

## March 2010

### Medical Updates



#### Is Your Doctor Using a Checklist?

*by Lloyd I Sederer, MD, OMH Medical Director; with Jeffrey A. Lieberman, MD, Director, NYS Psychiatric Institute*

Let's face it. Medical care has become a whole lot more complex. The scientific knowledge base and practice of medicine has expanded exponentially as scientists have plumbed the human body and mind to reveal its genetic, molecular, anatomic, physiological and psychological mysteries and developed ever-more sophisticated means to diagnose disease, treat patients and prolong life. Although this acceleration in progress holds great benefits for an individual's health, it poses a daunting challenge to physicians trying to keep up with the latest findings and developments. Who can provide state of the art care and deliver complex treatments to numerous patients day after day without error? No one. It is simply not humanly possible to be error free.

This is the premise wonderfully rendered by Dr. Atul Gawande in his most recent book, *The Checklist Manifesto: How to Get Things Right*. Gawande gets our attention right away by taking us into an Intensive Care Unit (ICU) where as many as 178 procedures, from putting in a urinary catheter to placing a catheter in the vena cava, the major vein leading to the heart, are routinely done; missing a step in any one of these highly complex procedures is no small matter since the consequences are grave, sometimes deadly. You would think that doctors would welcome anything that would help to ensure that they get it right -- including something as simple as a checklist. Sorry, yes is not the answer.

Airlines do it (and their safety record is legendary), builders do it, and even some financial institutions do it. But doctors? Not readily, is Gawande's conclusion. And he is right, proving his point scientifically using the example of the "19 Point Safe Surgery Checklist" that he pioneered through the World Health Organization (WHO). When this checklist was tested in eight very diverse countries it reduced deaths by 47 percent and post-operative complications by 36 percent! To make his case personally, Gawande tells the story of how a patient he was operating on would have died of a complication during surgery had he not used his own checklist. But has this checklist been adopted universally, even if not welcomed? Not at all. Only 10 percent of U.S. hospitals employ or are planning to employ checklists.

The tale of the challenge of checklists has immediacy as OMH develops and pilots a checklist for prescribing antipsychotic

medications. We developed this checklist with a group of experts after evidence became overwhelming that antipsychotic medications, while essential, carry many risks and are far from being prescribed according to the knowledge that exists about them. They are also very costly and a dollar spent unnecessarily on this treatment is a dollar less to spend on another treatment. The checklist is a set of eight questions that begins by asking a prescribing doctor (or nurse with prescribing authority) whether the patient has a diagnosis that warrants the use of this class of medications. It goes on to ask about side-effects, patient preferences, using multiple medications at the same time (called polypharmacy), and the physical health of the patient. The checklist, which we call SHAPEMEDs (an acronym or abbreviation using the first letter or portion of a key word for the eight questions), does not tell the prescriber what to do. Instead it asks whether the doctor has considered a set of essential aspects of quality care. Key information that supports the principles that underlie these questions is supplied on the back of the form or by a roll-over hyperlink on its electronic version.

As we pilot and implement this checklist we know it will be a challenge, as Dr. Gawande cautions. Why the reluctance?

First, no one likes being told what to do, including doctors. A common reason for not doing what is proven to work is the rejection of "cookbook medicine." That cry is amplified by statements that rigid rules constrain the art of medicine. But what will reduce what is called the "science to practice gap" in medicine (the gap between what doctors know and what they do)? In the delivery of mental health services, for example, as few as one in six people with depression receive minimally adequate care -- even though detection, diagnosis and [effective treatment can be routinized](#) and vastly improved. This level of performance can be improved, and must be. Careful thinking has somehow been confounded with mindless requirements.

Second, doctors are anxious about being sued. Anything that may be used as 'evidence' in malpractice law suits can evoke fear that it will be used by personal injury lawyers ready to pounce. While we will be silent about lawyers we will say that checklists and other means by which doctors demonstrate, in writing, they tried to do the right thing is the best protection should they be brought to court.

Third, there is the time argument. Agreed, doctors do not have enough time to do all they need to do. Ironically, it is the lack of time, the rush to do all that needs to be done, that increases the risk of error, as doctors look for shortcuts and may make unfounded assumptions and decisions. A simple checklist has what engineers

call a "forcing function," an inescapable path that truly reduces errors. And reducing errors always saves time, if not now then surely later.

And while there are other explanations for not using a particular checklist, one more bears mention -- namely when a checklist does not work: when a checklist does not produce the benefits it purports to deliver. This important argument can only be settled by evidence that the checklist, if used, will make medical care safer, better and cheaper. The WHO Safe Surgery checklist has been proven do so. As OMH pilots SHAPEMEDs in a sample of our 26 hospitals we will evaluate its impact and refine it so that it becomes worth its while.

I recently had a minor ambulatory surgical procedure and asked the anesthesiologist if he used a checklist. He is an accomplished doctor. But he did not use a checklist. I know that if SHAPEMEDs proves to be beneficial that I will encourage every patient and family I know to ask the doctor "...are you using a checklist when you prescribe an antipsychotic medication?" Wouldn't you want medicine to be as safe as science can make it be?

## **Providing Quality Services to Adults**

### **An Update on Personalized Recovery Oriented Services (PROS)**

*by Douglas P. Ruderman, LCSW-R*

With spring's arrival, it is apropos that I have heard the current status of PROS described as blossoming. PROS started in 2006 with a single seed at Behavioral Health Services North in Clinton County. That was the sole licensed PROS program for more than a year, and then Occupations Inc. of Orange County implemented PROS in 2007, followed by a number of programs in Suffolk County.

As recently as December 2009 there were a total of 21 licensed PROS programs, but the number of programs that were actively seeking licensure as a PROS program was growing and the number of inquiries about conversion to PROS has been expanding. As of March 1, 2010, there are 35 licensed PROS programs in 10 counties serving over 3,600 individuals (a complete list of PROS programs by location can be found by visiting the [OMH website](#) and clicking on [find a program](#)). OMH anticipates over twenty additional programs will be licensed by year's end. That is quite a growing season!

In addition to licensing programs, OMH has been busy changing the PROS regulations to make the program more user friendly. Changes included:

- Reducing the number of elements required to be reported on the CAIRS data collection system;

- Reducing the number of hours necessary to be eligible to bill for ongoing rehabilitation and support (ORS) from 15 hours to 10 hours;
- Modifying documentation requirements and enabling providers to collect supplemental documentation using a methodology they choose as opposed to regulatory mandated methodologies;
- Allowing individuals who received only intensive rehabilitation (IR) or ORS to also be enrolled in and bill for clinic treatment (CT);
- Modifying the registration in PROS from a batched process to a real time process, thus eliminating the pre-registration status and simplifying the pre-admission status;
- Allowing one of the two required ORS visits to be with a collateral; and
- Eliminating the financial penalty of no billing allowed for groups that exceed 15 recipients for community rehabilitation and support (CRS) and 8 recipients for IR - this will be monitored via re-certification process.

OMH is also excited that PROS is the initial target for the implementation of the Individual Placement and Support (IPS) model of supported employment. This evidence-based model has demonstrated employment rates of 40 – 60 percent, which is much better than the NYS rate of about 15 percent. We are partnering with the Psychiatric Institute of Columbia University's Center for Practice Innovations to provide technical assistance in small groups, regional forums, webinars, discussion threads and other distance learning formats.

In conclusion, PROS integrates rehabilitation, treatment and support services to assist individuals to achieve their chosen goals and reclaim their life roles in their community. PROS offers services to assist individuals to reclaim the role of worker or student, parent or grandparent, volunteer or friend, or to assist someone who has lost their natural support system and finds themselves socially isolated. PROS adapts to meet the needs of the 3,600 individuals now participating in services and by this time next year, that number will likely double. OMH looks forward to partnering with recipients, family members, community providers and local government in continuing to keep PROS a malleable program that can change to meet the needs of all its stakeholders.

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## **OMH & OASAS Piloting WSM+ to Promote Recovery From Co-Occurring Mental Health, Substance Use Disorders**

The New York State Office of Mental Health (OMH) and New York State Office of Alcoholism and Substance Abuse Services (OASAS), in collaboration with the Center for Practice Innovations at the New York State Psychiatric Institute, have launched a statewide initiative to promote wellness self-management for adults with both mental health and substance use problems.

Addressing an individual's whole health that includes enhancing both their mental and physical health is critical in sustaining recovery. This new wellness program provides individuals with tools necessary to make their own informed decisions and reach a goal of life-long recovery.

OMH Commissioner Michael F. Hogan, Ph.D., said, "Wellness Self Management is a proven, consumer friendly approach to recovery. Focusing on "dual recovery" for those individuals with mental health and alcohol/drug problems makes great sense. We hope these practical tools are soon widely used across New York State."

OASAS Commissioner Karen M. Carpenter-Palumbo said, "More than 40 percent of the individuals being treated for chemical dependence have a diagnosed mental illness. We recognize that a key component to their successful recovery depends on their ability to manage their health and wellness."

Since 2007, OMH has been implementing the Wellness Self Management (WSM) program, a curriculum-based clinical practice that provides information, knowledge and skills designed to help people make decisions that support recovery. Based on one of the nationally recognized evidence-based practices for adults with serious mental health problems, the curriculum has been organized into a personal workbook that is infused with principles of recovery such as shared decision-making, choice and hope.

OMH and OASAS have developed a new curriculum-based workbook modeled after the WSM approach that integrates mental health and substance use topics. The curriculum has been organized into a 57-lesson personal workbook that covers many different topics addressing recovery, including practical facts about mental health problems and treatment; coping and stress management; mental health wellness, relapse prevention, and the connection between physical and mental health problems. The

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format of each lesson includes important information followed by discussion points, a personalized worksheet and finally an opportunity to plan and implement an action step.

Over 30 agencies that serve individuals with co-occurring problems have been identified to participate in one of three learning collaboratives to field-test the new curriculum, known as WSM Plus (WSM+).

Learning collaboratives bring together agencies that share a common desire to improve services to individuals with both mental health and substance use problems. These agencies learn from each other by sharing practical and creative problem solving strategies as they implement and evaluate the WSM+ program. An upstate collaborative will involve six OASAS and six OMH programs; a downstate collaborative will involve seven OASAS and five OMH programs; and a third downstate collaborative will involve eight OMH programs.

Agency training kicked-off March 9 in New York City and March 12 in Albany. Evaluation of WSM+ will include collecting data on attendance, reasons for discontinuation, direct observation of practitioner skills, participant perception of progress on personally meaningful goals, and feedback from key stakeholders via a series of focus groups and interviews. Over the next 18 months, OASAS and OMH expect to finalize the WSM+ workbook and offer this resource to programs across New York State

## From the Field



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### The NYS Clinical Record Initiative

*by Robin Krajewski, Director, and Michael Hoffman, Deputy Director, Long Island Field Office*

Approximately two years ago the Long Island Coalition of Mental Health Agencies (Coalition) discussed with the Long Island Field Office (LIFO) their desire to develop a standardized set of medical record forms. The idea was that these forms would comply with the standards and regulations of the Office of Mental Health, Medicaid, Medicare, The Joint Commission and other regulatory authorities, and would support Medical Necessity documentation requirements, as well as a recovery-oriented approach.

MTM Services, an organization that has facilitated the development of similar projects in the states of Ohio and Massachusetts, was identified as the lead Consultants for the project. This ambitious initiative would develop a set of forms which can be used by mental health outpatient, residential, and day programs for both children and

adults. Because of the collaboration and recent initiatives by OMH and the office of Alcoholism and Substance Abuse Services (OASAS) in the area of co-occurring disorders, that agency was approached to become part of the project. The record will also enable agencies to make a transition from paper documentation to an Electronic Health Record.

Co-Facilitated by the OMH Long Island Field Office and the Coalition, Approximately 70 representatives from OMH and OASAS, Nassau and Suffolk County Mental Health Departments, and the Coalition agencies were organized into four teams, and held an initial meeting on March 18, 2009 with the project Consultants to discuss the scope and organization of the project, the decision-making process and values, timelines, committee and consultant roles and responsibilities, etc. The teams included:

- **Quality Management Council (QMC)** acts as the steering committee and decision-making body. The QMC approves all recommendations from the other project teams.
- **Compliance Review Team (CRT)** reviews all applicable standards and regulations to ensure that data elements comply with regulations of OMH, OASAS, DOH, HIPAA requirements, Medicaid standards, Corporate Compliance requirements, Federal standards, The Joint Commission, and COA accreditation standards.
- **Standardized Documentation Team (SDT)** reviews all required medical record form types, designs consolidated and standardized forms to minimize duplication and completion time, and develops a set of pilot paper forms and a pilot training manual to support the forms.
- **Consumer/Family Advocates Advisory Committee (CFAAC)** reviews all forms to ensure that they support a consumer and family-friendly terminology and a rehabilitation and recovery-oriented philosophy.

Over the past year the teams have met continually to accomplish their tasks. This required a great commitment of meeting time, and communication between the teams, their facilitators and the project consultants. This has resulted in a comprehensive, yet flexible set of forms and manuals. The next step is to complete a field test of the forms in actual clinical situations.

Over 80 programs operated by 40 agencies have volunteered to take part in the pilot phase of the project. On March 2, 2010, OMH Commissioner Michael F. Hogan Ph.D. kicked off a meeting with the agencies taking part in the pilot to underscore the mission and the

importance of the project, and to provide training and parameters for the pilot. The pilot forms will be field tested for a period of 6 weeks, with participants providing active feedback on their experience in using the forms and making suggestions for changes and improvements.

Following the pilot phase, the project teams will meet to review all feedback from the participants, and to amend and/or redesign the forms based on the field test. This will occur during this summer and it is expected that the elements in the revised form set will be finalized in the fall. Electronic Health Record vendors will be offered the opportunity to develop an electronic record based on the forms, that will be certified as compliant with the record.

While the Clinical Record Initiative has been born on Long Island, its product will be made available to providers throughout New York State. A great deal of interest has already been generated by the project. Agencies which were not initially involved in the project have indicated an interest in participating in the pilot. The project Co-Chairs, Robin Krajewski, Director of the Long Island Field Office and Dennis Demers, former administrator at Catholic Charities, have been asked to speak about the Clinical Record Initiative at the Behavioral Health Informatics conference in New York on April 1, 2010.

This is an ongoing initiative that will not end once the paper and electronic records are developed. Statewide teams will ensure the record remains compliant and useful to those using it. Forms and manuals will be revised whenever regulations and/or standards of the regulatory agencies are updated. It is our expectation that having a large variety of programs using the same set of forms will facilitate communication and improve collaboration between them, and will decrease concerns about medical necessity documentation.

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## Reaching Out to Raise Awareness

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## OMH Outreach and Public Education Working to Increase Understanding of Mental Health Issues

*by Laura Payak, Director, Community Outreach and Public Education*

The Community Outreach and Public Education Office (COPE) was established to address the need to reduce the burden of mental disorders through prevention and mental health promotion.

OMH is increasing overall awareness and understanding of mental health by developing and distributing information about the nature and impact of mental illness, effective treatments and services, useful preventive and coping strategies, and how to get help when it is needed. The agency's information dissemination strategies are

designed to reach as many New Yorkers as possible, with a particular focus on high-risk and high-need groups. Educational information is shared in many media: through print, through the [OMH Web site](#), through mass media campaigns aimed at building public awareness, and through outreach exhibits at community events, health fairs, and governmental functions.

In addition, COPE works on innovative mental health promotion projects. One such project is [Talk, Listen, Connect](#) (TLC), a collaborative effort with Sesame Workshop. TLC is a multi-phase outreach initiative offering resources and support to military families with young children. *Talk, Listen, Connect: Helping Families During Military Deployment* was launched in 2006. This critical outreach tool helps military families and their young children cope with the challenges of a parent's deployment and build resiliency in times of separation and change.

But with deployment comes changes, heroic determination, and adjusting to a new normal. [So in 2008, Talk, Listen, Connect: Deployments, Homecomings, Changes](#) was released to help support families experiencing multiple deployments or when a parent comes home changed due to a combat-related injury, addressing both visible (loss of limb, disfigurement) and invisible injuries (Traumatic Brain Injury, Post-Traumatic Stress Disorder).

*Talk, Listen, Connect: When Families Grieve* will be the third project to join the TLC family when it is launched this April. It will help families cope with the death of a parent. Most recent data states that one in 20 children under the age of 15 experiences the death of a parent, whether it be from illness, suicide, accident or war-related. Certain populations, such as military families, are more at risk of experiencing a sudden death. The death of a parent is one of the most difficult things a child can face; but children are not the only ones that feel overwhelmed. Grieving is a family experience and, thus, the entire family needs support during this most difficult time.

A primetime PBS special entitled *When Families Grieve*, hosted by Katie Couric and the Sesame Street Muppets, will Premiere April 14<sup>th</sup> at 8 pm EST (check local listings) in conjunction with the Month of the Military Child & Month of the Young Child. The hour-long special will present families' personal stories about coping with the death of a parent, as well as strategies that have helped these families move forward. In addition, copies of the special will be part of a multi-media, bi-lingual (English and Spanish) outreach kit for statewide and national distribution shortly after the airdate.

The *Talk, Listen, Connect: When Families Grieve* Kit will include:

- a DVD featuring the Sesame Street cast and live-action footage of families coping with loss,
- a DVD of the PBS *When Families Grieve* special,
- a guide for parents and caregivers offering tips, strategies, activities, and
- a children's story highlighting how one child remembers a loved one who died.

Two versions of the *When Families Grieve* kit will be available. One will be tailored to the needs of military families. The other will be useful for general population use.

For more information or to request kits after mid-April, please contact Laura Payack at (518) 474-7585.

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## **Providing Culturally Competent Services**

## **Social Considerations Important for the Provision of Culturally Competent Mental Health Care**

*by Rachel Levenson, Communications Specialist, Center of  
Excellence in Culturally Competent Mental Health*

The Nathan Kline Institute (NKI) [Center of Excellence in Culturally Competent Mental Health](#) maintains on its website [research-based profiles](#) of features of cultural groups that can impact their access to, receipt of and outcomes of mental health services. This article is an abstract of a profile of Hispanics/Latinos; for more information please visit our website.

New York State is home to over 3.1 million (16%) Hispanics. Those of Caribbean origin make up the largest majority of the NY Hispanic/Latino population (58%), followed by those of South American origin (15%), Mexican origin (12%), and Central American origin (9%) (2006). Nationwide Hispanics are the largest minority group, comprising 14% of the total population (2005). There is significant variability in the socio-demographic and cultural characteristics of different ethnic Latino subgroups such as Portuguese, Mexicans, Puerto Ricans, Cubans, etc. However, this brief report summarizes literature findings in which Hispanics were not differentiated by their specific heritage

The U.S. Office of Management and Budget currently uses Hispanic and Latino interchangeably, defining "Hispanic or Latino" as "a person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race". Socially, the terms have slightly different uses, but in this report they will be used

inter-changeably.

The majority of research studies indicate that Hispanics experience less psychological impairment than their non-Hispanic counterparts. There is some evidence that significant differences may exist in rates between groups with different national origins, as well as within groups between those with different levels of acculturation. Further, evidence suggests there is a significantly higher risk among U.S.-born compared to immigrant Hispanics for any disorder. This finding is consistent with the "immigrant paradox," a phenomenon which contributes protection against psychiatric disorders to foreign nativity, despite the stressful experiences associated with immigration. Hypotheses abound for such a phenomenon in Hispanics, among them the culturally-prevalent sense of reliance on family (*familismo*).

*Family cohesiveness, or familismo* is thought to serve as a protective factor, fostering positive social support and protecting individuals against mental health disorders even in the face of substantial environmental stressors. Social resources are often used instead of professional mental health services, although literature suggests that they do not effectively replace professional mental health services. These include the family and the network of friends and godparents, religious leaders, spiritualists, folk-healing practitioners and self-help groups. Because of somatic presentation of psychiatric distress, stigma associated with seeking mental health care, and low health literacy--often due to limited English proficiency--another line of help seeking is primary care doctors. Importantly, the somatic presentation of depression among Latinos may mislead these physicians, resulting in misdiagnosis, administration of unnecessary tests, and inadequate treatment.

Noted lower utilization rates of mental health services among Hispanics have been attributed to a reluctance to seek services because of fears of deportation, distrust of service providers, and fear of law enforcement. Hispanics have high rates of dropout and missed appointments, and poor medication adherence. The general lack of commitment to mental health care has been attributed to linguistic and financial barriers, as well as to preferred reliance on the family.

Significant levels of stigma are associated with mental illness in Latino culture. Studies suggest that individuals fear bringing shame to the family for seeking professional mental health services. The American way of life imposes cultural changes and structural strains on the traditional Latino way of life. Stresses of adaptation to American culture may undermine *familismo*. Effective mental health

care for Hispanics should incorporate an awareness of cultural presentation of symptoms and utilize the strengths of their natural support services.

## From the Facilities



[Photo Gallery](#)

### Artists from Mohawk Valley PC Visit OMH Central Office to See Their Work on Display

At OMH Commissioner Mike Hogan's suggestion, the 8<sup>th</sup> floor hallway at the agency's office building in Albany features rotating exhibits of artwork done by artists from across the state who are also recipients of mental health service.

On March 2, 2010, artists from the Utica area visited OMH to see the display of their work. All of the featured artists participate in the Creative Arts program located at The Corner, Mohawk Valley Psychiatric Center's newly named rehabilitation services building. The Corner is a place for friendship and new beginnings, with each letter of the name based on a goal identified by MVPC consumers: Citizenship, Opportunity, Recovery, New Beginnings, Employment, Relationships.



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### Creedmoor PC Employees Donate Thousands to Haitian Earthquake Relief

In a show of support for co-workers and their loved ones, employees of Creedmoor Psychiatric Center collected and donated more than \$5000 for Haitian Relief and Development. Representatives of nearly every department and discipline - from physicians and nurses to maintenance workers and housekeepers - participated in the humanitarian effort. Donna Clopton, Creedmoor PC's Employee Assistance Program Coordinator, took charge of the fundraising effort. Marguerita Walcott, Nutritional Services Administrator, coordinated the fundraising activities for the baked goods, and Brenda Hannibal, Secretary to the Executive Director, provided multifaceted administrative support.

## Everyone Counts!



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### Census 2010 is Easy, Safe and Important for New York

Every 10 years, our nation conducts a census — an effort to count every person living in the United States. The key to this endeavor is having every household fill out and mail back a completed census form.

The 2010 Census is easy. Questionnaires will be mailed to households across the country in March 2010. With only 10 questions, the 2010 Census questionnaire is one of the shortest ever.

Households are asked to provide key demographic information, including: whether a housing unit is rented or owned; the address of the residence; and the names, genders, ages and races of others living in the household.

The 2010 Census is safe. Title 13 of United States Code guarantees the confidentiality of census information, and establishes penalties for disclosing this information. By law, the Census Bureau cannot share respondents' answers with the FBI, the CIA, Welfare, Immigration, or any other government agency. No court of law can access individual responses. The same law prevents the Census Bureau from selling or giving away addresses. Census workers are sworn to secrecy. They know that if they give out any information, they can face a \$250,000 fine and a jail term of up to five years.

The 2010 Census is important:

- **Census data affect funding in your community.** Census data directly affect how more than \$400 billion per year in federal and state funding is allocated to communities for neighborhood improvements, public health, education, transportation, and much more. Spending just a few minutes to fill out your census questionnaire will help ensure your community gets its fair share of funding.
- **Census data affect your voice in Congress.** Mandated by the U.S. Constitution, the census is also used to apportion seats in the U.S. House of Representatives and to redistrict state legislatures.
- **Census data affect your representation in state and local government.** Census data are used to define legislative districts, school district assignment areas and other important functional areas of the government.
- **Census data inform your community's decisions.** The census is like a snapshot that helps define who we are as a nation. Data about changes in your community are crucial to many planning decisions, such as where to provide services for the elderly, where to build new roads and schools, and where to locate job training centers.

In April 2010, the Census will take a snapshot of everyone residing in the United States, regardless of age, race, or immigration status, delivering accurate information about our diverse and growing population. What we learn from this new portrait of American will transform what we know about ourselves. The 2010 Census is easy, safe, and important. Be Counted.

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