



July 21, 2017 – Maryland Department of Transportation (MDOT),
7201 Corporate Center Drive, Hanover, MD 21076

Department of Human Services
Office of Licensing and Monitoring

Agenda

Welcome

Darlene Ham

Contracts SSA Updates

Roger Lewis

University of Maryland

Jill Farrell

Title IV-E Waiver Project – Partnering for Success

Judith Schagrin

Incident Report

Lynn Wisner

Reminders and Wrap up

Darlene Ham

- Safety Report Updates
- Naloxone Flyer
- CPR & AED training

Questions and Answer Period

Next Quarterly Provider Meeting:

October 20, 2017 from 10 a.m. to 12 p.m. @ MDOT

Naloxone Saves Lives

Naloxone (NARCAN®, EVZIO®) is a prescription medication that **safely and effectively reverses an opioid overdose.**

Opioid is a class of drugs that includes **heroin** and **prescription pain relievers** like oxycodone (OxyContin®, Percocet®), hydrocodone (Vicodin®, Lortab®), oxymorphone (Opana®), hydromorphone (Dilaudid®), morphine (MS Contin®), fentanyl (Duragesic®) and methadone.

Naloxone does NOT:

- Cause Addictions
- "Enable" someone's drug use or addiction
- Give the user a "high"
- Have much potential to cause harm when administered appropriately, even if the person is not actually experiencing an opioid overdose.

Doctors, paramedics, and other healthcare providers have used it for decades.

Now many more people in Maryland can get access to naloxone to save a life.

How to Get Naloxone

1. **Ask your doctor** – Maryland law allows any healthcare provider who can prescribe drugs in Maryland (including physicians, physician assistants, advance practice nurses, dentists and others) to prescribe naloxone *to their* patients. Your provider can prescribe you naloxone if you are personally at risk for opioid overdose **OR** if you are likely to witness an overdose and be in a position to respond. State law includes legal protections for you and your provider (see below).
2. **Maryland Overdose Response Program** –The Maryland Overdose Response Program (ORP) offers in-person, hands-on training and certification in recognizing and responding to opioid overdose with naloxone. **Most ORP trainings are free to attend and also provide naloxone to trainees at no charge.** Visit the ORP website or contact the ORP for more information.

UPDATE: A statewide standing order is now in effect allowing pharmacists to dispense naloxone to ORP certificate holders without a prescription.

Pharmacies Stocking Naloxone (updated 12/19/2016) – The pharmacies on this list have been identified as currently stocking naloxone by the pharmacies' corporate offices. Those who have been trained under the Overdose Response Program may present their certificate at a participating pharmacy to get naloxone without a

prescription under the statewide standing order. Individuals should ask to speak to a pharmacist about naloxone. This list is updated bi-annually.

Naloxone Products

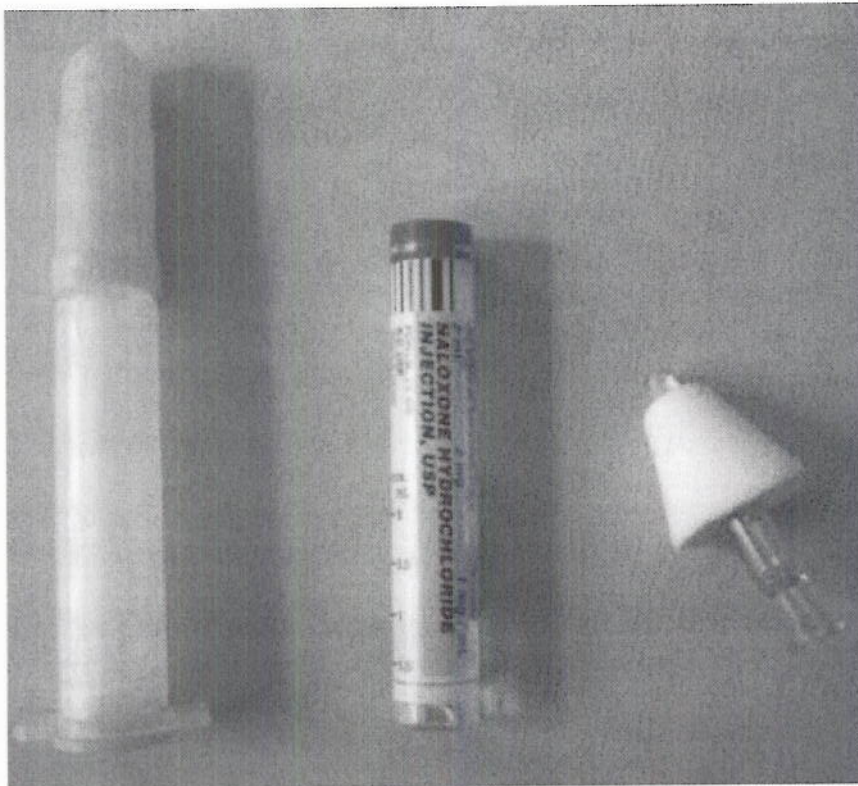
Naloxone can be injected into a muscle (intramuscular) or vein (intravenous) or sprayed into the nose (intranasal). Naloxone is often provided as part of a “rescue kit” that also includes:

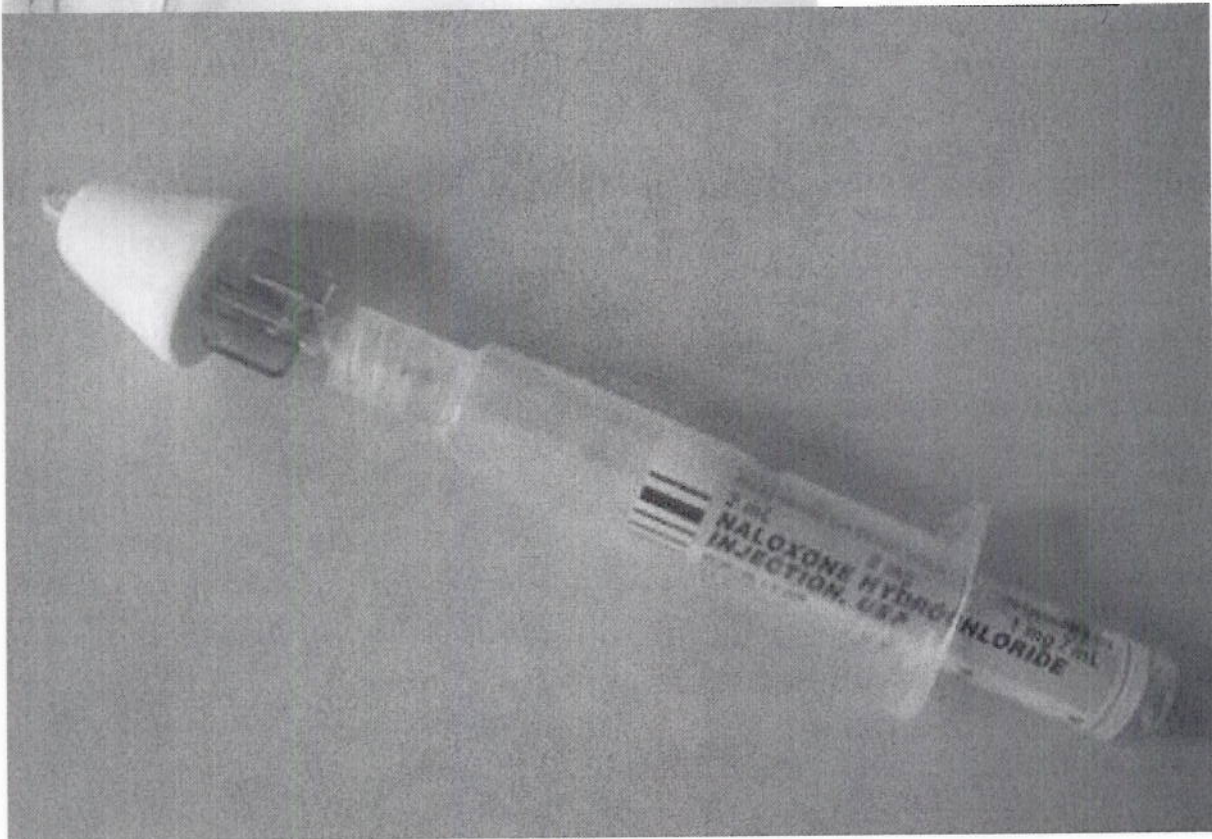
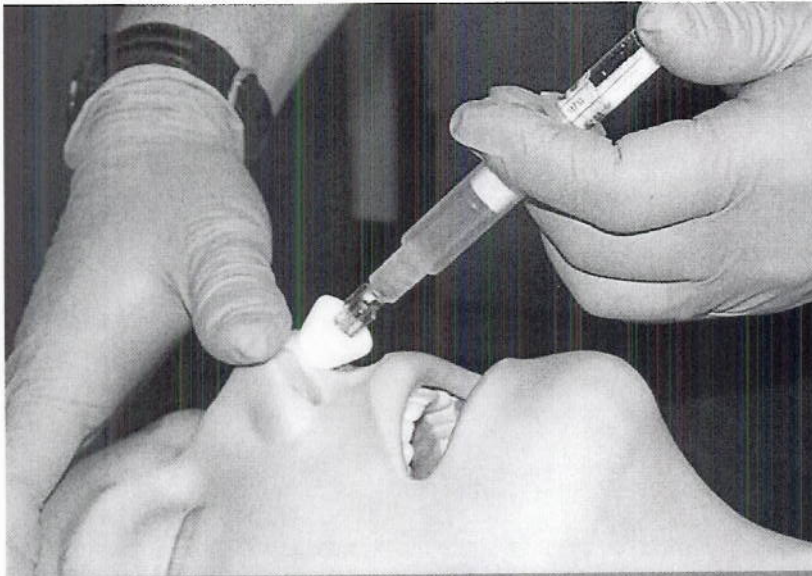
- paraphernalia for administration (nasal atomizer, syringe, needle)
- alcohol swabs
- non-latex gloves
- plastic face shield for rescue breathing
- printed materials with information on opioid overdose response and naloxone administration, overdose prevention tips and accessing addiction treatment and recovery services

There are 4 types of naloxone products available:

1. For intranasal administration: 2mg/2mL single-dose Luer-Jet prefilled syringe. Include one luer-lock mucosal atomization device (MAD 300) per dose dispensed.

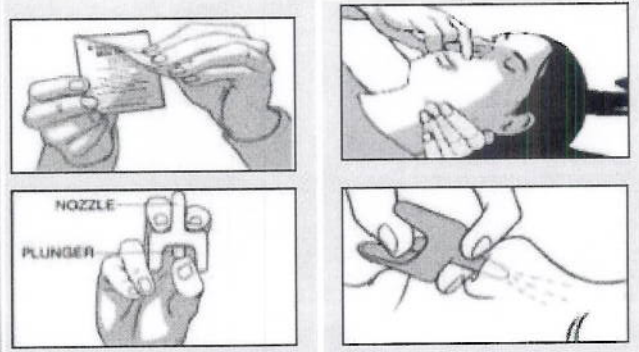
Directions for use: Spray 1 mL in each nostril. Repeat after 3 minutes if no or minimal response.





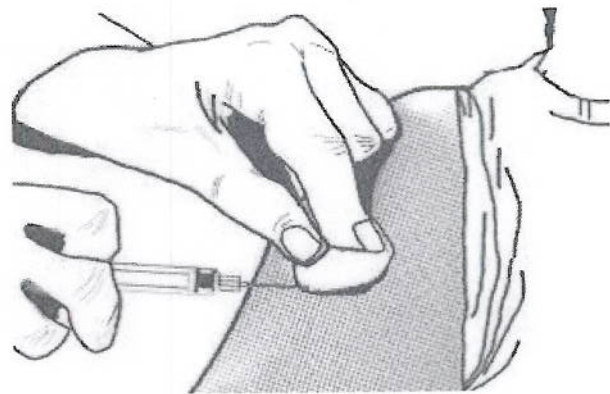
2. For intranasal administration: 4 mg dose

Directions for use: Place the tip of the nozzle in either nostril until your fingers touch the bottom of the patient's nose. Press the plunger firmly to release the dose into the patient's nose. Remove the device from the nostril and discard. Using a new device, repeat after 3 minutes if no or minimal response



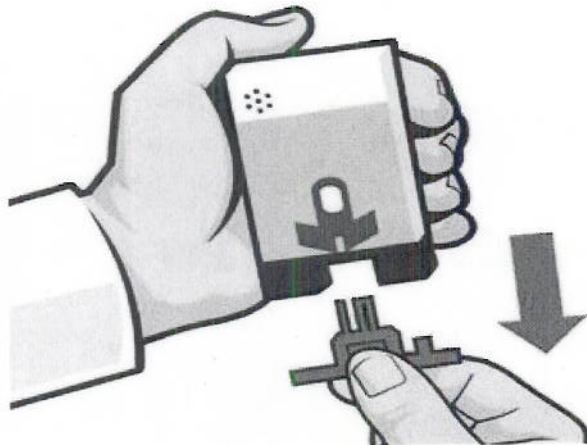
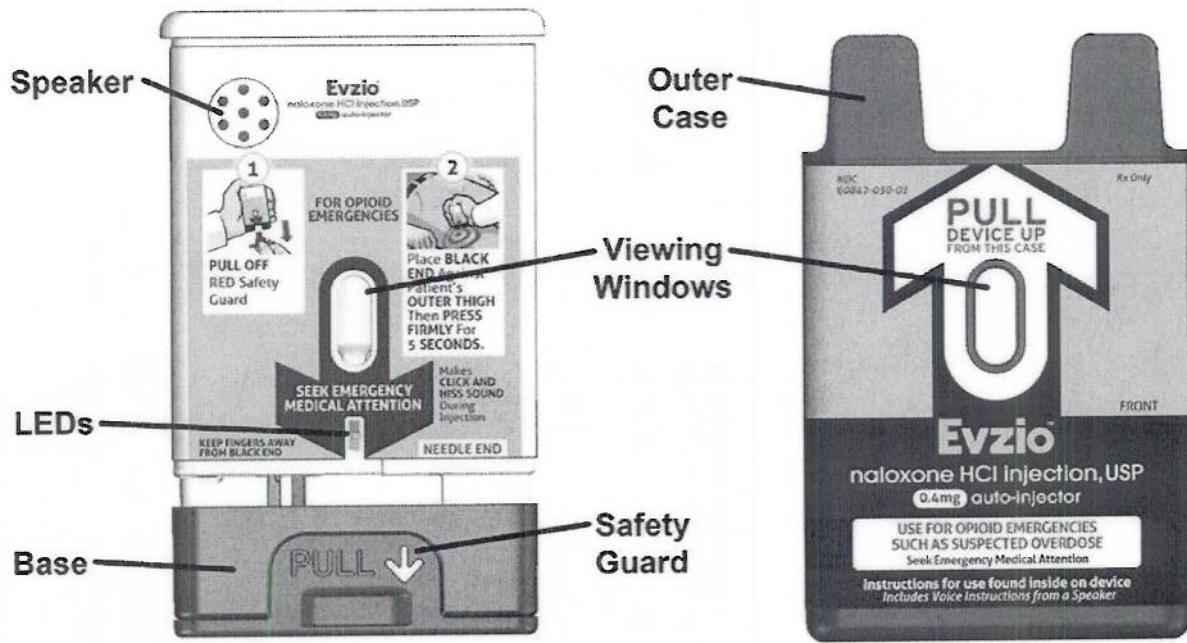
3. For intramuscular injection: 0.4/mL in 1mL single dose vials. Include one 3cc, 23g, 1" syringe per dose dispensed. Include face shield for rescue breathing and alcohol swabs if available.

Directions for use: Inject 1mL in shoulder or thigh. Repeat after 3 minutes if no or minimal response.



4. For intramuscular or subcutaneous injection: EVZIO® 0.4mg/0.4mL auto-injector,
#1 Two-Pack.

Directions for use: Follow audio instructions from device. Place on thigh and inject 0.4 mL. Repeat after 3 minutes if no or minimal response.



Recommended websites:

Department of Health and Mental Hygiene

<http://bha.dhmm.maryland.gov/NALOXONE/Pages/Naloxone.aspx>

The Overdose Response Program

<http://bha.dhmm.maryland.gov/NALOXONE/Pages/Home.aspx>

DHMH Naloxone Training Calendar

<http://bha.dhmm.maryland.gov/NALOXONE/Pages/Training-Calendar.aspx>

You Can Stop Overdose DEATH

www.dontdie.org



Partnering for Success

As many as 28% of children who enter foster care in Baltimore County as a result of the severity of their externalizing behavior, and behavioral health needs. As a result, we are implementing *Partnering for Success* as a IV-E waiver project, with the goal of preventing entries and re-entries into foster care. *Partnering for Success* is based on a multi-dimensional approach that includes cross-systems collaboration, engagement of families, adult learning principles, data-driven evaluation, and organizational and workforce enhancements using an implementation science framework.

Enhancing Cross-System Partnerships

Through Partnering for Success, child welfare caseworkers and mental health providers have the opportunity to enhance interagency collaboration and cross-system partnerships. Beginning with cross-training, participants have learned components and techniques to support and use **CBT+**, a publically available integration of evidence-based treatment elements that address depression, anxiety, trauma, and conduct problems. A local implementation team comprised of representatives from the local department and participating mental health agencies meets monthly to facilitate implementation, identify and overcome obstacles, and plan for sustainability.



Resources

Resources have been provided by the National Center for Evidence-Based Practices in Child Welfare to develop and sustain local capacity to train in CBT+ as well as monitor practice fidelity using practical quality assurance tools so that children and families in the child welfare population have access to an appropriate and quality EBP.



Access to a national web-site allows agency case managers, clinicians and supervisors access to resources as well as the ability to track individual and aggregate client functioning over time.

Support for Sites

One time learning opportunities do not alone translate into improvements in practice that are sustained over time. The *Partnering for Success* approach involves an integrated suite of activities and supports featuring pre- and post-learning, on-the-job application, clinical consultation, and capacity-building initiatives that will be jointly implemented across both child welfare and mental health systems.

Implementation Protocol

- The Baltimore County Department of Social Services' social workers complete an assessment, the PSC-17, to determine need for mental health intervention, and the targets intended to be the focus of the treatment
- When children are identified as needing intervention, a referral is forwarded to one of the participating agencies - THRIVE, Catholic Charities, and Advanced Behavioral Health. These are organizations who responded to an invitation to participate and committed to training and implementation of CBT+ and the Partnering for Success Model.
- A regular communication plan is developed between the DSS social worker and assigned clinician to support and monitor the intervention.
- The University of Maryland School of Social Work is conducting the evaluation required of IV-E waiver projects.

Partnering for Success: Communication Checklist

We are working together to use a sustainable, researched based approach to identify the behavioral health needs of children and engage youth and families to address these needs with the goal of preventing abuse and neglect. We help children and families to live more enriched and productive lives.

At initiation of referral and assignment of MH clinician

CW worker will:

- Provide contact information on the referral form including phone, cell, and email.

MH clinician will:

- Initiate communication to provide and obtain contact information for self and supervisor including phone, cell, email, and on-call contact information.

Both will:

- Develop mutually agreeable plan for monthly communication, including
- Date of communication
 - Time of communication
 - Preferred communication method (phone, cell, or email)
- Discuss case dynamics related to treatment needs and treatment goals

Additional communication expectations

CW worker will notify and discuss impact on treatment when any of the following occur:

- Considered removal – invite MH clinician to the FTDM
- Placement disruption – invite MH clinician to the FTDM
- Change in living arrangements/caregivers
- Change in child's status including arrests, AWOL, hospitalizations, school suspensions
- Change in permanency plan (if applicable)
- Crisis or change involving child's parents or significant family members
- Upcoming court hearings

MH clinician will notify and discuss impact on treatment when any of the following occur:

- Child misses 2 consecutive appointments or discharge warning letter is sent
- Child safety concerns are identified
- When medication changes occur
- When child discloses information about a caregiver that raises concerns
- If psychiatric hospitalization is recommended or child is hospitalized

Monthly contact expectations - APPLE

MH clinician will: Provide session updates

- Attending appointments regularly as scheduled with caregiver
- Participating actively and genuinely in structure and activities of the session
- Provider utilizing components of active treatment for the clinical target
- Learning, improvements and growth being observed
- Evaluation of assessments and how outcomes are being measured
- Document contact in EMR

CW worker will:

- Assessment of child's treatment progress and identified clinical targets
- Updates on any change in child's status not already reported above
- In-home supports for treatment such as: homework assignments, attendance, transportation, etc.
- Document contact in CHESSE contact note

Resolving communication issues

- Attempt to resolve the concern through direct communication with each other before raising concern within the appropriate supervisory chain.
- If attempts at communication via email or phone, have been unsuccessful for 3 or more business days, contact the appropriate supervisor, since much of the work is field based for CW and MH.
- If CW worker or MH clinician requires information on an urgent or emergency basis for a time- sensitive matter and there is no response, contact the appropriate supervisor.
- Bring systemic issues to the attention of agency's representative on the monthly PFS Leadership Team
- Encourage family engagement and partnership by using the partner's name when talking with the family.

What is CBT+?

CBT+ is an efficient and practical method of training community mental health providers in four Evidence Based Interventions (EBI): CBT for depression, CBT for anxiety, Trauma-Focused CBT, and parent management training.

The interventions are all based on cognitive behavioral and behavioral theory, consist of common components, and involve the application of common skills. These interventions address the typical clinical outcomes of child maltreatment. Providers trained in these four interventions have the capacity to reach a large majority of children seen in public mental health where most children in the CWS are served. The CBT+ approach encourages providers to adhere to a selected model but permits combined application of one of the other interventions or systematically selected modules from another when clinically indicated (e.g., child has an internalizing and an externalizing condition). CBT+ is being evaluated in Washington State and findings show increases in provider self reported understanding and skill in delivering the interventions.

How do we teach CBT+?

The CBT+ training approach is consistent with current empirical knowledge regarding effective EBP teaching methods. It addresses organizational implementation factors, and consists of a 3 day in-person learning session followed by 6 months of bi-weekly expert telephone consultation. Providers document of delivery of the model to at least two cases as demonstrated by entry of standardized assessment data and documentation of model adherence. The learning session incorporates adult learning principles and active learning methods (e.g., slides, video clips, role-plays, live practice, feedback, desk tools).

The CBT+ learning session teaches the core principles of CBT and behavioral therapy; assessment and engagement/motivational enhancement as common core elements; and the specific components of each of the EBIs. Providers learn to

administer standardized measures and provide feedback to clients, specific evidence-based engagement and motivational strategies and skills, and the components of each EBI; TF-CBT follows the model developed by Cohen, Mannarino and Deblinger.

Extensive supports are available for implementing and delivering CBT+. There is a web-based CBT+ Notebook containing cheat sheets, handouts and materials for providers and clinical materials including free standardized measures and handouts to use with clients. A web-based Toolkit is used for documenting competence, scoring measures and documenting client progress, and provider rostering.

Methods Supporting *Partnering for Success* Implementation

Child Welfare Staff

This track combines in-person and on-line learning, participation in practicums, and intensive case specific consultations. The content in this track is designed to enhance child welfare workforce knowledge and skills and aims to increase competencies in:

- Understanding the roles of EBPs in relation to children's mental health issues and parenting challenges
- Understanding common mental health problems among child welfare-involved children and youth
- Learning the importance of matching children to mental health treatment services which have demonstrated their effectiveness
- Using standardized screening tools to more precisely identify child and adolescent mental health needs in relation to the four *PfS* CBT+ treatment targets of anxiety, behavioral problems, depression and trauma
- Linking with EBP-based mental health providers and practitioners in your community
- Engaging families, children, youth, caregivers, mental health providers and other child serving systems in effective provision and monitoring of mental health services
- Ongoing partnering with mental health colleagues
- Monitoring the treatment progress of children and youth
- Learning and applying select components of *PfS* CBT+ which can be used with caregivers, children and youth to support and enhance the work of the clinician

Methods Supporting *Partnering for Success* Implementation

Mental Health Clinicians

This track ensures agency-based mental health clinicians and supervisors will build knowledge and skills in the delivery of *PfS CBT+*, a learning model integrating evidence-based approaches to treating anxiety, depression, behavior problems, and trauma. CBT+ was developed, implemented and evaluated in Washington State. It is designed to support mental health providers in delivering public domain EBP's that address common mental health problems of child welfare involved children and youth. CBT+ trains community mental health providers in four evidence-based interventions: CBT for depression, CBT for anxiety, Trauma-Focused CBT, and parent management training. The *PfS CBT+* model uses in-person learning and expert consultation, along with a host of desk tools, to increase knowledge and competencies in:

- Understanding mental health problems of child welfare involved children and youth, and their impact and effects on child welfare practices and the system
- Understanding the core principles of Cognitive Behavioral Therapy
- Utilizing standardized measures with children, adolescents and caregivers to assess for anxiety, depression and trauma
- Administering, scoring, and interpreting assessment results with families
- Demonstrating general knowledge and application of engagement strategies and motivational enhancement to involve children, teens and families in active treatment
- Demonstrating the ability to design, deliver and ensure highly individualized services and supports to children, teens and families using the skills of Cognitive Behavioral Therapy (CBT) to include:
 - CBT for Depression
 - CBT for Anxiety
 - CBT for Behavior Problems
 - Trauma-Focused CBT
- Ongoing partnering with child welfare colleagues

Pediatric Symptom Checklist (PSC-17) & Trauma Screen (Ages 4-17)—Foster/Kinship Version, Caregiver Report

Because parents/caregivers are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions.

Child's Name/ DOB: __

DSS Worker Name: __

Child's CHESSE Client ID #: Date Completed: 7/20/2017

(Not the CPS/Service Case #)

A Please circle the answer that best describes the child at the present time.

	NEVER	SOME TIMES	OFTEN	Worker Use Only			
				A	I	E	T
<i>A=Attention / I=Internalizing / E=Externalizing / T=Trauma</i>							
1. Fidgety, unable to sit still	0	1	2				
2. Feels sad, unhappy	0	1	2				
3. Daydreams too much	0	1	2				
4. Refuses to share	0	1	2				
5. Does not understand other people's feelings	0	1	2				
6. Feels hopeless	0	1	2				
7. Has trouble concentrating	0	1	2				
8. Fights with other children	0	1	2				
9. Is down on himself/herself	0	1	2				
10. Blames others for his or her troubles	0	1	2				
11. Seems to be having less fun	0	1	2				
12. Does not listen to rules	0	1	2				
13. Acts as if driven by a motor	0	1	2				
14. Teases others	0	1	2				
15. Worries a lot	0	1	2				
16. Takes things that do not belong to him or her	0	1	2				
17. Distracted easily	0	1	2				
TOTALS							
TOTAL OF ALL 3 SCORES							

B These next three questions are about violent, traumatic or upsetting events that may have happened to the child or that the child witnessed at any time in their past. Please answer if these behaviors have occurred (not the event) within the past 2-4 weeks.

1. Gets very upset if reminded of the events	0	1	2				
2. More physical complaints when reminded of the events, such as headaches or stomach aches	0	1	2				
3. Can't seem to stop thinking about the events, even when he or she tries not to	0	1	2				
TOTAL TRAUMA SCORE							

- | | | |
|--|---|--|
| Referred for CBT+?
<input type="checkbox"/> Yes (check) | <input type="checkbox"/> Advanced Behavioral Health
<input type="checkbox"/> Catholic Charities
<input type="checkbox"/> Thrive | No (check)
<input type="checkbox"/> Not clinically significant symptoms
<input type="checkbox"/> Child already in treatment
<input type="checkbox"/> Family refuses treatment/insurance issues
<input type="checkbox"/> Treatment not proximately available
<input type="checkbox"/> Other: _____ |
|--|---|--|

SCORING GUIDE ON BACK

Source: http://www.massgeneral.org/psychiatry/services/psc_forms.aspx Trauma Questions: Validated by OK TASCC and OU Health Sciences Center

Pediatric Symptom Checklist (PSC-17) & Trauma Screen (Ages 4-17)—Foster/Kinship Version, Caregiver Report

Pediatric Symptom Checklist 17 Scoring

Instructions for Scoring

A A PSC-17 score of (15) or higher in Section A suggests the presence of significant behavioral or emotional problems.

The *Pediatric Symptom Checklist-17* (PSC-17) is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible.

The PSC-17 consists of 17 items that are rated as “Never,” “Sometimes,” or “Often” present. The total score is calculated by adding together the score for each of the 17 items. Items that are left blank are simply ignored (i.e., score equals 0). If four or more items are left blank, the questionnaire is considered invalid.

To determine what kinds of mental health problems are present, determine the 3 factor scores on the PSC-17:

- The PSC-17 Attention Subscale (Score 7+):
- The PSC-17 Internalizing Subscale (Score 5+):
- The PSC-17 Externalizing Subscale (Score 7+):

B A Score of (1) or higher in Section B suggests the presence of significant Trauma related behavioral or emotional problems.

Gardner W, Murphy M, Childs G, et al. The PSC-17: a brief pediatric symptom checklist including psychosocial problem subscales: a report from PROS and ASPN. *Ambulatory Child Health*. 1999;5:225–236.
03/19/08

Chaffin, M. and Wilsie, C. Trauma Screening Tool Development: a report for the OK-TASCC grant (2014)

pfs Rev. 2/22/17

CBT + Data Analysis

The data set contains 80 individuals treated for between 2 and 5 months using CBT+. Some of these individuals have completed treatment, and some remain in treatment.

Each individual was assessed at admission and then during treatment using the relevant scale for their diagnostic category for at least three assessments to determine current outcomes of treatment.

Based on the assessment, individuals endorsed symptoms that placed them into five diagnostic groupings, each measured with a separate scale. The same scale used at admission is then used to assess outcomes during treatment and at discharge.

The table below indicates the diagnostic categories and the scales used to assess behavior for each category:

Diagnostic Category	Scale
Depression	MFQ
Anxiety	SCARED
Behavior	PSC-17
Post-Traumatic Stress	CATS

The table below is a summary of the population distribution over the five month period. It includes a listing of the diagnosis category and the number of clients who endorsed a normal range of symptoms at admission, those endorsing a clinical range at T1, those endorsing a clinical range at T2 (Not Improved), and those endorsing a normal range at T2 (Improved). The number of clients who were at normal levels at both T1 and T2 is also shown.

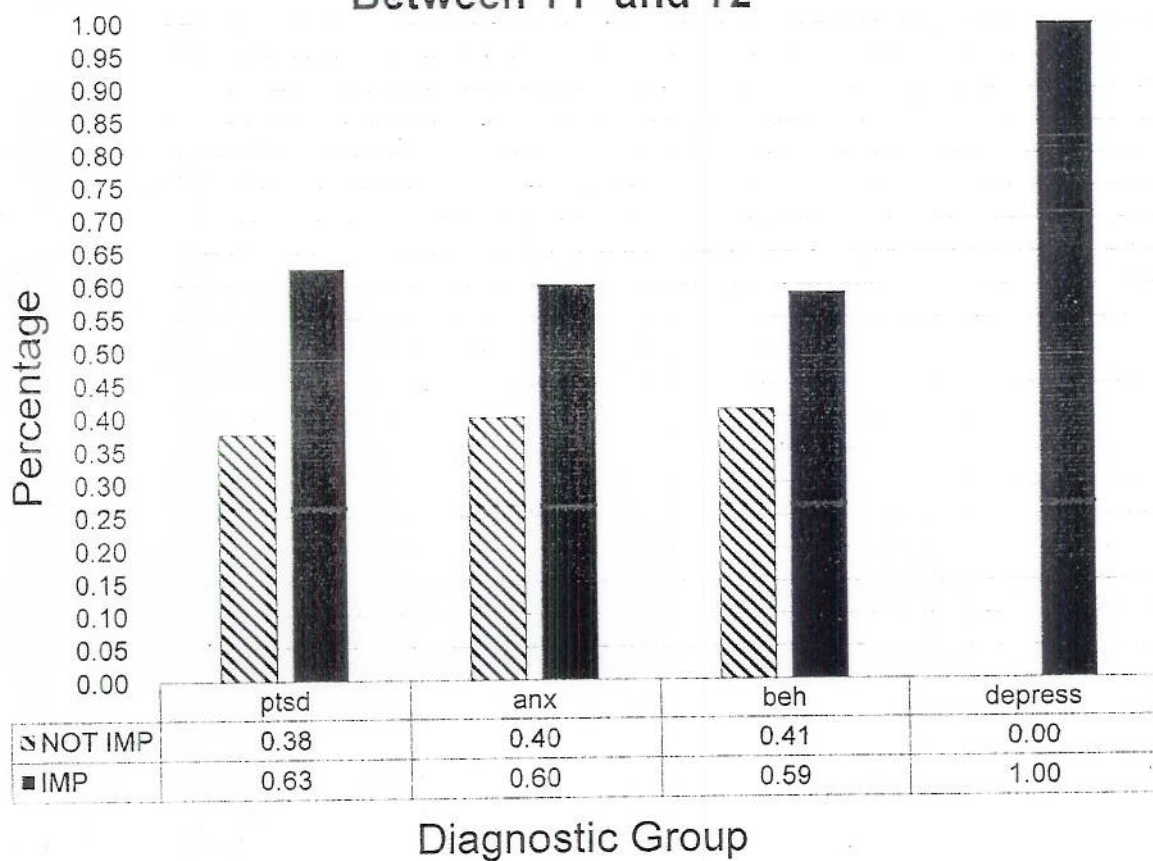
Overall, 63 clients endorsed items placing them in the clinical range. Of these 63 clients, 44 improved to a normal range while 19 did not or have not yet improved while still in treatment).

DIAGNOSIS	NORMAL RANGE AT ADMISSION	CLIENTS AT CLINICAL RANGE AT T1	CLINICAL RANGE AT T2	NORMAL RANGE AT T2
PTSD		16	6	10
ANXIETY		15	6	9
BEHAVIOR		17	7	10
DEPRESSION		15	0	15
		63	19	44
NORMAL*	17*			17*

***Not used in outcome analysis**

The chart below is a graphic representation of the percent improvement over 5 months of each of the diagnostic categories. A data table is included to illustrate the numeric value of the percentage improvement for each category.

Percent Improved By Diagnostic Category Between T1 and T2



All diagnostic areas showed moderate improvement with the implementation of CBT+ interventions over the 5 month measurement period. The most significant improvement occurred with those endorsing depression items at T1. All (100%) clients endorsing depression improved to normal scale levels with CBT+ interventions.