**Department of Health and Mental Hygiene**

**Behavioral Health Administration**

**Maryland Crisis Hotline Operations Workgroup**

**May 23rd, 2017**

Brief Minutes

**Attendees:** Kathleen Rebbert-Franklin, BHA; Laura Burns-Heffner, BHA; Mary Viggiani, BHA; Barry Page, BHA; Sue Jenkins, BHA; Aidelaide Weber, BHA; Chelsea Bednarczyk; Heather Dewey for Adrienne Breidenstine; Suzi Borg; Jinlene Chan; Linda Fauntleroy; Chris Garrett, DHMH; Quinita Garrett; Holly Ireland; Tim Jansen; Rachel Larkin; Katie Dant (for Seth Noble); Abby Marsh for Jen Kelly; Dan Martin; Pat Miedusiewski; Beth Schmidt; Kathy Stevens; Trish Todd; John Winslow. **On phone**- Darren McGregor, BHA; Shannon Hall; Kate Farinholt.

1. Welcome and Introductions – Kathleen Rebbert-Franklin
2. Review of minutes- Minutes approved without correction
3. Completion of Review of Hotline Services Grid (mechanism to guide discussion for development of recommendations)

*Service Delivery continued- comments and questions for items in this area:*

**LOC referral requests**-

* Discussion of what currently occurs when a caller requests referral for a specific program (current protocol is to refer to local health department for assessment). Hotline call specialists generally attempt to follow protocol, but will refer to other resources or a specific program or if caller insists, or based on other information presented by caller. Often depends on time of call as to what can be offered. Lack of access to immediate care is gap in system. Hotline doesn’t provide the service, does attempt to connect and f/u. Hotlines do crisis stabilization, safety assessment and linkage to a resource/referral, but can’t control system outside of hotline. Want operators to be able to provide more specific information to make a direct connection, may not be realistic within current system. They provide the best information they have, do best they can with information provided to them.
* Consensus is that caller needs access for assessment for LOC prior to referral, immediate mechanisms for assessment and placement are lacking in system.
* What can mobile crisis provide related to SUD crisis? Is Mobile Crisis available for a family member requesting assistance with a SUD crisis similar to MH crisis?
* Currently call specialists activate a 911 response for suicidal calls (or chat based on ip address), talk to first responders, follows least restrictive/least invasive methods per Lifeline accreditation and SAMHSA standards.
* Need to look to future of system-how to incorporate movement towards 1) crisis assessment centers; 2) crisis residential beds; and 3) moving funds to Beacon for fee for service payment. *May need to form additional workgroups for system issues beyond scope of this workgroup*.

**Recommend** callers receive information about what to expect within current referral system based on time of call and location/knowledge of current resources.

**Recommend** accreditedmobile crisis teams be available for dispatch to respond to a SUD crisis call and provide level of care assessment accepted by Beacon Health or other insurance companies for residential placement at that time**. Additional resources will need to be provided for mobile crisis.** *Note- the State Behavioral Health Advisory Committee (BHAC) is working to develop a strategic plan for mobile and walk in crisis services statewide. The Hope act requires that the State adopt recommendations from the BHAC. This could address issue of immediate assessment.*

**Recommend** private insurance companies be asked to put dollars in to the system? **Proposed in past and not passed by legislature.**

**Recommend** consideration of Tele-health for assessment in rural areas via regional centers.

**Recommend** connection to and increased capacity for recovery supports.

**Required standards**-

* May need more training and experience in SUD required now that specialists are handling these calls.

**Review of screening workgroup materials**-

**Crisis Hotline Screening Recommendations** **1 & 2 below**.

1. The HOPE Act language should be interpreted by DHMH to focus on evidence-based screening processes, rather than instruments, to ensure the hotline has the ability to screen for MH and SUD needs, cognitive or intellectual functioning, infectious disease, and acute somatic conditions.

2. The Maryland Crisis Hotline Workgroup should assess what screening tools the regional hotlines are currently using and research tools for cognitive/intellectual functioning, infectious disease, and acute somatic conditions that could be integrated into the screening process. The goal is to provide each regional hotline operator with the same tools as a way to ensure there is consistency across the entire hotline system.

**Recommend** apossible change in legislation wording to incorporate above concept of use of a process, leading to appropriate EB tools as needed, using standardized EB tools & processes, to include those recommended/required by current accrediting bodies.

* Request for Hotlines to send Laura information about screening tools and processes currently being used for review.

**Statistics-**

* Discussion on what should we collect, and what is currently being collected. Requests for data to be outcome based, to include Customer satisfaction, were customers connected to services, (based on f/u calls), this is being done now. Request for data on if caller was diverted from high level services? Much harder to collect as is subjective and based on self-report. Resources determine how many get call back, priority to high level suicide calls. Chat is very hard to f/u with. All providers indicate they try to do f/u, varying rates of return.
* How is data used for program improvement? Can look at data by individual or group for quality assurance/improvement processes.
* Is there already a standard matrix of common items being tracked? All providers share same system, but each has individual reports.
* There is a parallel process going on with child mobile crisis services data.
* Is there a standard average time for calls or chats?
* Important to capture collateral calls as well as initial caller. Possibly also collect and compare time spent on collateral calls.
* Eastern Shore CSA willing to share their data requirements with group.

**Recommend** development of a small group to look at current data collection process for calls, chat & text, with intention to standardize data definitions, elements, and outcome and caller satisfaction measures. Procedures would include training and QA for the data reporting process. (Volunteers included Suzi, Quinita, Rachel, Chelsea, Holly, BHSB staff. To be time limited workgroup to review and develop consistent data reporting metrics for MCH providers.

**Recommend** request for legislation for emergency/police departments to follow up on an IP address if requested by Hotline call specialist.

1. Additional request for input- BHA will have one additional listening session for others who have not been able to participate in the formal process. A draft of recommendations will be sent to MCH Hotline workgroup members prior to this meeting. Listening session participants will be provided an opportunity to review draft recommendations, and give input into recommendations the workgroup has developed for workgroup and DHMH final consideration.
2. Assign Tasks for Next Meeting-

* Review draft recommendations and provide feedback
* Hotline providers to send Laura information on current screening tools/processes
* Data workgroup members connect and begin data review process

1. Next Meeting: June 27th, @ 2:30-4 Ground Floor Training room, Voc Rehab Building