Department of Health and Mental Hygiene
Behavioral Health Administration
Maryland Crisis Hotline Operations Workgroup

April 25th, 2017
Brief Minutes

Attendees: Kathleen Rebbert-Franklin, BHA; Laura Burns-Heffner, BHA; Mary Viggiani, BHA; Barry Page, BHA; Chelsea Bednarczyk; Adrienne Breidenstine; Suzi Borg; Jinlene Chan; Jennifer Kelly Dail; Kate Farinholt; Linda Fauntleroy; Chris Garrett, DHMH; Quinizi Garrett; Holly Ireland; Tim Jansen; Katie Dant (for Seth Noble); Dan Martin; Pat Miedusiewski; Robert Pitcher; Ginger R; Beth Schmidt; John Winslow; Kim Wireman. **On phone**: Nancy Rosen-Cohen

1. Welcome and Introductions – Kathleen Rebbert-Franklin

2. Review of minutes- Minutes approved without correction

3. Review of Hotline Services Grid (mechanism to guide discussion for development of recommendations)

   The purpose of the grid was reviewed; it is simply a mechanism to provide information regarding current requirements, and to structure discussion about current or future requirements in to logical categories.

Hotline Services Grid review-

A question about accreditation standards was raised- what are they and what is required, are there other accrediting bodies available?

- Information on currently required standards and approximate costs was provided. (Detailed information on accreditation standards was forwarded to workgroup members prior to first meeting, please use for reference). Other organizations that do accreditation were mentioned, including CARF, COA, with approximate costs ranging from 2,500 for 1st 3 years, up to approximately 7,000 for a more expensive entity. There are annual membership fees In addition to initial and ongoing review fees.
- Additional information and questions were deferred for discussion during the Accreditation Standards portion of the grid.

Service delivery – comments and questions for items in this area:

Screening-

- Is there a standard screening tool being used by all providers for SUD? Not a consistent tool currently.
- **Recommend** we explore utilization of a standard tool such as the CAGE.

Evidence Based screening-

- How can you screen for cognitive functioning on phone? Not believed to be a function that can be accomplished in a telephone screening.
- The thinking was that all pieces required in bill could potentially be screened for, depending on how the call goes. The caller would provide the lead for what needed to be screened. Call specialists would lean on evidence based tools. The EB part of the requirement refers to screening tools. COMAR assessment is a 45 minute process, but bill requires screening, not assessment, and is not considered treatment so 42CFR does not apply.
- Baltimore City is doing SUD & MH screening currently, using icarol, just asking questions, not a specific tool, and not for everyone, depends on their needs.
- Suggest screening for cognitive or intellectual functioning could be accomplished with something like a mini-mental; determine orientation to place, person and time. We shouldn't re-create the wheel, use what is already available.
- Is Baltimore's screening tool an EB protocol? No, not sure one exists.
  AAS doesn't require a specific tool for suicide risk or mental health assessment.
- We need to do a search for EB screens for all areas-Does it need to be age based? We need to do due diligence to check for existing screens. Volunteers? Pat for SUD-cage, reach out to SAMHSA, Tim will check re MH tools this week, Adrienne will also volunteer.
- Practicality speaking, doing a screening that lasts 55 minutes won't work, may need to go back to legislature to re-word bill.
- Suggestion we see bill requirements as framework, not to be taken too literally, only if call goes that way, looking at whole health of person. Don't get hung up on EB part, see where calls lead.

Risk assessment for OD-

- Already do this as part of safety assessment when possible. What does that mean? If there is a referral source available at time of call. Otherwise, will follow-up with offer of call back.
- Question- does this mean OMHC no longer need to be available 24/7? They should be the warm hand-off from the crisis hotline.
- Offering of call back, how is that documented? Need to be careful to not violate caller confidentiality if did not get permission first, do as part of safety plan, can do after a call reviews if any concerns about way call went as well.
- Reviewed DHMH expectation for call back if SUD caller not able to be warm-transferred to an assessment location for services.
- Can call info be given to the Health Department after the fact? Concerns expressed re HIPPA, other violations. Issue needs further discussion with AG's office. Majority of people calling want help and will agree to follow up call, but need to be careful. Typically caller is family, not person using-75% is family except in Baltimore City, where most are seeking help for themselves.

Comment about wanting to make this state of the art crisis system-hotline is just one component.
For exa.- where to send someone for next step at 2am, we identified as problematic for whole system.

- Do we have data on types of calls? Some caller data is available, may not be comprehensive to all questions.
- Recommend that data collection needs to be uniform, need to decide what we should be collecting. *Will defer for discussion to section on data and reports.*
- SUD calls have tripled in March since naloxone campaign ads and MPT show in mid-February.

- Parents want to know where in state services may be available after hours; parents would go anywhere to get their family member help.
- Hotlines try to connect people at all hours, just can't always find something open. Right now, it's caller to caller, not a systems approach.
- Need solid list of all places to send people for detox, resources/procedures change daily, this is the main thing Family Navigators need.
- Concept of a crisis bed exists for MH, is there an equivalent for SUD? Being created now, matches 3.7wm. Simply not enough beds. Crisis beds in SUD new concept beyond Baltimore City. May be some at Walden?
- Why only 5 hospitals that detox? What about statewide? Why not other hospitals?
- All this is Post hotline work, Cures grant will create crisis SUD beds around state-should replace need for some current hospital detox beds.
- Need to note the lack of available, reliable resources after hours for post hotline recommendations.

- AA County uses their warm line for other needs such as transportation- to supplement crisis needs.

Referring callers-
- Yes, required by standards

Follow-up with callers-
- Currently required (Hope) and accreditation standards

Crisis chat-
- Service is currently limited by funding constrictions. All providers except Baltimore City do some chat & text and would like to have full time capability.
- **High recommendation** to make this available full time. Would need to add money and staff. Chats take longer, technology is currently available. What is the need? How to determine? Some data is available from Every Mind, which does most of chat for system. Recommend we determine need?
- Project in Baltimore-artificial intelligence system with referral based on algorithm via Abel grant. MCF said they have found that text is safer for girls-

Suicide prevention, intervention and postvention-
- Lifeline and AAS has standards for all. Discussion ensued about hospitals and interpretation of suicidality based on method, plan, etc. Hospitals don't consider potential overdose as suicide? Language needs to be clear-this is my plan. Each hospital, ED is a different experience.
- Problem for future discussion.

Written rescue-
- Providers have them. Least restrictive, detailed protocols, standard operational procedures.

Other crisis management-
- This includes support for grief, housing, food, etc. Providers identified as COA.

Connect to mobile crisis-

- Yes, as it exists. Restrictions based on county boundaries.
- Not part of the role of this group, but we should identify the lack of statewide mobile crisis or walk in crisis services as a gap in system. How to use mobile crisis for SUD is part of post work.
- Recommend as very important to have access to walk in and mobile crisis. Also need standardization.
- There is explicit best practice language around need for this service.

Conduct local outreach-

- Question/discussion about how counting hours, travel included? Concern that outreach can get concentrated in certain areas?
- Why is it in COA? Is it useful? Providers do not believe outreach should be their responsibility. Takes too much staff time-lots of work. Center Directors do the work.
- Requirements for marketing and outreach are in all CSA contracts for sub-vendors.
- Outreach needs to be a statewide effort to have statewide impact-should we mandate this for providers? Not just duty as assigned.
- What about faith community? Depends on the community, usually incident based. Not enough funding to make it happen in all.
- Providers go where they can get in. can't get in schools right now, doors open, close, varies, depending on current leadership. Every county does something different.
- Need more than cards-should be creating other supplies/materials, give aways.
- Group support for statewide plan for outreach, should leverage other partners like NAMI, etc.
- Recommend that all materials for all groups should have state 800 number-Make part of COA for all state providers.
- Legislation passed that 800 number needs to be on student id-good reminder.
- Recommend BHA talk to each state agency about this recommendation.

4. Assign Tasks for Next Meeting-

   Volunteers to research evidenced based screening tools for areas covered in Hope bill include Pat, Tim & Adrienne.

   Announcement from Chris Garrett re Opioid Operational Command Center (OOCC) needing ideas for emergent needs, email Chris directly with ideas at Christopher.garrett@maryland.gov

5. Next Meeting: May 23th, 2017 @ 10:00 Ground Floor Training room, Voc Rehab Building