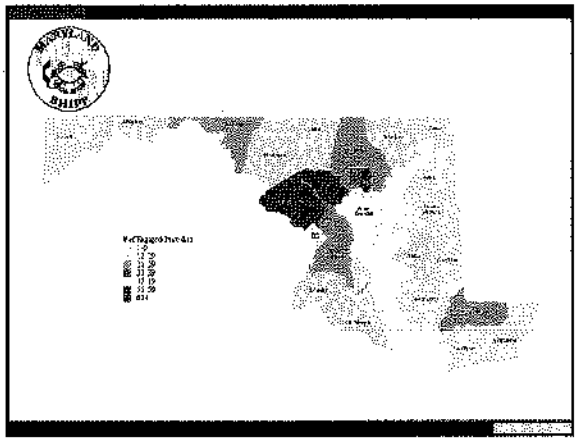
- Developed to help support the efforts of primary care providers to assess and manage the behavioral health needs of their patients from infancy through the transition to young-adulthood
- In collaboration with University of Maryland School of Medicine, Johns Hopkins Bloomberg School of Public Health, Salisbury University; partnerships with community/advocacy groups
- Piloted Fall 2012, Statewide July 2013

Funding

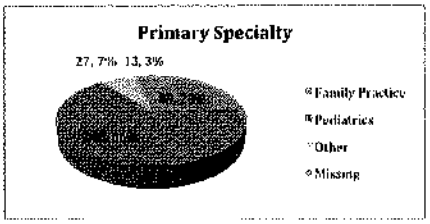
- Made possible through funding from the Maryland Department of Health and Mental Hygiene (DHMH)
  - DHMH/BHA funded statewide initiative for mental health consultation and training program for children and adolescents

Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP)

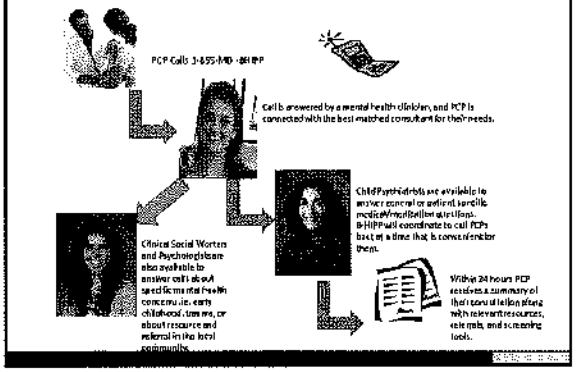




Enrolled Provider Primary Specialty



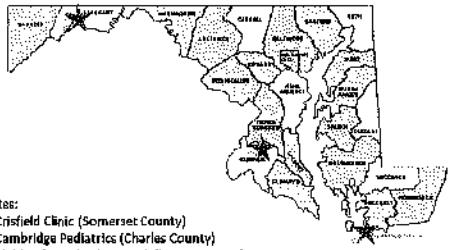
The BHIPP Consultation Process



MD BHIPP Tele Consult

- January 2015 - Integration of telepsychiatry consultation into MD BHIPP
- Aim
  - To further support providers in underserved areas by assisting in diagnosis, assessment and treatment planning
- Model of Care
  - One-time Consultation
    - Patient Centered Consultation
    - Provider Centered Consultation
  - Diagnostic Clarification
  - Medication Specific Recommendations
  - Brief Interventions

MD BHIPP Tele Consult



Pilot Sites:
- Crisfield Clinic (Somerset County)
- Cambridge Pediatrics (Charles County)
- Children's Medical Group (Allegany County)

Educational Settings

- ~70-80% of children and adolescents who receive mental health services access that care in the school setting
- Variety of services:
  - Evaluations, medication management, evaluation for support services, continuing education for staff, consultation on specific and general school issues.
- Advantage of evaluating children in the familiar and ecologically valid setting of school:
  - Minimal disruptions to their classroom time or parents' workday
- Challenges in the school setting:
  - Privacy, adequate space and other infrastructure for the service, especially in overcrowded schools.
- Schools that are able to make these accommodations have demonstrated benefit to youth and educators

Cunningham et al., 2013; Goldstein & Myers, 2014; Grady et al., 2011; Jones & Hoagwood, 2000

School Mental Health Program

- The SMHP provides mental health services in 25 Baltimore City schools to students who would otherwise be ineligible to receive these greatly needed services
- Required rotation for 2nd year fellows
- Strong clinical structure
  - Primary clinician as coordinator
  - Clinician embedded in the school

CSMH
Center for School Mental Health

School Mental Health Program

- October 2014 – Pilot
  - Expansion of telepsychiatry programs to the SMHP
  - Services not limited to medication management
    - Differential diagnosis, psychoeducation, consultation to clinicians and school administration
- School Year 2015-2016
  - Expansion of psychiatric services in 25 Baltimore City schools
    - Increased access to care
    - In past years, several schools did not have access due to limited workforce
  - 3 armed approach
    - Telepsychiatry only, In-person only, Hybrid
  - Inclusion of all 2nd year fellows in experience

CSMH
Center for School Mental Health

Garrett County Health Department

- Consultation, collaborative and direct psychiatric care to children/families in Garrett County (Western MD)
  - Child Psychiatry Fellows supervised by faculty
  - Improves access to care by overcoming barriers of travel
  - Program success
    - Designated staff liaison
    - Ongoing coordination with community resources

Wells House

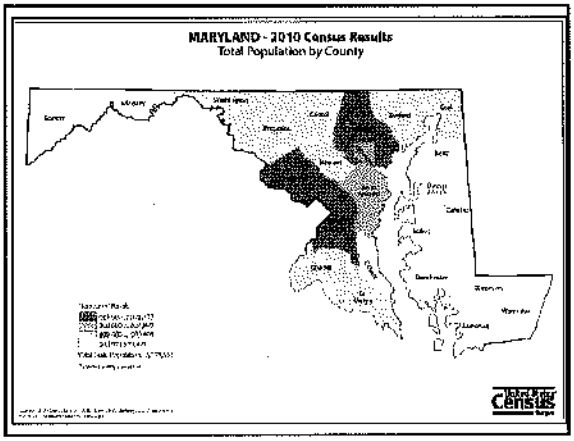
- Wells House, Inc. is a nonprofit facility in Hagerstown that provides substance abuse treatment to adult patients, including suboxone treatment
- Led by Drs. Eric Weintraub and Chris Welch
- Primarily suboxone medication management and consultation to Wells House staff

What have we learned?

- Increased access to care
  - Reaching patients in rural and underserved areas
- Relationships are key
  - Collaboration and integration with other disciplines
  - Therapists, PCPs, school administrators, etc.
- Decreased travel time
- Increased efficiency

What have we learned?

- Challenges
  - Significant practice change for providers
  - Not all patients are suitable for telepsychiatry services
  - Technology



UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

Thank you!

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References

American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. (2001). The new morbidity revisited: a renewed commitment to the psychosocial aspects of pediatric care. *Pediatrics, 108*, 1227-1230.

American Medical Association, Physician Characteristics and Distribution in the U.S. American Medical Association Press, Washington, DC., 2010.

American Psychological Association. APA Survey of Psychology Health Service Providers. 2008. Retrieved from http://www.apa.org/pubs/info/reports/2010-health-service.pdf

Boydell, K. M., Volpe, T., Keates, A. & Greenberg, N. (2007). A review of the outcomes of the recommendations made during pediatric telepsychiatry consultations. *Journal of Telemedicine and Telecare, 13*, 277-281.

Bird, D. C., Dempsey, P. & Merlyn, D. (2004). *Addressing mental health workforce needs in underserved rural areas: Achieving potential and challenges.* Maine Rural Health Research Center, Edmund S. Muskie School of Public Services, University of Southern Maine.

Crone, T., Correy, J. S., Turvey, C. L., Ken, A., & Spargo, G. (2015). Technological considerations for the delivery of real-time child behavioral healthcare. *Journal of Child and Adolescent Psychopharmacology*

Connor, D. F., McLaughlin, T. J., Jeffers-Terry, M., O'Brien, W. H., Side, C. A., Young, K. M. & Antonelli, R. C. (2006). Targeted child psychiatric services: A new model of pediatric primary clinician–child psychiatrist collaborative care. *Clinical Pediatrics, 45*, 425-434.

Cunningham, D. L., Connors, J. H., Lever, N. & Stephan, S. H. (2013). Providers' perspectives: Utilizing telepsychiatry in schools. *Telemedicine Journal and E-Health, 19*, 763-768.

Gelenberg, S. & Myers, K. (2010). Telebehavioral health: A new collaboration for pediatricians and child psychiatrists. *Pediatric Annals, 39*, 79-84.

Elford, D.R., White, H., St John, K., MacMorgan, B., Granger, M. & Browning, R. (2000). A prospective satisfaction study and cost analysis of a pilot child telepsychiatry service in Newfoundland. *Journal of Telemedicine and Telecare, 7*, 73-81.

References

Gloff, N. E., LeNoue, S. R., Novins, D. K., & Myers, K. (2015). Telemental health for children and adolescents. *International Review of Psychiatry, 27*(6), 513-524.

Grady, B., Lever, N., Cunningham, D. & Stephan, (2013). Telepsychiatry and school mental health. *Child and Adolescent Psychiatric Clinics of North America, 22*, 81-94.

Grevenstein, N., Hayden, K.M. & Volpe, T. (2006) Pediatric telepsychiatry in Ontario: Service provider and caregiver perspectives. *Journal of Behavioral Health Services & Research, 33*,105-111

Lawson, O. D., O'Brien, K., McCann, R. A. & Mishkind, M. C. (2013). Home-based telemental healthcare delivery training: What you need to know. *Telemedicine and E-Health, 19*, 628-633.

Myers, K., Valentine, J. M. & Melzer, S.M. (2007). Feasibility, acceptability, and sustainability of telepsychiatry for children and adolescents. *Psychiatric Services, 58*,1493-1496

Myers, K. M., Valentine, J. M. & Melzer, S. M. (2008). Child and adolescent telepsychiatry: Utilization and satisfaction. *Telemedicine Journal and E-Health, 14*, 131-137

Myers, K. M. & Cain, S. (2008). Practice parameter for telepsychiatry with children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*, 1408-1413.

Reese, M. & Hazelwood, K. (2000). School-based mental health services: A research review. *Child and Family Psychologist, 7*, 233-241.

Roth, D.E. Mind and Body Works, Honolulu, HI. http://www.mind-bodyworks.com/telehealth.html

Yellowlees, P., Shore, J., & Roberts, L. (2010). Practice guidelines for videoconferencing-based telemental health - October 2009. *Telemedicine Journal and E-Health, 16*(10), 1074-89. doi:10.1089/tmj.2010.0140

About ECHO

Project ECHO (Extension for Community Healthcare Outcomes) is a collaborative model of medical education and care management that empowers clinicians everywhere to provide better care to more people, right where they live.

The ECHO model™ does not actually "provide" care to patients. Instead, it dramatically increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions such as hepatitis C, rheumatoid arthritis, chronic pain, and behavioral health disorders among many others. It does this by engaging clinicians in a continuous learning system and partnering them with specialist mentors at an academic medical center or hub.

Project ECHO

Project ECHO started as a way to meet local healthcare needs. Sanjeev Arora, M.D., a liver disease doctor in Albuquerque, was frustrated that thousands of New Mexicans with hepatitis C could not get the treatment they needed because there were no specialists where they lived. The clinic where he worked was one of only two in the entire state that treated hepatitis C.

Dr. Arora was determined that all patients in need of treatment should get it. He created Project ECHO so that primary care clinicians could treat hepatitis C in their own communities.

Launched in 2003, the ECHO model™ makes specialized medical knowledge accessible wherever it is needed to save and improve people's lives. By putting local clinicians together with specialist teams at academic medical centers in weekly virtual clinics or teleECHO™ clinics, Project ECHO shares knowledge and expands treatment capacity. The result: better care for more people.

Treatment for hepatitis C is now available at centers of excellence across New Mexico, and more than 3,000 doctors, nurses and community health workers provide treatment to more than 6,000 patients enrolled in Project ECHO's comprehensive disease management programs for myriad conditions. A 2011 study (http://www.nejm.org/doi/full/10.1056/NEJMoa1009370) published in the *New England Journal of Medicine* showed that the quality of hepatitis C care provided by Project ECHO-trained clinicians was equal to that of care provided by university-based specialists.

What's more, Project ECHO has expanded—across diseases and specialties, across urban and rural locales, across different types of delivery services, and even across the globe. Today, Project ECHO operates 39 hubs for nearly 30 diseases and conditions in 22 states and five countries outside the U.S., including sites within the Department of Defense healthcare systems.

Project ECHO: a model for expanding access to addiction treatment in a rural state

Miriam Komaromy, MD
Medical Director, Project ECHO Addiction treatment program
9/12/10

Project ECHO is a program pioneered at the University of New Mexico (NM), designed to expand the capacity of primary care providers (PCPs) working in rural and underserved areas to provide care for common complex diseases such as hepatitis C and addiction. The model is based on training and ongoing support provided to PCPs via weekly tele/video conferences in which didactic presentations are followed by case discussions in which PCPs present challenging clinical cases and get feedback from specialists based at the University and from colleagues around the state. Participation decreases professional isolation and helps PCPs become content experts in the area of focus. The program has been highly successful in expanding access to high-quality treatment for hepatitis C.

In 2006 we launched an ECHO program focused on expanding access to addiction treatment in our large, rural state. NM ranks 2nd in the nation for opioid overdose deaths, and has a multigenerational problem with heroin addiction as well as a burgeoning problem with opioid analgesic addiction. Therefore, our focus has been on expanding access to treatment for opioid addiction, although we have also provided training and support for treatment of alcohol, stimulant, and other types of chemical dependency.

Our program has focused on providing the following services:

1. **Training in the use of buprenorphine**: We have used a hybrid model of training. We have offered 8-hour live trainings in areas all over the state. We have tailored these to state and local needs, and have included a focus on harm-reduction/overdose prevention, education about local resources, and live patient panels, as well as more traditional pharmacology and clinical use issues. Some participants have participated in these trainings via teleconference. We have also provided PCPs with the buprenorphine training DVD from the American Association of Addiction Psychiatrists' online certification program as the formal mode of training. At the end of each training we assist physicians in completing the online certification application. The trainings are free of charge, and we offer free CME/CEUs. Since 2006 we have trained 156 physicians and 62 midlevel providers, and a total of 352 trainees (also including RNs, pharmacists, counselors, and administrators). Our program has trained approximately 60% of the total 258 physicians currently certified to prescribe buprenorphine in NM, and we currently rank 5th in the nation for number of certified physicians in the US (the only southwestern state in the top 10).
2. **Weekly teleconference to provide ongoing support for PCPs offering addiction treatment**: Since 2006 we have conducted a weekly 2-hour teleconference focused on addiction treatment. We offer free CME/CEUs for participation. Partipating faculty include an Internist/Addiction specialist, a psychiatrist, a public health nurse, and a therapist. More than 536 clinical cases have been presented. Participants from 42 different communities have joined the

teleconference since 1/08 (see map at the end of this report). There were 79 participants in 2008, 130 in 2009, and 111 so far in 2010. In 2010 alone we have offered 29 didactic presentations on a wide variety of topics including compulsive gambling, medical marijuana, trauma-informed treatment of women, traumatic brain injury, grief counseling, urine drug testing, and mindfulness-based treatment of addiction.

3. Local conferences and grand rounds presentations on addiction-treatment topics: We have found that establishing local connections is crucial for expanding interest in treating addiction. Making live presentations to local PCPs also helps develop mentorship relationships, and the ECHO addictions faculty have fielded more than 800 consultation calls from local providers in the last 4 years.
4. Producing educational materials for use in recruiting PCPs to provide addiction treatment and patients to engage in treatment. We have produced a DVD with the local educational television station that we have used for recruiting PCPs to participate in opiate addiction treatment. We have also worked with an independent filmmaker and the NM Department of Health to collaborate on the production of DVD aimed at incarcerated individuals, educating them about the risk of opiate overdose death after release and about the effectiveness and availability of treatment.
5. Monitoring patient care: as part of the process of co-managing patients with PCPs we monitor patient logs submitted by some of the ECHO-trained and supported PCPs, and give feedback on the process of care. To date we have received logs on approximately 1700 patients on buprenorphine, indicating that we have had a substantial impact on improving access to opiate addiction treatment.
6. In summary, the ECHO addiction treatment program has succeeded in raising interest and awareness about the problem of addiction, and expanding the availability of high-quality addiction treatment in this poor, rural state.

TELEHEALTH POLICY UPDATES

Sen. Hatch & Schatz Propose Studies to Prove Project ECHO Effectiveness

Last week Senators Hatch and Schatz released language for the Expanding Capacity for Health Outcomes Act (ECHO Act), a bill that would require studies and reports examining the use of technology enabled collaborative learning and capacity building models to improve programs of the Department of Health and Human Services (DHHS). The bill requires the Secretary to examine the models and their ability to improve patient care and provider education. The bill specifies that the examination must include a number of topic areas such as mental health and substance use, chronic care, specialty care shortages, and health care in rural areas, among others. The Secretary (in collaboration with the Health Resources and Services Administration) would then be required to publish a study that analyzes the use, impact, and barriers of such a model, and make recommendations.

The bill would also require the Comptroller General of the US to prepare and publish a similar report, with a focus on the model's adoption in state and federal government programs. The Comptroller would then be required to submit a report to Congress regarding how the findings of the report have been addressed, recommendations to congress, a list of technology-enabled collaborative learning and capacity building models funded by DHHS and a toolkit of best practices for the model's implementation.

RMC Health Care Committee Meeting

September 6, 2016
1:00 pm to 3:00 pm
Maryland Department of Agriculture, 50 Harry S Truman Parkway, Annapolis
Agenda

Invited participants: Members of the RMC Health Care Committee
Tom McLoughlin, Chair
Charlotte Davis, Executive Director
Meredith Donaho, Program Administrator

I. Welcome and Introductions — Tom McLoughlin

II. Review and Adoption of the June 7, 2016 meeting minutes

III. Featured Guest Speaker

a. Walter Sallee, Health Care Specialist, Maryland State Department of Education

IV. MAERDAF and RMPIF Grant Update

V. MRHA Grant Update

VI. State Office of Rural Health's Maryland Rural Health Plan Update

VII. Maryland Health Care Commission's Work Group on Rural Health Care Delivery Update

VIII. Other Issues

IX. Adjourn

Next Meeting: October 4, 2016, 1:00 pm to 3:00 pm, Conference Call

RMC Health Care Committee Meeting
September 6, 2016
Maryland Department of Agriculture, Annapolis
Minutes

Participants: Tom McLoughlin, Chair; Charlotte Davis, Rural Maryland Council; Lara Wilson, Maryland Rural Health Association; Kerry Palakanis, Crisfield Clinic; Justine Springer, Maryland Department of Health and Mental Hygiene; Dr. David Pruitt, University of Maryland School of Medicine; Holly Ireland, Mid-Shore Behavioral Health; Karen Kverno, Johns Hopkins University; Meredith Donaho, Rural Maryland Council

Guest Speakers: Walter Sallee, Maryland State Department of Education; Alicia Mezou, Maryland State Department of Education

The meeting convened at approximately 1:15 pm.

Chairman McLoughlin called the meeting to order and welcomed participants.

I Action on Minutes
The minutes from the June 7, 2016 meeting were presented for review. Dr. Pruitt requested that the name Dr. Wolf be revised correctly to Dr. Gloff. No other comments or suggestions were made. Upon Motion properly made and seconded, the minutes were accepted as amended.

II Department of Education Interaction with School Based Health Center Programs Presentation
Mr. Walter Sallee, Health Care Specialist, Maryland State Department of Education, and Ms. Alicia Mezou, School Health Services, Maryland State Department of Education, provided an overview of the Maryland School Based Health Centers Program. It was explained that SBHCs are health centers located in schools or on school campuses and provide onsite comprehensive preventive and primary health services. Staffed by professionals with prescriptive authority, the centers provide primary care services related to lab work, diagnosis, dental, psychiatric, and school safety.

Following their presentations, there was extended discussion., Included among the topics addressed was the awareness that the local health department or the local board of education is usually the service provider. However, the service delivery model varies across the state, and is sometimes shared between the local health department and local school board. Thirteen programs in Maryland are currently offered by the local board of education, and in one jurisdiction it is provided by the local hospital. Also mentioned was the role of School Counselors in areas where no SBHC is located.

Responding to another question regarding locations, it was pointed out that SBHC contacts are listed on the website: www.marylandsbhc.org. Additional information can be obtained from the Maryland Assembly of School Based Health Centers, a state agency representing SBHCs, at its website: http://masbhc.org/.

In summation, Ms. Mezou and Mr. Sallee offered their assistance in furthering the Committee's efforts and suggested that its members consider attendance at future interdisciplinary meetings for school based clinics. Also they will make available additional data related to SBHC's activities in mental health care services and the different levels provided. Upon receipt of the data, it will be presented as an agenda item and reviewed at the next Committee meeting.

After the question and answer session concluded, Ms. Mezu and Mr. Sallee were thanked for their presentations and excused from the balance of the meeting.

III MAERDAF and RMPIF Grant Update

Charlotte Davis, Executive Director of the Rural Maryland Council, provided an update concerning the FY17 MAERDAF and RMPIF grant programs. MAERDAF received a total of ninety-five applications requesting $2,026,212.28 in funds; $555,917 in funds were available. Forty-two organizations received funding, ten of the organizations were health care, including: Allegany Right; Asian American Center of Frederick; Chesterwye Center, Inc.; Compass Hospice Regional; Crossroads Community, Inc.; Eastern Shore Area Health Education Center; For All Seasons, Inc.; MAC, Inc.; MedStar St. Mary's Hospital; and, Women Supporting Women. Forty-three RMPIF applications have been received, including seventeen health care focused applications. The RMPIF applications are currently in the review process.

IV State Office of Rural Health's Maryland Rural Health Plan Update

Lara Wilson provided an update on the Maryland Rural Health Plan reporting that her agency, MRHA, has contracted with the Maryland Department of Health and Mental Hygiene to accept that responsibility. She also advised that MRHA has submitted a proposal for additional funding to RMC, to create a more robust rural health plan by conducting rural listening sessions across the state. That proposal will be presented to the RMC Executive Committee at its meeting on Tuesday, September 13, 2016.

V Maryland Health Care Commission's Work Group on Rural Health Care Delivery Update

It was reported that the Maryland Health Care Commission Work Group convened a meeting on August 29th to discuss health care delivery, specifically focused on the five Mid Shore Counties of the Eastern Shore. Senate Bill 707 – Freestanding Medical Facilities, was the major focus of the meeting including the concept of converting underutilized hospitals to free-standing medical facilitiesas well as barriers to health care access in rural communities, specifically transportation.

VI Other Issues

The Chair reported that the RMC Health Care Committee should be completing its activities by December 2016. He summarized Committee's deliberations since its first meeting in March2015, its identification of the three short term objectives and the efforts developed to address them. He advised that he will draft a final report which will be shared for further input from Committee members prior to the November meeting; then edited for final review at the November meeting and the final report presented at the Committee's December meeting. Thereafter, the formal report will be presented to the Executive Board at its Annual Meeting in December.

VII Adjourn

There being no further business to be brought to the Committee's attention, the meeting was adjourned at approximately 3:05 pm.

Next Meeting: Tuesday, October 4, 1pm-3pm, via Conference Call.

Maryland State Department of Education

School Based Health Centers Program

An Overview: September 6, 2016

About MSDE

- Under the leadership of the State Superintendent of Schools and guidance from the Maryland State Board of Education, the Department develops and implements standards and policy for education programs from pre-kindergarten through high school.

About MSDE

- SBHCs are health centers, located in a school or on a school campus, which provide onsite comprehensive preventive and primary health services.

What are SBHC Programs?

- Health Centers located in schools or on a school campus
- Provide onsite preventive and primary health services, may include:
  - Mental Health
  - Oral Health
  - Ancillary and Supportive Services
- Staffed by a variety of health professionals

Maryland Landscape of SBHCs 2014-2015

78 SBHCs	**28,162** Students Enrolled	**12,571** Students Served
66,792 Visits	**25,459** Somatic Care Visits	**20,297** Mental Health Services
18,491 Case Management Services	**1,545** Oral Health Care	**What Next?**

Operations and Funding

- SBHC Sponsors
  - County Health Departments
  - Federal Qualified Health Centers
  - School Districts
  - Universities
- Operations: Requirements
  - State Standards and Regulations
  - Connection to School Health Services
- Funding Resources

More Information

- SBHC website: www.marylandsbhc.org

Questions????

Thank You!