DATE: February 27, 2020

BILL NUMBER: HB 1382

COMMITTEE: Appropriations

BILL TITLE: Children in Out-of-Home Placement - Placement in Medical Facilities

DHS POSITION: Letter of Information

The Department of Human Services (the Department) respectfully offers this letter of information regarding House Bill 1382 (HB 1382). As drafted, HB 1382 seeks to prevent foster children from staying in an acute care setting beyond medical necessity, after they have been treated for a medical emergency and deemed ready for discharge. As we approach the problem, it is critical that our focus remains on what is in the best interests of the children, and that we not implement a solution that would create additional trauma and risk for those children.

Foster Youth in Maryland who Require an Acute Care Setting

For the last two years, the Department has been asked to provide a report to the Joint Chairmen of the Senate Budget and Taxation and the House Appropriations Committees on the number of youth in out-of-home placements under the Department's care who experience an emergency hospital stay beyond medical necessity. This report specifically identifies youth in out-of-home placements who have been admitted to either a medical or psychiatric emergency room, and for whom the Department does not have an appropriate placement for them to transition into upon discharge because of the complexity of their diagnoses.

It cannot be overstated that these children have severe medical, psychiatric, behavioral, mental, or developmental health needs. Examples of these overstay cases include: children who are suicidal and/or a threat to others, children who swallow glass or other dangerous items, children who set fires to their homes and residential treatment facilities, and children with sexually aggressive behavior who have attempted to sexually molest a parent, caregiver, or another child. Medically fragile children in the care of the Department may require 24 hour one on one nursing services, respirators, peripherally inserted central catheter (PICC) lines, may have difficulty maintaining their body temperature, and require medication management. In most cases, children are rejected from multiple placements before finding a provider who has the necessary programming and services to meet the child's needs. The Department knows that the lack of available placements for these children is extraordinarily problematic. However, if there is no appropriate placement to transition the child upon discharge from the emergency facility, these youth must stay in an acute care setting for their own safety and the safety of others, until a placement becomes available.

In our most recent report submitted to the Maryland General Assembly, out of the 4,556 youth in the Department's care, 63 youth experienced a hospital stay beyond medical necessity between August of 2018 and

November of 2019. During the 2019 data collection period, the average length of overstay for medical emergency admissions was 23 days. The average length of overstay for psychiatric emergency admissions was 13 days. In the same data collection period, youth stayed in an emergency care setting beyond medical necessity between 1-40 days. There were 3 outlier cases of youth who stayed 127, 184, and 636 days beyond medical necessity.[1]

On January 29, the Appropriations subcommittee for Health and Human Services was presented competing data on this issue. There are several points of clarification needed to understand the discrepancy between the data presented to the committee, and the Department's data. First, the data in the Department's report is based on MDH data. The data included in the Department's report was accurate at the time the data was retrieved from MDH, and at the time the report was submitted. For example, while the report indicated that there were zero overstay cases in the month of November, a later data pull indicated there were ultimately 12 overstays that month.

Second, the data presented to the committee does not define this population of children in a way that is consistent with the Department's definition. We believe strongly that the children included in data presented to the committee, includes children that are not necessarily in the custody of the Department at the time of admission to the hospital. Most of the children included are brought to the hospital by a family member or caregiver. Once the involuntary commitment issue is adjudicated, and an Administrative Law Judge determines the child does not meet the requirement for involuntary commitment, it is then that the family member or caregiver refuses to pick the child up from the hospital. It is only at this point that the child is brought to the attention of the Department for the first time. Many of these children are appropriate for traditional foster care settings, and are transitioned to their new placement quickly.

In these cases, the hospital overstay is not attributable to the Department. Since the child is in the custody of their parent or caretaker at the time the hospital overstay occurs, and the Department has not been notified or recruited to provide assistance, there is no opportunity for the Department to plan for the child's discharge. The Department requested the data that was presented to the subcommittee, so we can reconcile the gap in our numbers.

House Bill 1382

HB 1382 makes the following changes to current law:

1. Creates a 30 hour cap on the amount of time a child may remain in the hospital beyond medical necessity; prohibits the medical facility from keeping the child more than 30 hours for evaluation after discharge from the acute level of care, even if the child has no appropriate placement to transition to
2. Prohibits a court from requiring the hospital to keep the child beyond medical necessity, even if the child has no appropriate placement to transition to, and discharge is not in the best interest of the

[1] Examples of the outlier cases include instances where the child's family has entered into a Voluntary Placement Agreement (VPA) with the Department. These cases are particularly challenging, because while the child is in the State's care, the parent or caregiver still retains legal decision making authority over the child's placement. For instance, in the case of the 636 day overstay, the child's care taker refused multiple available placement resources for the child. This is problematic when working in a landscape where the resource options are already very limited.

child; renders any previous findings of an Administrative Law Judge (ALJ) absolute

3. Prohibits the Department from taking the child to an emergency facility for treatment, if that child has experienced a hospitalization for the same behavior or symptoms within the last 7 days
4. Prohibits an emergency hospital facility from treating a child if they were admitted to an emergency facility within the last 7 days for the same behavior or symptoms
5. Requires the Department to reimburse the hospital for any costs associated with the child's stay beyond medical necessity. It should be noted, the Department currently provides the hospital compensation in the event of an overstay.

HB 1382 correctly identifies a serious problem: children should not remain in a psychiatric or emergency facility for lengthy stays after discharge. However, the bill improperly delegates decision-making duties regarding the best interests of children to hospital staff and ALJs who may lack critical information regarding the child's history and behaviors. Decision makers may also lack information critical to identifying available, appropriate, and least restrictive placements for each child. Consequently, in its current form, HB 1382 fails to provide for the case-by-case evaluation of the child's condition and circumstances to transition the child to appropriate placements.

The bill as written, allows an emergency room physician to decide whether the child is ready for discharge. The Department believes the child is best served when the decision to discharge the child is made by a multidisciplinary team. This team should include emergency room doctors, any other doctors or specialists the child sees regularly, the child's social worker, the facility that must prepare to receive the child post discharge, and the child's family or caretaker.

The prohibition on providing a child emergency medical treatment on the basis that they had a previous admission within seven days fails to acknowledge the factors contributing to these readmissions. If a patient presents at the emergency room, the hospital is legally required to provide medical treatment, regardless of whether the patient is a readmission.[2] Post discharge complications are not uncommon, and a previous admission does not negate the potential need for another emergency medical intervention. Additionally, it is possible that a child who requires a readmission within seven days was prematurely discharged from the first emergency facility.

Ongoing Interagency Efforts

No child should remain in a psychiatric or other acute care facility longer than absolutely necessary. However, the solution to this problem needs to address the underlying cause—the lack of appropriate programming and resources for this particular population of children. This was compounded by the fact that in 2014, Sheppard Pratt Health System returned their license for psychiatric respite services. DHS lost 24 beds when this program closed.

The Department of Human Services, the Department of Health, the Department of Juvenile Services, other state partners, community partners, providers, and advocates have identified the need to develop additional placement capacity for children and youth. In particular, stakeholders have focused on children with complex

[2] 42 U.S.C § 1395dd (a)

needs and challenging behaviors, which is critical to reducing the incidents of hospital overstays. The Departments are aggressively exploring both near and long term solutions.

In March of 2019, the Department participated in a coordinated Strategic Vision Group (SVG), to study the state of post-acute care services in Maryland. The work group was facilitated by Health Management Associates, led by the Department of Health. The final report was published in September of 2019. The number one key finding for barriers and challenges to serving children and transitional age youth was capacity and practice.

The State's pathway to solution this problem should align with the chief recommended actions in the post-acute care study. Some of which include:

1. Build out and approve referral protocol
2. Develop infrastructure to support a real time bed capacity inventory tool
3. Increase capacity of high quality Residential Rehabilitation Programs that are responsive to the current needs of children and transitioning age youth
4. Increase capacity for in state Residential Treatment Centers
5. Implement 24/7 crisis response teams, including a mobile crisis team
6. Build intensive community-based outpatient services for children
7. Evaluate the effectiveness of Local Care Teams and make improvements
8. Educate stakeholders to develop a clearer understanding of the Voluntary Placement Agreement process

The implementation of the Family First Prevention Services Act (FFPSA) also offers opportunities to serve this particular population of youth, who are at risk of experiencing a hospital overstay. FFPSA is designed to provide evidence based prevention services to serve children at imminent risk of entering foster care and their families. The hospital overstay voluntary placement agreement (VPA) youth are prime candidates for some of the evidence based services included in the Department's prevention plan. As a reminder, the goal of a VPA is for the child to receive treatment for his/her disability or behavioral health challenge and then to return home. FFPSA offers the opportunity to provide evidence based mental health and stabilization services that will support children in living safely with their families within their communities.

Behavioral and mental health services is one of three service categories included in FFPSA that can be utilized to meet the prevention and intervention needs of this population. Some of the behavioral and mental health services included in our plan focus on supporting families and youth in transitioning from an acute hospital setting and preparing for a safe return home. Services provided may include: family engagement strategies; support with discharge planning and ongoing intervention; crisis intervention and stabilization service.

Our goal is to develop an integrated system building model to collectively address the challenges we face in providing "best practice" services with sustainable outcomes for this highly complex population.

The Department appreciates the opportunity to share this information with the Committee. The Department respectfully requests that this information be seriously considered during Committee deliberations.