HB1382_Brooke Lierman_FAV

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Position: FAV

Brooke E. Lierman
Legislative District 46
Baltimore City

Environment and Transportation Committee

Chair
Land Use and Ethics Subcommittee

Joint Committee on Administrative, Executive, and Legislative Review

Joint Committee on Ending Homelessness

Joint Committee on Pensions

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

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Testimony in Support of HB 1382 - Foster Children in Out-of-Home Placement - Placement in Medical Facilities
February 27, 2020 * Appropriations

What this bill matters

Today, there are multiple Maryland foster children being held in hospital emergency departments even though they have no medical reason for being there. They have been held for days and weeks and even months - no school, no outside exposure, no exercise, no playing in parks, no normal interactions with friends and family. The Department of Human Services has failed these children. This bill aims to fix this dire situation.

HB 1382 addresses the issue of foster care children being held longer than medically necessary in hospitals due to DHS's failure to ensure appropriate placements (i.e. family settings). Across the state, right now, there are foster children languishing in inpatient and medical facilities *after discharge or judicial release*. Some children are held for days past discharge; others for weeks or even months if a placement is not readily available. Other children are being shuffled from one hospital to the next until a hospital will admit them or until a placement becomes available. **This is illegal and inhumane.** There are several Supreme Court cases (*O'Connor v. Donaldson, Addington v. Texas, Olmstead v. L.C*., etc.) that clearly define the due process rights of individuals facing involuntary civil commitment in a physiatric facility, and those rights are being violated in the cases of these foster children in Maryland today.

It is imperative that children are **not** kept in such a restrictive environment any longer than is medically necessary. The hospital in general, and a psychiatric facility in particular, is a traumatizing place for children. The issue involves several agencies and stakeholders, many of whom you will hear from today. It also involves many children who are caught in a web of bureaucracy and are literally stuck in hospitals across the state. None of them are able to be here today, but the stories of several of these children are presented on the slides I have included.

This is a very complex and very troubling issue, which will require both carrots and sticks to correct. The bill before you focuses on ensuring that DHS discontinue its illegal and immoral practice of abandoning children in emergency rooms. DHS is failing to invest in foster care families and family supportive services to ensure that these children do not need to go into the emergency room to begin with, and have a home to go to when they are ready for release.

Because this is a difficult issue, I look forward to hearing suggested amendments and working with all those parties who are looking out for these children to do the following: 1) increase the availability of and support for foster families 2) invest in a family-first model that prioritizes keeping children with families to avoid entering foster care, and 3) fostering

collaboration between DHS and MDH so that they can achieve continuity of care and expediting appropriate placements for foster children.

What this bill does

HB 1382 requires the Department of Human Services and local DHS offices to:

- Remove a child from a hospital, emergency or inpatient facility after a medical exam by a psychiatrist shows that the child no longer needs medical or intervention care (because it is illegal to involuntarily detain anyone in a psychiatric hospital if they don't meet criteria, decided in *O'Connor v Donaldson*, 422 U.S. 563, 1975).
- Remove a child from an inpatient facility within 4 hours after the medical team agrees that the child no longer meets criteria for civil commitment and agrees to discharge the child, or an administrative law judge orders the discharge after a hearing.
- Report to a hospital any information regarding hospitalizations or attempted hospitalizations of a child within the previous 7 calendar days if certain criteria are met.
- Immediately begin placement planning for a foster child committed to an inpatient facility and report on placement planning to the Court within 7 days.
- Reimburse the hospital, emergency department, or inpatient facility for the costs associated with the child's overstay.

HB 1382 prohibits a local DHS agency from delivering a child to another hospital, emergency facility, or inpatient facility if a medical evaluation of the child in the previous seven calendar days determined that the child did not require medical intervention or care, and if no new behaviors are exhibited.

HB 1382 prohibits an emergency facility from keeping a child longer than is authorized, or admitting unnecessarily a child due to the inability of DHS to locate an appropriate alternative placement.

HB 1382 prohibits a Court from committing a child for inpatient care if an administrative law judge or clinical staff has made a determination that the child does not require such treatment. The bill also makes clear that a Court cannot commit a child solely because DHS is unable to find a suitable placement for the child.

HB 1382 requires all residential child care programs and regional institutes for foster children to report on the names of children who stayed at the facility beyond the licensing limit or beyond the time determined to be clinically necessary.

This legislation will prevent unnecessary hospital overstays by holding DHS accountable for the appropriate placement of foster children. It creates enforcement and reporting mechanisms to prevent vulnerable children from being overlooked or abandoned in unsuitable environments.

Why you should vote for this bill

Foster children are already particularly vulnerable and many are highly traumatized. Keeping children in facilities where they have limited access to important resources like school, enrichment activities and social connections will only further traumatize these

children - and it is a violation of these children's constitutional rights. This legislation protects foster children from being abandoned and forces DHS to find less restrictive placements for children when they are discharged or released from medical or psychiatric care.

This bill is essential to hold the local DHS agencies accountable for their actions, inform state agencies, CINA attorneys and other involved entities to protect foster children in the future from being subject to these atrocities. The courts have already established precedent that prohibits this the practice of warehousing foster children. This bill codifies it and provides opportunities for enforcement. This bill will hold agencies responsible, clearly delineate each party's role, and promote transparency so that we can do better by our foster children.

HB1382_Legal Aid_FAV_Erica LeMon
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February 27, 2020

The Honorable Maggie McIntosh
Chair, Appropriations Committee
Room 121, House Office Building
Annapolis, MD 21401-1991

RE: TESTIMONY IN SUPPORT OF HOUSE BILL 1382
Children in Out-of-Home Placement – Placement in Medical Facilities

Dear Chair McIntosh and Members of the Committee:

Thank you for your invitation to present testimony on HB 1382. The Legal Aid Bureau, Inc. (Maryland Legal Aid) is a private non-profit law firm that represents indigent persons in civil matters throughout Maryland. As a part of this representation, Maryland Legal Aid's staff provides legal services to over 2,000 Maryland children every year in the child welfare system who participate in Child in Need of Assistance (CINA) and Termination of Parental Rights (TPR) proceedings. Consequently, Maryland Legal Aid has expertise in matters concerning child welfare, children in foster care and particularly, youth who are aging out of foster care.

As advocates of children across the state, Maryland Legal Aid attorneys have represented foster youth subjected to lengthy stays in emergency rooms and inpatient psychiatric units even after the hospital has cleared the youth for discharge. HB 1382 discourages this use of hospitals and short-term psychiatric units as out-of-home placements. It requires local Departments to immediately begin placement planning for children evaluated for inpatient care and provide the court with a placement plan within a certain period of time. Further, it prohibits courts from committing a child for inpatient care and treatment in a psychiatric facility.

HB 1382 is necessary because of teenage clients such as one we will refer to as "John," a teenager, that came to the attention of the local Department because his father was unwilling to take him home from the emergency room. After being in the emergency room for four nights without anywhere to go, John waited in the emergency room for one additional night after the court temporarily committed him to the Department. Due to his untreated mental health, John had to be psychiatrically hospitalized shortly after being placed in a group home. His time in the hospital was supposed to be short-term and he was discharged after a month when he stabilized on

medication. Unfortunately, his previous aggressive behaviors prevented the Department from finding a placement for him. Due to his pending eighteenth birthday, the Department requested the court to order John to remain psychiatrically hospitalized, to prevent him from signing himself out of the hospital. On John's behalf his attorney advocated for his discharge from the hospital and that his CINA case be closed on his eighteenth birthday because the Department was not providing him with services during his time in their custody and his father was willing to be a resource for him. However, the court ordered John to remain psychiatrically hospitalized. The hospital's attorney and staff were dismayed by the court's order and provided documentation to John's attorney, social worker, and the court about his unlawful retention at the hospital. Eventually John was discharged from the hospital, but it took a three month stay in the hospital and two emergency hearings to achieve this result.

Sadly, John's story is not unique. Another teenage client, "Jane," waited in a windowless, locked room of a hospital emergency department for over three weeks after an attempted suicide. While waiting in the emergency department she did not receive any medical care, she did not attend school, and was without underclothes and her prescription glasses. She eventually was admitted to an inpatient psychiatric unit. After three days inpatient, her treating physician wrote a letter to the Department recommending that she be placed at a Residential Treatment Center (RTC) because her treatment needs could be met in a less restrictive environment. All of the RTCs in the area had lengthy waiting lists, which is not uncommon. Jane remained hospitalized for a month before she was discharged to an approved relative. While Jane was uncomfortable with this living arrangement, it was better than remaining unnecessarily hospitalized.

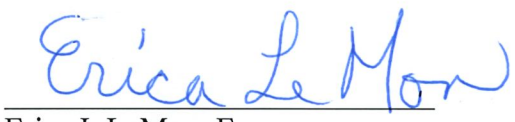
Under HB 1382, the court will be able to find that reasonable efforts for a child were not made when the local Department fails to immediately retrieve a child from medical facilities. The ability to make a finding of no reasonable efforts is an important change that will encourage local Department's to work more efficiently to find placements for children. All too often, social workers and case workers avoid visiting discharged clients in hospitals in an effort to avoid the hospital requiring the worker to take the discharged youth.

In the case of "Jill", she waited at the hospital for three weeks after discharge and her social worker would not even return her phone calls. Hospital staff consistently called the social worker because Jill grew depressed and agitated while waiting for a placement. Jill's attorney was in constant contact with Jill and the hospital staff, and requested an emergency hearing because Jill's mental health decompensated while Jill waited with uncertainty about her next move. The Department's refusal to communicate with hospital staff and Jill is the antithesis of reasonable efforts.

Children should only be removed from families and placed out-of-home when it is necessary for their welfare or in the interest of public safety. Prolonged stays in hospitals are contrary to the welfare of children and potentially compromises their emotional and physical safety. In our role as child advocates for children across the state of Maryland, we recognize and see first-hand the shortage of appropriate out-of-home placements. We also recognize that there are times when our clients need treatment in restrictive environments such as inpatient psychiatric units. However, emergency rooms and inpatient psychiatric units should never be used as out-of-home placement alternatives after children have stabilized and are ready for discharge.

Statutory clarification is needed because juvenile courts have become complicit in the inappropriate placement of children because of the lack of proper placements presented to the court. It appears that the juvenile court does not think it has authority to override the agency or does not really understand the criteria for involuntary commitment. Therefore, the Administrative Law Judge determinations that involuntary commitment is no longer authorized is virtually ignored. CINA attorneys for the youth are left without recourse and the kids left feeling hopeless.

For the reasons stated above, Maryland Legal Aid supports HB 1382 and asks that this committee give it a favorable report.



Erica I. LeMon, Esq.
Director of Advocacy for Children's Rights
Maryland Legal Aid

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BILL: HB1382

POSITION: SUPPORT

DATE: February 27, 2020

The Mental Health Division (MHD) of the Office of the Public Defender represents clients in involuntary civil commitment hearings in 33 hospitals across the State of Maryland. Last year the MHD represented children in approximately 380 involuntary civil commitment cases. The vast majority of those children were in the custody of DSS. Since 2017, the OPD has worked with hospitals around the State to address the issue of children remaining on involuntary inpatient psychiatric units after discharge or judicial release. After a number of unsuccessful attempts to resolve this issue in Maryland courts, the MHD sought the assistance of two law firms, Venable, and Brown, Goldstein and Levy, to pursue civil rights litigation on behalf of these foster children in Federal Court. We also worked with Maryland legislators to develop legislative solutions to this issue.

The Mental Health Division of the Office of the Public Defender supports this bill for the following reasons:

1. Since at least 2017, children in local DSS custody are languishing in inpatient psychiatric units after discharge or judicial release because DSS, citing lack of available placement options, refuses to remove them.
2. Prolonged hospital stays are very destructive to children who already are highly traumatized due to physical abuse, sexual abuse, or neglect.
3. Foster children who needlessly occupy scarce inpatient psychiatric beds cause other children to suffer longer stays in emergency departments waiting for scarce beds to open.
4. DSS has been aware of this problem since at least 2017 has done nothing to resolve the issue.
5. Neither the hospitals nor the courts have been able to solve this issue.
6. This bill forbids DSS from failing to remove a child from a hospital or emergency room when the child does not require medical intervention or care.
7. This bill clarifies that no overlapping jurisdiction exists which would allow various county DSS agencies or courts to sidestep the Maryland Health-General Article requirements for receiving involuntary inpatient care.

Children are Languishing in Inpatient Psychiatric Units

Since 2018, the MHD has represented approximately 90 children who were either bounced from emergency department to inpatient psychiatric unit to emergency department or who remained hospitalized on inpatient psychiatric units after discharge or judicial release because DSS refused to remove them.

Prolonged Hospital Stays are Destructive to Children

Prolonged hospital stays are very destructive to children. Foster children have already been traumatized by abuse and neglect. Many of them have been abandoned by their biological parents. Many foster children have behavioral difficulties derivative of the trauma they suffered. These children, who feel abandoned yet again, begin to deteriorate emotionally and behaviorally when DSS refuses to remove them from the hospital after they have been discharged or judicially released. Children who have been unnecessarily hospitalized can become angry and act out impulsively. The lack of schooling and the isolation from friends, siblings, and other family can cause children to lag behind peers when they return to school, and can impact their social development. Inpatient psychiatric units are acute care units and are not designed to provide long term care. Accordingly, these units typically do not provide educational programs or other age appropriate therapeutic activities that would be available to foster children in appropriate long term placements. The State is failing these vulnerable children.

Inpatient Psychiatric Bed Shortage

There is currently a severe shortage of inpatient psychiatric beds for children in Maryland. Children may stay for days or weeks in emergency departments waiting for beds on inpatient units. This shortage is even more acute for children with autism spectrum disorder or other neurocognitive disorders. Warehousing children who do not meet the criteria for involuntary commitment in inpatient psychiatric units exacerbates this shortage. While prompt removal of children from inpatient psychiatric units will not solve the bed shortage issue, every little bit helps.

DSS is Aware of this Issue

DSS has been aware of this issue since at least 2017, and has seemingly done nothing to resolve this issue. DSS continues to warehouse foster children in emergency departments, sometimes moving children from emergency department to emergency department, and on inpatient psychiatric units simply because they have no other placements available. Despite the current publicity surrounding this issue and the interest shown by legislators and child welfare organizations, DSS continues (as recently as today) to unnecessarily hospitalize these children.

Courts and Hospitals Alone Cannot Fix This Issue

The use of hospitals to warehouse children is illegal, but hospitals cannot safely discharge minor foster children to the streets. Hospitals have worked with the OPD to file Petitions for Writs of Habeas Corpus seeking the release of these children in Circuit Courts around the State. Circuit Court judges have been reluctant to act on these Petitions. Most courts have been

unwilling to order DSS to remove the illegally held child, frequently relying on the existence of a concurrent CINA case to avoid hearing the merits of the Habeas Petition.

This bill clarifies that no overlapping jurisdiction exists which would allow various county DSS agencies or courts to sidestep the Health General requirements for receiving involuntary patient care, and gives hospitals a statute to rely on when DSS abandons their wards despite a physician ordering discharge or a judge ordering release.

HB1382_Venable_FAV_Mitch Mirviss

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February 27, 2020

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The Hon. Maggie McIntosh
Chair
Committee on Appropriations
121 Lowe House Office Building
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Re: **HR 1382 Position: SUPPORT WITH AMENDMENTS**

Dear Chairperson McIntosh and Members of the Committee:

Maryland is in the midst of an ongoing placement crisis for foster children that the State has failed to address. The consequences are tragic: according to estimates of the Office of the Public Defender ("OPD"), approximately 90 foster children each year have been warehoused in psychiatric hospitals without medical justification or have been kept in emergency rooms of hospitals for extended periods of time without medical justification.

A. The Horrific Practice of Keeping Foster Children in Psychiatric Hospital Facilities When They Do Not Require Hospitalization.

During 2019, the OPD represented one child who had been wrongly hospitalized on seven different occasions. Some children were hospitalized three or four times. As we speak here today, there are foster children who are stuck in a surreal, highly illegal *Cuckoo's Nest* world. In Baltimore City, where a federal consent decree prohibits use of hospitals as ersatz foster care placements, seven different children have overstayed in hospitals since the beginning of the year—less that two months. One of these children is only *six years old*.

This is a disaster. In my 35 years of representing foster children in Baltimore, I have never seen anything this bad. That includes children sleeping in hard chairs in DSS office buildings without showers or bathing facilities; dozens of children sheltered in a motel run by social services without adequate supervision; and children stuck in residential treatment centers because less restrictive placements are not available.

Children have been discharged by their treating psychiatrists or released by administrative law judges because they do not meet the criteria for involuntary hospitalization but remain stuck in the hospital because the local DSS refuses to pick up the children, stating that no placement is available. Juvenile judges have resorted to ordering the placement of children in private psychiatric hospitals for no reason other than the lack of an appropriate placement. Children have

moved from E.R. to E.R., staying days and sometimes weeks at a time, for no reason other than the lack of an appropriate placement.

Hospitals are not licensed child placement agencies. These placements are illegal and unconstitutional, yet they persist because DHS lacks adequate placements. Federal legislation, the Families First Services Prevention Act of 2018, prohibits use of congregate-care placements for foster children, yet here in Maryland we are using the very worst, the absolutely most restrictive types of placements—psychiatric wards and E.R.s—for our most vulnerable, highest need children. A psychiatric hospital is a terrible place for a child: he or she does not go to school, does not have contact with the community, is separated from family and friends. These children already are highly traumatized, highly vulnerable children, and yet we traumatize them further.

Children are kept in hospitals because Maryland has a shortage of adequate foster care placements. It has failed to develop an appropriate array of supportive services that can allow children to live in community placements without disruptive hospitalizations. DHS has failed to plan for the actual needs of its foster care population, failed to acknowledge the problem, and failed to budget for services that would fix the problem. Its preferred course of holding children in hospital while waiting for beds to open up in out-of-state residential treatment centers, is the worst possible response.

This past September, Health Management Associates, on behalf of MDH's "Post-Acute Care Workgroup," prepared and submitted to MDH a comprehensive report addressing the problem of child and adult hospital overstays and recommended many reforms, including budget reforms, that would help ease the problem. To my knowledge, no action has been taken by MDH or DHS despite having been presented the report months ago.

B. HB 1032.

These egregious violations of the children's civil rights. both constitutional (substantive due process under the Fourteenth Amendment) and statutory (the ADA and Section 504 of the Rehabilitation Act of 1973) have occurred for at least the last two years, and yet the State has failed to act. Because the State will not take steps to fix the problem, it is up to the General Assembly to step in and enact strong measures that will prevent DSS agencies from continuing to mistreat foster children in this way. HB 1382 addresses four aspects of the problem: (1) providing legal clarity and financial protection to hospitals, (2) imposing clear prohibitions and enforceable sanctions on local DSS agencies, (3) ensuring that juvenile courts do not mistakenly commit children to hospitals who have already been determined not to meet the medical criteria for involuntary hospitalization, and (4) providing accountability by requiring prompt reports and disclosure of pertinent information.

1. *Hospitals*. HB 1032 strengthens the Health-General Article provisions regarding involuntary hospitalizations. (a) It prohibits E.R.s from keeping foster children beyond the 30-hour limit under current law in cases where a local DSS cannot find an appropriate alternative placement for the child. (b) The odious practice of shuttling foster children from E.R. to E.R. will be stopped, as hospital E.R.s will be prohibited from admitting children who do not exhibit new behaviors or who have been discharged from another E.R. within the last seven days. (c) Equally essential, the bill requires immediate removal of a child from a psychiatric hospital no later than four hours after the medical staff determines that the child does not meet the criteria for hospitalization or discharges the child, or an administrate law judge orders discharge of the child. DSS must pick up the child within this four-hour window. (d) If a local DSS seeks to hospitalize a child, it must provide the hospitals with full information about prior hospitalizations and relevant history within the preceding seven days so that it will know if the child previously was found not to require hospitalization or if DSS is pursuing serial hospitalizations to evade legal limitations. (e) If, despite these protections, a child ends up hospitalized inappropriately, the State no longer can profit from the hospitalization by failing to reimburse the hospital for the cost of care (which typically is denied by insurance and Medical Assistance because it is not medically necessary).

2. *DSS agencies*. In addition to requiring the local DSS to pick up children in their custody who have been discharged or found appropriate for discharge from a hospital, HB 1382 would impose further requirements. (a) It would prohibit DSS from seeking hospitalization for a child less than seven days after the child was previously determined not to require hospitalization. (b) For any foster child admitted to a hospital for inpatient mental health evaluation, DSS must begin placement planning immediately. That planning must include short or long-term plans as appropriate, identification of relatives willing to participate in clinical and discharge planning and in-program activities for the child, and accommodations necessary for successful placement of children with disabilities. (c) DSS must submit this plan to the juvenile court within seven days of hospitalization, unless the child has been determined to need ongoing inpatient treatment, in which case the court may extend the deadline.

3. *Juvenile courts*. The current practice of some juvenile courts to override the legal decisions of administrative law judges or clinical decisions by the hospital's medical staff that the child does not meet the criteria for involuntary hospitalization would be halted. Juvenile courts could not override these decisions and commit the child. Finally, should DSS refuse to pick up a child who has been discharged by a hospital or been determined not to meet the criteria for involuntary hospitalization, the juvenile court must enter a finding that the local DSS has not made "reasonable efforts" for the child, which results in a federal sanction (temporary loss of federal Title IV-E subsidy) against DSS. This will provide the necessary deterrent to ensure that the agency does not suspend its duty to care for the child due to the assumption (usually proven false) that a placement is not available.

4. *Accountability*. The bill also addresses the lack of accountability that has allowed these violations (and related overstay issues discussed below) to persist and accelerate. (a) For children who are not placed within seven days of hospitalization, DSS must report to the juvenile court and the child's CINA attorney on its efforts to find a placement. (b) The names of all such children must be reported to the DHS Secretary every thirty days. (c) DHS must annually report to the General Assembly the number of children who were kept in hospitals when medical criteria for discharge were not met. (d) All residential child care centers (group homes, diagnostic facilities, and residential treatment centers) and RICA facilities must report to Disability Rights Maryland on a monthly basis the names of all foster children who have "overstayed" past license limits or clinical recommendations.

5. *Amendments*. In several places, HB 1382 conflates the separate issues concerning E.R.s and psychiatric hospitals. The Office of the Public Defender has proposed technical amendments fixing these issues and several others. I strongly support these technical amendments.

C. The Broader Placement Crisis in Maryland.

The Committee should understand that the hospital overstay problem is one facet of a much larger placement shortage. Too often, foster children are stuck in limbo, placed on waiting lists for foster homes, therapeutic foster homes, and other placements; sometimes they stay for months in a short-term "diagnostic facility" that is supposed to be limited to 30 or 60-day stays. These overstays then clog up the system for the next group of children. Indeed, before the current crisis involving hospitals had occurred, BCDSS was using its office buildings as illegal overnight shelters, a practice once used during a prior placement crisis fifteen years ago. These are symptoms of a broader shortage of placements and a lack of appropriate supportive services to facilitate stability in placements. In Baltimore City, children change placements at more than twice the national average. (The actual rate is impossible to know because BCDSS does not accurately record placement changes.)

I represent the class of Baltimore City foster children in the custody of the Baltimore City Department of Social Services ("BCDSS") in the federal class action, *L.J. v. Massinga*. Since 1988, the Department of Human Services ("DHS") and BCDSS have been subject to a federal consent decree, as substantially modified and expanded in 2009, governing conditions and services for the foster children and their families. Defendants have never been in substantial compliance, and they are far from compliance now. The modified consent decree ("MCD") prohibits placement of Baltimore foster children in hospitals, offices, and other unlicensed placements. Despite the MCD's clear prohibition of the practice, Defendants never disclosed that they have been using hospitals as illegal placements. I first learned of it when the OPD sounded the alarm nine months ago. But for the OPD, this practice would have remained a State secret.

Indeed, DHS does not collect accurate information about the practice. Its end-of-year JPR report to the General Assembly is inaccurate, ignoring several hospitals where children have been placed, apparently not counting children who had been placed in E.R.s, and indicating progress that is contradicted by the Office of the Public Defender's own caseload. At a formal *L.J.* meeting last summer, Defendants reported that no Baltimore City foster children had been inappropriately hospitalized in the preceding three months when in fact three children had been kept in hospitals despite not meeting the criteria for involuntary hospitalization. BCDSS has promised to stop the practice yet seven children already have been wrongly hospitalized in 2020.

DHS and MDH need to procure a realistic assessment of the placement shortage, a plan for addressing it, and a realistic budget for the services and placement array that would ensure that all of Maryland's thousands of foster children live in safe, appropriate, and lawful placements in the community. Their current budget is wholly insufficient to meet that need. Among other things, DHS should have more emergency foster homes, more funds for paying for DDA placements, and funds available to pay for children to stay in hotels (with appropriate supervision by aides), a practice used in the 90's with considerable success.

The State's budget for legal counsel representing these children in juvenile court also is insufficient. Even though the psychiatric health of these children often is in dispute, the children's counsel lack resources to pay for experts to testify that hospitalization is unnecessary and harmful. The OPD has such resources and often is able to prevail in administrative hearings as a result. It makes no sense for juvenile courts to determine whether hospitalizations are needed without the benefit of expert opinions to challenge the oft-erroneous opinions of local departments.

Though extensive reform is needed, HB 1382 would, if enacted, curb the worst aspects of the crisis. No foster child should be warehoused in a psychiatric hospital or an emergency room merely because the State has failed to take steps to develop appropriate placements for the children. This is a clear dereliction of our *parens patriae* responsibility to care for these abused and neglected children as if they were our own.

Very truly yours,

/s/ Mitchell Y. Mirviss

HB1382_DisabilityRightsMD_Parsley
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Position: FAV

Disability Rights Maryland

Empowerment. Integration. Equality.

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Disability Rights Maryland
Testimony before the House Appropriations Committee
February 27, 2020

House Bill 1382 - Children in Out–of–Home Placement – Placement in Medical Facilities: Requires DHS to take steps to identify and place children in appropriate community placements and eliminate unneeded psychiatric hospitalization of children with disabilities in their care.

POSITION: SUPPORT

Disability Rights Maryland (DRM) is Maryland's designated Protection and Advocacy agency, and is federally mandated to advance the civil rights of people with disabilities. DRM advocates for systemic reforms and policies that improve services and supports for youth with disabilities, and ensures that their rights are protected. We regularly advocate for children in DHS care and custody who stay in clinical settings long past when they are recommended for discharge, because DHS has not been able to locate a safe placement for them. In many cases, these children remain hospitalized for months while DHS searches for a placement. It is important that new community placements, preferably therapeutic foster care or small community group homes, are developed and funded, as well as preventive and wraparound services to prevent crises and psychiatric hospitalizations whenever possible.

House Bill 1382 recognizes the grave impact that excessive time in hospital and institutional settings has on youth with emotional and behavioral disabilities.

We strongly believe that youth with disabilities have the right to live and thrive in their communities. DRM regularly receives calls from foster families, guardians and family members of youth in DHS custody who lack appropriate placements and services. Under the *Americans with Disabilities Act*, public entities, including DHS, are required to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). By definition, children overstaying their clinical treatments have no medical reason to be in a restrictive hospital setting and are appropriate for community-based placements or residential treatment programs. Further, children with disabilities have the right to a "free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living" under the *Individuals with Disabilities Education Act*. 20 U.S.C. 1400(d). Many of these children are denied their legal rights while hospitalized. When youth overstay hospital or inpatient treatments, the result is heartbreaking. Youth in overstay circumstances face significant harm, such as isolation, loss of friendships and significant relationships, severe trauma, and risk of abuse. Youth in these circumstances frequently cannot go outside or breathe fresh air for weeks or months on end,

often receive a paltry education through home-hospital teaching, and face daily living in highly sterile spaces.

Emergency rooms and hospitals are not designed to, nor do they provide, individual therapy, treatment, habilitation, ongoing behavioral support, and other services that children need to address the underlying behaviors and trauma that resulted in their hospitalization. These settings prioritize stabilization and medication of patients, with an eye to discharging them to ongoing services at the earliest possible date. Extending clinical stays beyond their medical necessity only hinders children and can exacerbate existing disabilities.

One of our current clients, "Frank," [1] a thirteen year-old young man in DHS custody, had been waiting in the hospital for an appropriate community placement since November, 2019. Prior to November, Frank lived with a foster family who were certified as therapeutic providers. This placement ended due to abuse from his then-foster mother, and the resulting instability resulted in Frank going into crisis and being admitted to the hospital for psychiatric treatment, where he remained for approximately two-and-a-half months. As a result of DRM's advocacy, he was recently moved to a temporary, 90-day placement at a Residential Treatment Center. Due to Frank's extensive abuse history, his being in a hospital environment was especially traumatizing. He had been removed from his biological home due to pervasive abuse and neglect, and his trauma at what he perceived as abandonment at being left in an inpatient psychiatric unit for months triggered numerous aggressive behaviors towards staff. The result was that he was physically restrained and injected with sedatives on multiple occasions. Frank's hospitalization disrupted a successful educational placement with caring teachers, and geographically separated Frank from his education guardian, who regularly spent time with Frank in the community. His education guardian calls Frank daily, and Frank always asks her when he'll be able to "go home." Frank does not have a long-term residential placement identified.

We acknowledge that DHS does submit applications to residential treatment programs and residential child care programs on behalf of hospitalized kids in their care and custody, and that it is difficult to find placements for children with challenging behavior. Additional community placements, including therapeutic foster care and small community group homes, are urgently needed. Preventive and wraparound services are needed to help kids remain in the community and out of crisis. Discharge planning should begin early in the child's stay, and back-up plans should be identified. Additional collaboration between sister agencies like the Developmental Disabilities Administration and the Behavioral Health Administration should be encouraged. All too often, it appears that DDA, BHA and DHR engage in prolonged negotiations over who will accept responsibility for finding and funding a placement for the child. It is our conclusion that urgent changes are necessary ensure that children and youth in DHS

[1] Our client's name has been changed to respect confidentiality.

care and custody and ensure are discharged from the hospital at the earliest possible time and receive appropriate care and services in the community.

House Bill 1382 also requires reporting to DRM, which allows for client advocacy and informs broader systemic-reform efforts.

As Maryland's Protection and Advocacy agency, DRM is deeply committed to ensuring that children and youth with disabilities do not overstay their clinical treatment and return to their communities as quickly as possible. Currently, we are only informed of these cases through client intakes and referrals, meaning that we do not know the overall scope of this issue. HB 1382 requires that each residential child care program and regional institute for children and adolescents report overstay data to DRM monthly. DRM has historically seen overstays occur due to a lack of proper supports within the community. With enhanced reporting, we will better be able to understand the scope of the problem and to advocate for effective solutions to keep youth in their communities.

Thank you for the opportunity to present this information to you today. For more information, please contact Luciene Parsley, Esq. at 410-727-6352 ext. 2494 or LucieneP@disabilityrightsmd.org.

HB1382 Free State Justice_FAV_Mark Procopio
Uploaded by: Procopio, Mark
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Bill: HB1382
Title: Children in Out-of-Home Placement – Placement in Medical Facilities
Date: February 27, 2020 1:00 p.m.
Committee: Appropriations Committee
Position: Support with Amendments

To the Honorable Delegate Maggie McIntosh and Esteemed Members of the Committee:

FreeState Justice is a statewide legal advocacy organization that seeks to improve the lives of low-income lesbian, gay, bisexual, transgender, and queer ("LGBTQ") Marylanders. We work across Maryland to provide free civil legal aid to LGBTQ Marylanders with low incomes who are facing discrimination. Those clients include individuals who are in the foster care system or experiencing out-of-home placement.

FreeState Justice **supports HB1382 with amendments**, which establishes that the Department shall report certain information to the General Assembly that is disaggregated by county, placement type, age, sex, ethnicity, and amount of time overstayed, if youth experiencing housing instability are kept in an emergency facility or an inpatient facility, despite not needing medical care.

LGBTQ youth are overrepresented in unstable housing and the foster care system. For LGBTQ youth, disclosing their sexual orientation, gender identity, or gender expression can lead to verbal and physical harassment, oftentimes resulting in out-of-home placement or homelessness. In 2019 a study found that 30.4% of youth in foster care identify as LGBTQ, with 5% as transgender[1]. The same study reported that LGBTQ youth in out-of-home placements experience further mistreatment including verbal and physical abuse, and more frequent hospitalization for emotional and physical reasons. Discrimination of these youth in the foster care system and even in healthcare facilities has far more detrimental effects, usually leading to homelessness.

[1] Baams L, Wilson BDM, Russell ST. LGBTQ Youth in Unstable Housing and Foster Care. Pediatrics. 2019;143(3): e20174211

The language of the bill should be amended to request data to be disaggregated by: county, placement type, age, sex, ethnicity, amount of time overstayed, **sexual orientation, gender identity, and gender expression.** This bill will increase data reporting of LGBTQ youth in out-of-home placement and foster care, giving us a better understanding on how to best support LGBTQ Marylanders.

FreeState Justice strongly urges the Committee to issue a favorable report with amendments on HB1382.

Thank you for the opportunity to comment on this important legislation, and please do not hesitate to contact us if we can be of further assistance.

Sincerely,
Mark A. Procopio
Executive Director

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HB1382_MHAMD_FWA_Altema
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MENTAL HEALTH ASSOCIATION OF MARYLAND

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House Bill 1382 Children in Out-of-Home Placement –
Placement in Medical Facilities
House Appropriations
February 27, 2020
Position: SUPPORT WITH AMENDMENTS

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health, mental illness and substance use. We appreciate this opportunity to present testimony in support with amendments of House Bill 1382.

HB 1382 establishes a timeline for out-of-home placements after a child is treated in a psychiatric facility.

In Maryland, community behavioral health services are often inaccessible to families and their children living with a mental illness. Recent closures of several residential treatment centers (RTCs) have only exacerbated this lack of access. More restrictive emergency departments are increasingly being utilized for behavioral health care due to the limited options in community behavioral health program for children. The Maryland Hospital Association released data demonstrating that some children have been hospitalized "more than 100 days past medically necessary while they waited for a transfer."[1] This is alarming and demonstrative of a system that is woefully under-resourced to discharge minor patients from a hospital to a community program.

Children and youth with behavioral health needs are often faced with fewer treatment options than adults. Mental Health Association of Maryland has seen an uptick of helps calls from families seeking services for a child with a behavioral health concern that is stuck in the emergency department. These children are having hospital overstays in a setting that could worsen their condition and further delay their recovery. HB 1382 is a good start at responding to the issue but additional measures should be taken to improve the children's system of care.

MHAMD supports amendments being offered that will coordinate efforts across various departments, local jurisdictions, and expand resources in the community to meet the critical needs of children and youth visiting emergency departments.

For this reason, **MHAMD supports this bill with amendments and urges a favorable report.**

[1] The Washington Post. "MD youths needing psychiatric care find long waits, drives." December 11, 2019. (https://www.washingtonpost.com/local/md-youths-needing-psychiatric-care-find-long-waits-drives/2019/12/11/516058a2-1c6e-11ea-977a-15a6710ed6da_story.html)

For more information, please contact Irnande Altema at (410) 967-3164

NASW_FWA_HB 1382
Uploaded by: ciekot, ann
Position: FWA

NASW MARYLAND CHAPTER
National Association of Social Workers

Testimony before House Appropriations Committee
February 27, 2020

House Bill 1382: Children in Out of Home Placement – Medical Facilities
*** Support with Amendments***

On behalf of the National Association of Social Workers – Maryland Chapter, an organization representing social workers statewide, we applaud the effort to shine a light on the too long-overlooked issue of placements for youth who are among the state's most troubled. We are asking for your support, with amendments.

I am a social worker who retired after dedicating my 35 year professional career to the delivery of foster care and adoptions services, I've been a foster parent, and for the last 19 years I've spent a week with our youth in care at an overnight camp to reunify siblings. In short, I have substantial 'hands on' experience with youth in foster care, and with the issues highlighted by HB 1382.

Some may be unaware that the state's child welfare system is responsible not just for children and youth who have been maltreated, but also for those whose severe behavioral health and/or developmental disability has overwhelmed their parents' ability to cope. Behaviors may include acts of severe aggression leaving victims, including caregivers, in the hospital; sexualized behaviors that include compulsive and public masturbation and victimization of family members; acts of physical and sexual harm to family pets; self-harming behaviors that include cutting, suicide attempts or engaging in risky behavior such as frequent AWOLS. While on AWOL some may have sexual encounters with older men and/or multiple sexual partners bordering on sex trafficking. Other attempts at self-harm may include compulsively swallowing objects such as batteries, glass, metal, and screws. Make no mistake, despite these atypical and scary behaviors, every one of these children is deserving of the very best care possible.

Over the last 15 years, residential care fell into disfavor, not a bad thing on the face of it; whenever possible children need to live in stable family homes. But for this and a myriad of other reasons, roughly 300 therapeutic residential beds for children closed. Doing away with capacity, however, didn't do away with the need.

Because treatment beds for children with severe behavioral health disorders and/or severe developmental disabilities are in such short supply, these youth are languishing for as long as a year in temporary placements. While a handful may remain in psychiatric hospitals, more are in placements designed to be temporary, sometimes necessitating the approval of very costly 1:1 or even 2:1 staff. We suspect substantial funds are being dedicated not to solving the problem but perpetuating it.

As Maryland treatment center resources were drying up, eliminating out of state placements became a priority in 2016. Although a laudable goal, no state has capacity to meet the needs of all of its youth. Fire-setters, for example, are an especially difficult population to place; the good news is that the

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numbers are too small to design a facility specific to their needs. Although the paucity of sufficient resources in Maryland make out-of-state placement inevitable, to discourage these placements, DHS designed what were called "speed bumps" by one official – bureaucratic delays that feel to the caseworker like intentional efforts to thwart meeting children's needs. As a result, children wait months for placement while this bureaucratically driven process winds its way to a conclusion.

Finally, lengthy emergency room waits for children displaying such unsafe behaviors that evaluation for in-patient psychiatric hospitalization is warranted have grown substantially, as graphically illustrated on the attached chart. This is a serious problem facing not just children in foster care, but also children in the community at large.

What solutions can we recommend?

- We have finally taken the first step by openly recognizing that there is a serious problem, and that Maryland has insufficient resources to serve the children in our legal or physical custody (some are in foster care via voluntary placement for disabilities.)
- As a stop gap measure, re-open psychiatric respite programs like those once available for children awaiting placement in a residential treatment center. Use this model to also accommodate severely developmentally delayed youth awaiting placement in a more long-term program.
- The scarcity of therapeutic programs is not a problem the Department of Human Services can solve in a vacuum. Expanding residential treatment access and increasing psychiatric in-patient beds are the purview of the Maryland Department of Health and requires its immediate attention.
- Revamp the protocols for approving out of state placements to be child, not system, centered. Maintain a high standard for approval but until in-state alternatives exist, expedite those that are necessary.
- Convene a workgroup dedicated to the development of a data-driven and robust resource plan with participation from DHS, MDH, local department staff, MARFY providers, attorneys, and others. Accountability for progress may be in the form of regular reports to this committee.

We want to salute DHS for making some headway by opening a handful of new beds for children with this profile. But while some progress may have been made, it's not clear that the child serving agencies – especially MDH – have any real sense of awareness or urgency about the gravity of the problem or its solutions. We need to more aggressively address the bottlenecks, identify the real obstacles to placement – querying local department staff would be illuminating - and require that all state agencies contribute to improving the quality of care for children that are among our most vulnerable, albeit a challenge and costly to serve.

Respectfully,

Judith Schagrin, LCSW-C
Chairperson, Legislative Committee

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Uploaded by: Kasemeyer, Pam
Position: FWA

Maryland Association of
Resources for Families & Youth

TO: The Honorable Maggie McIntosh, Chair
Members, House Appropriations Committee
The Honorable Brooke E. Lierman

FROM: Pamela Metz Kasemeyer
Danna L. Kauffman
Richard A. Tabuteau

DATE: February 27, 2020

RE: **SUPPORT WITH AMENDMENT** – House Bill 1382 – *Children in Out-of-Home Placement – Placement in Medical Facilities*

The Maryland Association of Resources for Families and Youth is a statewide network of private agencies serving at-risk children and youth and advocates for a system of care in Maryland that meets the needs of children and families. MARFY is a program of Maryland Nonprofits and **supports with amendment** the passage of House Bill 1382.

On behalf of the provider community in Maryland, we would like to thank you for your attention to the critical issue facing children and families in Maryland's child welfare system today. The system is seriously under-resourced as well as being complex, and these factors have led to a long-term degrading of the options available to provide appropriate services for children with significant mental health and behavioral needs.

The Maryland Association of Resources for Families and Youth brings together the provider community to have a collective voice in improving the child caring system in Maryland. Since the publication of the article in the *Baltimore Sun*, we have been working with our members to help to unbundle the many issues that contribute to the crisis of hospital overstays and other situations where critical needs are not being met. Attached please find our briefing paper with additional information on the issues and potential solutions. Fundamentally, the system needs more resources to function at a baseline level of adequacy that is not the case at this point. Still, the "system" spans many different departments, jurisdictions and public and private agencies, and additional resources need to be well coordinated with targeted systemic improvements.

Thank you again for your attention to this matter, and we look forward to working collaboratively with you, the Department of Human Services, the Maryland Department of Health and others to solve the problems in an expeditious manner.

For more information call:
Pamela Metz Kasemeyer
Danna L. Kauffman
Richard A. Tabuteau
(410) 244-7000

Maryland Association of Resources for Families and Youth

Legislative Briefing on Issues Related to Youth Hospitalization Over-Stays

All youth in Maryland should have access to appropriate services, regardless of their level of need. When a child is removed from their family, the removal itself is traumatic, compounding the traumas that led to that removal, such as abuse, neglect, trafficking victimization, and behavioral health challenges. The system of care is designed to have a graduated level of care, depending on the needs of the child, starting with community-based prevention services. The Family First Prevention Services Act was designed to create more programs for prevention. Once a placement needs to be made, foster care and treatment foster care are preferred because the best place for children to grow up is within a caring family environment. However, some children's mental health and behavioral needs are severe, and even well-trained and supported treatment foster care families are unable to keep them safe and meet their needs. In these cases, therapeutic group homes, diagnostic centers and residential treatment centers are utilized, and in some cases hospitalization is necessary.

Being removed from one's family is itself a traumatic event. Being removed from a particular placement such as a failed foster family placement, is also a traumatic event where a child feels rejected and further loses trust in themselves and in adults. These traumas inflicted *by our system* are part of the problem leading to dead-end hospitalization.

Over the past 10-12 years, Maryland has worked to reduce the number of children in care, and has reduced the number of children in care by about half. While the goals of these reductions were laudable, little attention was given to the unintended consequences, and the savings achieved were not reinvested back into prevention and ensuring the system had all the components it needed. We are now seeing the number of children in care increase again, partly due to the opioid crisis.

Providers know that if we provide clinically appropriate services on the front end for youth in care then we could significantly reduce the number of youth requiring hospitalization and hospitals being used as placement which results from the current lack of resources. Maryland needs substantial resource development (i.e. creation of new programs) and funding to match the growing needs of the youth in child welfare. One part of the system that is present in other states and is woefully lacking in Maryland is availability of 24/7 mobile crisis services that result in reducing the need for higher levels of services.

CURRENT CHALLENGES IN THE SYSTEM

Referral Process- Referrals are sent from the Department of Human Services to providers generally via email which include the reason for referral, request for a specific placement and when available, past clinical and educational documentation. If the youth is not placed in the appropriate placement from the beginning it will likely result in placement disruption, ejection or hospitalization. Some factors leading to failed placement include:

- Placement is often needed immediately and Departments of Social Services (DSS) at the local level report feeling desperate to find placement otherwise the youth may end up sleeping at the DSS office. This is particularly challenging going into the weekend and can lead to finding a "bed" versus a program that will benefit the youth.

- If a youth comes into care over the weekend there is no "shelter" available thus youth are placed wherever a bed can be located. Historically, DSS had shelter placement available for youth.
- The acuity of mental health issues has spiked significantly over the past few years and providers don't have adequate funding and resources to provide the services that the youths actually need.
- Youth are being referred to (less intensive) therapeutic levels of care despite a recommendation for residential treatment center (RTC), while they wait for a bed due to the shortage
- The referral does not always include the full clinical picture thus compromising the providers' ability to accurately assess the appropriateness of the youth in their program.

Suggestions:

- Address the shortage of RTC's and other more intensive programs, and enable youth who need those programs to be assigned to them immediately when the need is clear.
- Create a uniformed referral process that all Departments of Social Services use requiring specific information. This should be created in conjunction with the State and providers.
- Require oversight in the Department regarding how referrals are developed.

Hospitalizations- When a youth goes to the ER to be assessed for inpatient, these are issues we face collectively. Without adequate resources, the proposal in the bill of limiting the number of days a youth can remain in the hospital will not be feasible.

- Youth often sit in the ER for days on end waiting for an assessment.
- If it is determined they need inpatient, it can often take 72 hours up to a week to locate a bed and then get an acceptance from the inpatient unit.
- The youth have to be supervised until they are admitted which requires provider agency staff to remain at the ER 24/7 with little to no relief from the Department of Social Services. This incurs extensive overtime and contributes to staff burnout.
- Often youth are not admitted despite the extensive clinical information we have provided because they are not presenting an imminent risk at the ER.
- One jurisdiction that does have a mobile crisis team is Montgomery County. However, if the crisis team is called, it can take hours. When the police accompany the crisis team and the youth has to be transported, the police use force so they are being treated as a criminal versus mental health issue, thus compounding trauma. There are limited mobile crisis services throughout the state.
- Once a youth is admitted to the inpatient unit, the communication from the hospital to the provider is extremely limited, if at all, until we are contacted in regards to the youth being discharged. This means the hospital is making medication adjustments and clinical decisions with little to no history about the youth except their presenting behaviors.
- If the hospital is having team meetings, providers are not contacted.
- If a youth is inpatient and does not have placement available upon discharge, the local DSS team sends out the referral request and frequently the presenting symptoms are too acute to accommodate.
- Regarding children with complex medical conditions, discharges are often complicated and held up due to lack of approval for nursing coverage. Without Medical Assistance/DHMH approval of home health care nursing services for the most complex, the risk can be life or death so the child remains in the hospital due to lack of nursing coverage. These arrangements must be in place before discharge.

- Providers rarely get recommendations in writing from the hospital unless we pursue them. When received, they are for the most part brief and of little help.
- When we are able to meet or discuss with the inpatient staff it is a social work or nurse speaking for the team with no thought to discharge unless we address it. One social work staff at a hospital stated "we have no time to do discharge planning". Discharge dates are set quickly without confirming the child has a place to go, and providers are not involved or able to prepare appropriately for a child-specific safety plan. If providers refuse to take the child back due to safety concerns, this puts us at odds with DSS if they chose to accept the child's discharge.
- When youth are in diagnostic placement they frequently overstay the maximum amount of days because there is no available placement.

Suggestions:

- Increase beds available in the state to meet needs of the youth and their increasing mental health needs to include: therapeutic group homes, respite services, diagnostic services, and consider creating a "shelter" short term placement.
- Institute universal mobile crisis response teams throughout the state.
- Departments of Social Services should be more involved when youth are hospitalized.
- Create a workgroup with hospitals, providers, the Department of Health and the Department of Human Services to address concerns collectively.
- A Family Involvement Meeting (FIM) should be facilitated prior to hospital discharge

Staffing issues- The entire system is experiencing severe staffing shortages across the board from social workers to direct care staff to foster parents:

- Most critically there is a social work crisis nationwide which has significantly impacted our ability to fill vacant positions. We are competing with the state that has access to the Title 4-E program and offer a more competitive salary.
- DSS workers often report being overworked and have caseloads that are not manageable which is often evident in their involvement.
- Direct care staff are not making a livable wage, so care is at risk of being compromised because of burn out due to having to work multiple jobs. There is a high turnover rate.
- Recruitment of foster parents is extremely difficult. When they do onboard we are often at risk of losing them due to the acuity of the youth in their homes. Social workers have to respond to crisis situations more frequently to attempt to prevent placement disruption which also contributes to burnout.
- There are numerous vacancies at DHS/ SSA and high turnover which impedes our ability to make progress on identified issues. There is also a disconnect in information being shared with the local DSS staff. Local DSS teams all operate differently which causes confusion.
- A significant amount of money is spent on providing 1:1 staff for the youth as a stop-gap measure when an appropriate placement is not available. This money should be reallocated to prevent the problem versus being reactive and ineffective.

Suggestions:

- Extend incentives for social work recruitment and retention to private providers (currently Title IV-E funds are used to cover tuition and other incentives only for social workers going into government positions).
- Increase per diem rates to pay staff competitively and train properly.
- Expand the requirements to allow agencies to hire other mental health professionals aside from social workers.
- Departments of Social Services should be required to attend state level meetings with SSA/DHS/Providers to decrease the break down in information sharing

Resources to Implement Family First Prevention Services Act: While the concept is critical in regards to preventing youth from entering care, there is concern that the fiscal note required to meet the standards in the Act will not be approved by the Interagency Rates Committee.

- The new law requires residential programs to be Qualified Residential Treatment Providers (QRTP). Funding is not available to cover obtaining accreditation, implement evidence based programming, have access to a nurse 24/7, and provide 6 months of aftercare services as required by the Act. There is a significant fiscal note that will be required to implement. If the IRC does not approve this then there is substantial risk of programs closing thus reducing the amount of beds available
- The RFP issued in November for RCC has stringent requirements that also require a significant rate increase to allow providers to continue to operate.
- There could be an increase in the need for foster homes and we are collectively struggling to recruit and retain qualified parents.

Suggestions:

- Ensure adequate funding is allocated to prevent further reduction in beds.

HB1382_CatholicCharities-FWA-KevinKeegan
Uploaded by: Keegan, Kevin
Position: FWA

CATHOLIC CHARITIES BALTIMORE

CHERISHING THE DIVINE WITHIN ALL

House Bill 1382
BUDGET RECONCILIATION AND FINANCING ACT

House Appropriations Committee
February 27, 2020

Support with Amendment

House Bill 1382 was introduced to address the issue of foster youth remaining in hospitals after discharge. Catholic Charities of Baltimore supports HB 1382 with amendment. We are appreciative of the conversation this bill has sparked regarding the behavioral health system of care for children in Maryland.

Inspired by the gospel to love, serve and teach, Catholic Charities provides care and services to improve the lives of Marylanders in need. We are committed to a Maryland where each person has the opportunity to reach his or her God-given potential. We fulfill this commitment as a provider of behavioral health services to children through school based behavioral health services, out-patient mental health clinics, a diagnostic unit, a residential treatment center and a nonpublic special education school.

Children and youth should be in the least restrictive environment that fits their needs. We agree with the sponsor that children should not be left in hospitals after discharge. However, we believe the solution for this problem involves more parties than just local DSS and workers. This is a system wide issue that expands across the purview of many departments.

Over recent years there have been significant reductions to the number of children in foster care and in congregate placements. The youth who remain in care are the ones who are the most traumatized and have the highest needs. At this moment we have a desperate need for resources to serve these youth but no one is focused on creating a robust development plan for youth. In fact, instead of developing new resources, we are hemorrhaging existing ones.

The State of Maryland has lost critical programming that served a very high-need population. Residential treatment centers serve youth whose needs are just a step below inpatient psychiatric care. In recent years, two residential treatment centers providers closed their facilities resulting in a reduction of 130 licensed beds. Prior to their closing there were approximately 500 licensed beds, so this reduction represents approximately a 25% capacity lost. These programs are licensed through MDH.

Ten years ago a DHS licensed program, High-Intensity Respite, was discontinued. This program was operated at Sheppard Pratt Hospital, and looked like an inpatient unit, although it was under contract with DHS for exactly the purpose that we are discussing here, to serve as a program that could manage and program for children at that high end of the continuum who did not need to be in a hospital, but had no identified option at that time. This was not a perfect solution, but it did serve a significant purpose and I believe the problem we are facing has been exacerbated since the closing of this program. It would be possible to quickly bring this program back.

The restrictions on children being placed out of state without a plan to develop in state resources has also exacerbated the problem. It has been a usual practice over the years to place children out of state whose needs could not be met in Maryland. Under the current funding system for providers there is no allowance for individualize rates to support a child's unique needs. This lack of individualized rates has resulted in specialized services not being developed in Maryland. Every few years a crisis sparks conversations about development individualized rates but we have yet to see a new sustainable payment model.

I understand that some may not see MDH as a critical partner in this process, although in addition to their responsibility about maintaining an adequate number of RTC placements, Medicaid plays a critical role in

drawing down federal dollars to support treatment being provided in these programs, and a failure to involve them in the discussion will result in leaving significant federal dollars on the table.

With this legislation I believe that we must urgently create a robust resource development plan involving the legislature, DHS, MDH, local DSS, MARFY providers, attorneys for the youth, and others. This process should also require the plan and progress be presented to this committee regularly. The youth and adults served by these programs deserve the very best our State can offer.

As part of HB 1382, Catholic Charities of Baltimore urges the committee to develop and mandate a structure for creating a robust resource development plan. Thank you for your consideration of our views.

Submitted By: Kevin Keegan, Director of Family Services

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Uploaded by: Schagrin, Judith
Position: FWA

NASW MARYLAND CHAPTER
National Association of Social Workers

Testimony before House Appropriations Committee
February 27, 2020

House Bill 1382: Children in Out of Home Placement – Medical Facilities
*** Support with Amendments***

On behalf of the National Association of Social Workers – Maryland Chapter, an organization representing social workers statewide, we applaud the effort to shine a light on the too long-overlooked issue of placements for youth who are among the state's most troubled. We are asking for your support, with amendments.

I am a social worker who retired after dedicating my 35 year professional career to the delivery of foster care and adoptions services, I've been a foster parent, and for the last 19 years I've spent a week with our youth in care at an overnight camp to reunify siblings. In short, I have substantial 'hands on' experience with youth in foster care, and with the issues highlighted by HB 1382.

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Because treatment beds for children with severe behavioral health disorders and/or severe developmental disabilities are in such short supply, these youth are languishing for as long as a year in temporary placements. While a handful may remain in psychiatric hospitals, more are in placements designed to be temporary, sometimes necessitating the approval of very costly 1:1 or even 2:1 staff. We suspect substantial funds are being dedicated not to solving the problem but perpetuating it.

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numbers are too small to design a facility specific to their needs. Although the paucity of sufficient resources in Maryland make out-of-state placement inevitable, to discourage these placements, DHS designed what were called "speed bumps" by one official – bureaucratic delays that feel to the caseworker like intentional efforts to thwart meeting children's needs. As a result, children wait months for placement while this bureaucratically driven process winds its way to a conclusion.

Finally, lengthy emergency room waits for children displaying such unsafe behaviors that evaluation for in-patient psychiatric hospitalization is warranted have grown substantially, as graphically illustrated on the attached chart. This is a serious problem facing not just children in foster care, but also children in the community at large.

What solutions can we recommend?

- We have finally taken the first step by openly recognizing that there is a serious problem, and that Maryland has insufficient resources to serve the children in our legal or physical custody (some are in foster care via voluntary placement for disabilities.)
- As a stop gap measure, re-open psychiatric respite programs like those once available for children awaiting placement in a residential treatment center. Use this model to also accommodate severely developmentally delayed youth awaiting placement in a more long-term program.
- The scarcity of therapeutic programs is not a problem the Department of Human Services can solve in a vacuum. Expanding residential treatment access and increasing psychiatric in-patient beds are the purview of the Maryland Department of Health and requires its immediate attention.
- Revamp the protocols for approving out of state placements to be child, not system, centered. Maintain a high standard for approval but until in-state alternatives exist, expedite those that are necessary.
- Convene a workgroup dedicated to the development of a data-driven and robust resource plan with participation from DHS, MDH, local department staff, MARFY providers, attorneys, and others. Accountability for progress may be in the form of regular reports to this committee.

We want to salute DHS for making some headway by opening a handful of new beds for children with this profile. But while some progress may have been made, it's not clear that the child serving agencies – especially MDH – have any real sense of awareness or urgency about the gravity of the problem or its solutions. We need to more aggressively address the bottlenecks, identify the real obstacles to placement – querying local department staff would be illuminating - and require that all state agencies contribute to improving the quality of care for children that are among our most vulnerable, albeit a challenge and costly to serve.

Respectfully,

Judith Schagrin, LCSW-C
Chairperson, Legislative Committee

More children in Maryland find long wait for mental health beds

Most children and adolescents who visit emergency rooms in Maryland for psychiatric reasons spend less than 24 hours there. However, due to a statewide shortage of inpatient beds for youths in crisis, more individuals than ever are spending anywhere from 24 hours to 20 or more days in an emergency department, waiting for a bed in a mental health facility.

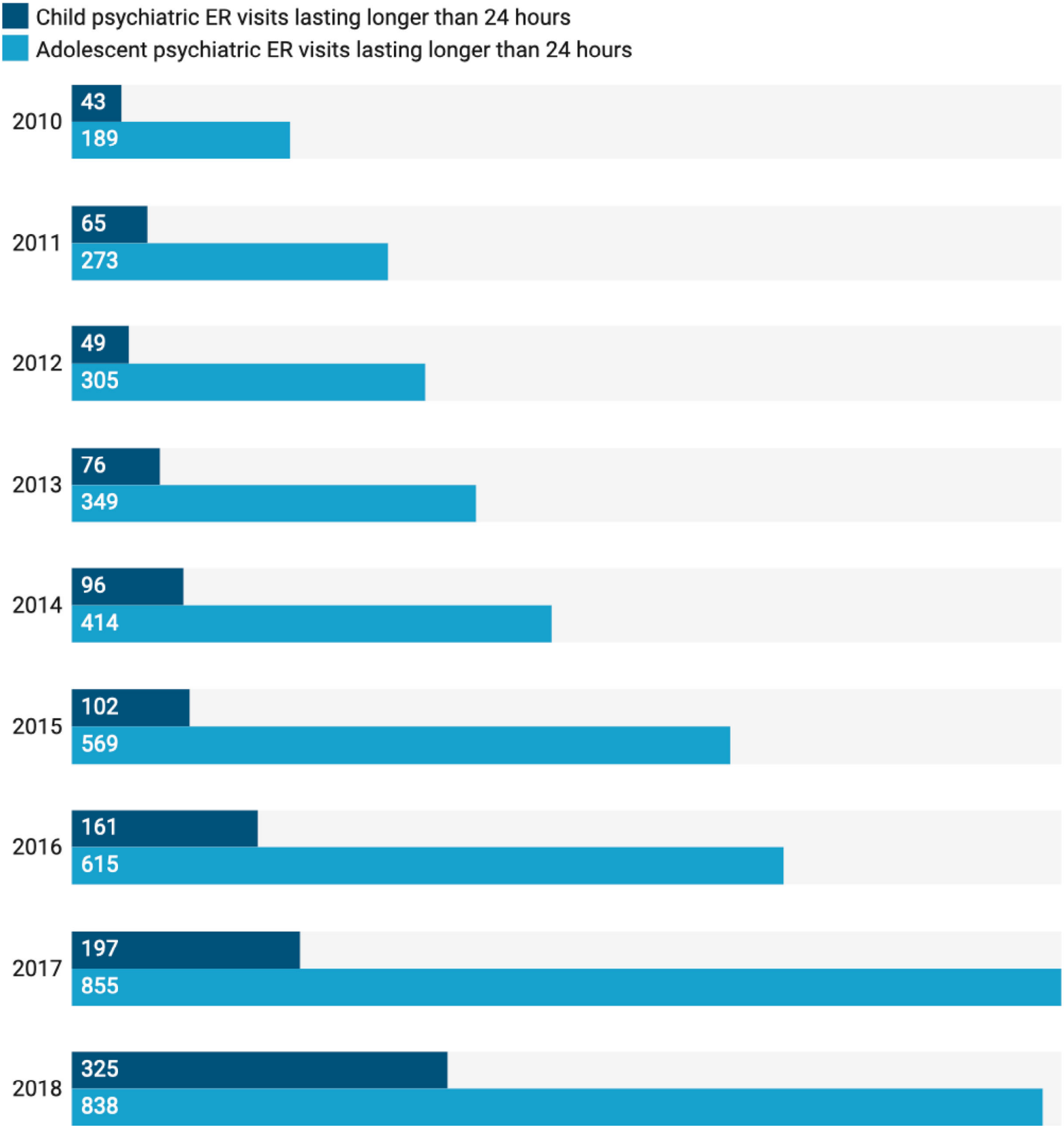

Chart: Natalie Jones • Source: Maryland Health Care Commission • Get the data • Created with Datawrapper

MDJudiciary_UNF_HB1382
Uploaded by: Jones, Tyler
Position: UNF

MARYLAND JUDICIAL CONFERENCE
GOVERNMENT RELATIONS AND PUBLIC AFFAIRS

Hon. Mary Ellen Barbera
Chief Judge

187 Harry S. Truman Parkway
Annapolis, MD 21401

MEMORANDUM

TO:	House Appropriations Committee
FROM:	Legislative Committee Suzanne D. Pelz, Esq. 410-260-1523
RE:	House Bill 1382 Children in Out-of-Home Placement – Placement in Medical Facilities
DATE:	February 19, 2020 (2/27)
POSITION:	Oppose

The Maryland Judiciary opposes House Bill 1382. The bill amends § 3-816.1 of the Courts and Judicial Proceedings Article, which governs out-of-home placement for children in need of assistance. The bill creates new restrictions and procedures for youth who are placed in a psychiatric care facility or emergency facility.

First, the bill contains several mandatory provisions, as outlined in the summary above. The Judiciary traditionally opposes mandatory provisions on the grounds that it is important for judges to have discretion to weigh the individual facts and circumstances of a particular case.

Second, the bill would hamstring the court's ability to hear evidence and make findings of fact and would instead require the court to base much of its decision on the administrative law judge's (ALJ) findings, in essence substituting the ALJ's judgment for its own. This runs counter to the court's mandate to hear all the evidence and make a determination based on the best interests of the child.

Lastly, removing the court's authority to order a youth to be held at a facility pending placement increases the risk of harm to both the child and the community. It is often exceedingly difficult to find a placement for these youth, and the placements that exist are often out of state. Even when a placement can be found, it is not likely to be feasible to transfer a child to that placement within the timeframe mandated by this bill, and the bill would strip the court of its authority to order a youth to be kept in a facility while the arrangements for his or her placement are being made. This includes, for example, a youth for whom a placement has been found, but at which there is a wait list, or a youth for whom the only available placement is out of state, and arrangements for transportation and other logistics simply cannot be made within the timeframe required.

cc. Hon. Brooke Lierman
Judicial Council
Legislative Committee
Kelley O'Connor

HB1382_FosterKids_LOI_KennedyKrieger
Uploaded by: arneson, emily
Position: INFO

Kennedy Krieger Institute

February 27, 2020

The Honorable Maggie McIntosh
Chairman
House Appropriations Committee
Room 121 House Office Building
Annapolis, MD 21401

Re: Letter of Information on House Bill 1382 - Children in Out-of-Home Placement - Placement in Medical Facilities

Dear Chairman McIntosh:

Kennedy Krieger Institute applauds the bill sponsors of House Bill 1382 for serving as tireless advocates for some of Maryland's most vulnerable children and adolescents.

Maryland's youth must have access to appropriate services, regardless of their level of need. When a child is removed from their family, the removal itself is traumatic, compounding the traumas that led to that removal, such as abuse, neglect, trafficking victimization, and behavioral health challenges.

A child or adolescent who is made to endure unnecessary or extended hospitalizations will have little to no access to ongoing education, outdoor recreational activities, or community and family engagement. This is not only detrimental to the child, it is a significant resource drain limiting the hospital's ability to admit and treat more patients. Placement agencies are overwhelmed in their attempt to find the appropriated placement and treatment option for the child in the community. This often leads to the child remaining in the hospital or being placed in an inappropriate placement which inevitably leads to a return to the hospital.

These traumas, also known as Adverse Childhood Experiences (ACEs), are associated with increased risk for a broad range of negative social outcomes, psychiatric and substance use disorders, health risk behaviors, and medical health problems.

Trauma, especially when untreated, can have devastating long term effects to an individual, including major health concerns (obesity, diabetes, depression, cancer), behavior (smoking, alcoholism, drug use) and decreased life potential (graduation rates, academic achievement).

Kennedy Krieger recognizes the abundant systemic challenges and appreciates the effort of the Committee to engage in meaningful conversation on solutions.

Respectfully,

Bradley L. Schlaggar, MD, PhD
President and CEO

HB1382_SSAB
Uploaded by: CC SSAB, CC SSAB
Position: INFO

Calvert County Social Services Advisory Board
200 Duke Street
Prince Frederick, MD 20678
Phone 410.980.7814

DATE: February 27, 2020
BILL NUMBER: HB1382
COMMITTEE: Appropriations
BILL TITLE: Children in Out-of-Home Placement - Placement in Medical Facilities
POSITION: Letter of information

House Office Building
Annapolis, Maryland 21401

Dear House Appropriations Committee,

The Calvert County Social Services Advisory Board (SSAB) respectfully submits this this letter of information regarding House Bill 1382 (HB1382). HB 1382 is intended to solve a serious problem. Currently, children in foster care who have complex needs and behaviors may experience a hospital "overstay," if an appropriate placement cannot be secured by the time the child is ready for discharge from the hospital. It is important that as we go forward in identifying a solution to this problem, we remain focused on what is in the best interest of the children we serve. 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 child; renders any previous findings of an Administrative Law Judge (ALJ) absolute
3. Prohibits the Local Departments of Social Services 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 of Human Services to reimburse the hospital for any costs associated with the child's stay beyond medical necessity. It should be noted, the Department of Human Services currently provides the hospital compensation in the event of an overstay.

The Calvert County SSAB recognizes the urgency of addressing the number of children and youth who remain in acute settings beyond medical necessity. The issue of child welfare-involved children and youth remaining in hospitals and psychiatric institutions beyond medical necessity is highly complex. This problem requires a comprehensive, multi-disciplinary and collaborative approach to increase the availability of clinically appropriate and well-supported placements for youth to both prevent hospitalization and respond holistically so they can discharge when ready. Additionally, a robust and high functioning placement and service array would be able to ensure children and youth remain stable after discharge and do not return to a hospital setting. Viable

solutions require child- and family-serving public agencies (e.g., MDH, BHA, DDA, DJS, etc.) and providers (e.g., congregate care, psychiatric hospitals, therapeutic or treatment foster care, etc.) across the state to share responsibility and collaborate together to build an appropriate and sufficient array of placement settings, primarily family-based, that can provide safe, stable and nurturing homes in a timely manner for children and youth demonstrating this specialized set of needs.

Children and youth in psychiatric hospital settings, particularly beyond medical necessity, typically present with a chronic history of severe and complex behavioral and mental health issues that have resulted in the youth having experienced multiple placement changes as well as severe instability in their social, home and community functioning. Many states are grappling with accessing mental health services for this high-risk population. However, what we know is that without adequate, individualized, and well-coordinated services, these children are more likely to remain in highly restrictive environments reducing the likelihood of timely reunification or permanency despite reasonable efforts.

Children who have been placed in psychiatric hospitals engage in behavior that is unsafe for themselves and for the communities. The behaviors demonstrated are indicative of pervasive exposure to trauma, violence, substance use and other adverse childhood experiences, which is displayed as episodic acute crisis. The children and youth requiring have emotional and intellectual disabilities, sexually reactive and sexualized behaviors, co-occurring disorders (high aggression and low IQs), and self-injurious and assaultive behaviors. The children and youth are victims of extreme abuse and neglect, toxic stress, and lack of sufficient early intervention. Based upon the description, when they are ready for discharge there are few placement providers willing to accept a child with a history of intense behavioral and/or mental health challenges, most of whom have inconsistently received appropriate treatment within a therapeutic milieu.

HB 1382 undermines the complexity of these overstay cases, and the legislation is not curative of the underlying problem—a deficiency in placement resources across the State. We appreciate the opportunity to share this information with the Committee. We hope this information will be seriously considered during Committee deliberations.

Sincerely,

_____

Karen Lane
Chair, Calvert County Social Services Advisory Board

HB1382_JohnsHopkins_INFO_Coble
Uploaded by: Coble, Annie
Position: INFO

JOHNS HOPKINS
UNIVERSITY & MEDICINE
Government and Community Affairs

HB 1382
Letter of Information

TO: The Honorable Maggie McIntosh, Chair
House Appropriations Committee

FROM: Annie Coble
Policy Analyst, Johns Hopkins University and Medicine

DATE: February 27, 2020

Thank you for the opportunity to share our unique experiences relating to **HB 1382 Children in Out-of-Home Placement-Placement in Medical Facilities.** Johns Hopkins appreciates the sponsors attempt to put into motion procedures to protect the vulnerable children who are being harmed by unnecessary hospitalizations due to insufficient community-based treatment.

Johns Hopkins has a long history of, and a substantial commitment to, providing care for persons who suffer from mental health and substance use disorders. Our nationally ranked department of psychiatry treats a higher percentage of medically compromised psychiatric patients than any other hospital in Maryland. Hopkins expert team includes the Division of Child and Adolescent Psychiatry, which is devoted to meeting the behavioral needs of our young patients through a multidisciplinary approach to both the treatment and research of child psychiatric disorders.

Over the past several years, due to insufficient community based treatment, our Child and Adolescent Psychiatry inpatient units have experienced an alarming increase in the length of stay for our young patients. Citing testimony Johns Hopkins submitted in 2017, some children have been hospitalized for as long as 115 days beyond what is medically necessary. During this extended and unnecessary hospitalization children have little to no access to ongoing education, outdoor recreational activities, or community and family engagement. This extended hospitalization is not only detrimental to the child, it is also a significant resource drain limiting our ability to admit and treat more patients. The cost to the hospital and the state is significant; inpatient services cost $2,109 per day. For the child hospitalized for 115 days beyond what is medically necessary, the expense was $242,535. This is critical funding that could otherwise be dedicated to more efficient and appropriate treatment for multiple children. While we have performed a recent assessment of these figures, anecdotally we can confirm that this problem has only escalated since 2017.

Generally these increases in the length of stay are attributed to a lack of both appropriate community and inpatient placements and sufficient state processes to address out-of-home placement when needed. Throughout the state there is a shortage of neurobehavioral inpatient beds that are designated to meet the increasing needs of children who are both

developmentally disabled and behaviorally impaired. This lack of capacity often results in children languishing in hospital emergency departments or inpatient units, and occasionally placed out of state where they are segregated from their family and surroundings. The various channels of state government that are responsible for addressing the needs of these children are challenging to navigate for social workers responsible for finding appropriate placement prior to discharge. The responsible agency often varies based on diagnoses or age of the patient, with coordination needed, but lacking when more than one agency or department is involved. The development of a standard multi-agency approach to finding and securing appropriate community based care would dramatically improve the lives of these children.

This issue is not unique to Johns Hopkins hospitals; hospitals across the state are experiencing the same problem. Children kept in medical facilities because of a lack of appropriate alternatives is a systemic problem and requires a comprehensive review by all the stakeholders.

cc: Members, House Appropriations Committee
Delegate Brooke E. Lierman

HB1382-LOI-Coble 2.27.20
Uploaded by: Coble, Annie
Position: INFO

JOHNS HOPKINS
UNIVERSITY & MEDICINE
Government and Community Affairs

HB 1382
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cc: Members, House Appropriations Committee
Delegate Brooke E. Lierman

HB1382_DHS_DHS
Uploaded by: DHS, DHS
Position: INFO

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.

HB1382_MarylandCoaltionFamilies_LOI_AnnGeddes
Uploaded by: Geddes, Ann
Position: INFO

HB 1382 – Children in Out-of-Home Placement – Placement in Medical Facilities

Committee: Appropriations
Date: February 27, 2020
Letter of Information

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for someone with behavioral health needs. Using personal experience as parents, caregivers and other loved ones, our staff provide one-to-one peer support and navigation services to parents and caregivers of young people with mental health issues and to any loved one who cares for someone with a substance use or gambling issue.

HB 1382's goal is to address a problem that has been evident for years and continues to grow: the problem of children who are in out-of-home placements being stuck in inappropriate settings - namely hospitals and psychiatric facilities. This is part of a larger problem of a lack of resources for children and youth with intensive mental health needs and/or significant developmental disabilities and/or severe behavior problems.

There has been a strong impetus over the last decade to close residential psychiatric facilities for children and instead serve youth with community-based services, but robust community-based services have failed to materialize. In 2008, 848 children and youth were served in Maryland Residential Treatment Centers; by 2018 that number had dropped to 454. That decade saw the closure of hundreds of psychiatric residential treatment beds in Maryland. While the desire to serve children in their communities whenever possible is commendable:

- There are still children who need more intensive psychiatric services. These children have not gone away.
- Many services that would help to keep children and adolescents in their community placements, such as 24/7 Mobile Response and Stabilization Services, crisis beds, respite, and high-fidelity wraparound, don't exist in Maryland.

The dramatic decline in the number of psychiatric residential treatment beds has had the consequence of children lingering in inpatient units, because there is nowhere appropriate for them to go on discharge. Families sometimes refuse to take a child home from an inpatient unit because they feel they cannot care for them in their home, further creating a bottleneck.

This has had a domino effect – children now can sit in emergency departments for days, weeks and sometimes months, waiting for an inpatient bed. Youth with severe developmental disabilities can be particularly difficult to place in an inpatient unit.

The problem of kids in out-of-home placements being stuck in medical facilities is larger than just children involved with the Department of Human Services. The entire system is clogged with children and families needing help. This issue must be addressed by the Children's Cabinet. The Behavioral Health Administration, the Governor's Office for Children, and the Developmental Disabilities Administration should all be key players in addressing this pressing crisis.

Contact: Ann Geddes
Director of Public Policy
The Maryland Coalition of Families
10632 Little Patuxent Parkway, Suite 234
Columbia, Maryland 21044
Phone: 443-741-8668
ageddes@mdcoalition.org

HB1382 - LOI FINAL
Uploaded by: Johnston, James
Position: INFO

Maryland
DEPARTMENT OF
JUVENILE SERVICES

217 East Redwood Street
Baltimore, MD 21202

Boyd K. Rutherford
Lt. Governor

Larry Hogan
Governor

Sam Abed
Secretary

DATE: February 27, 2020

BILL NUMBER: HB 1382 - Children in Out-of-Home Placement - Placement in Medical Facilities

DJS POSITION: Letter of Information

The Department of Juvenile Services (DJS or department) is providing information for HB 1382.

The Department of Juvenile Services is committed to partnering with the Department of Human Services (DHS) and the Maryland Department of Health (MDH) to ensure Maryland youth have access to a continuum of behavioral health supports that will meet their diverse needs.

DJS is currently engaged in efforts with our agency partners and community stakeholders to build upon the behavioral health continuum in Maryland. Specifically, for justice involved youth that crossover to other human service agencies, DJS is implementing the following strategies:

Crossover Youth Practice Model

DJS continues to promote strategies to develop a multi-systems approach to addressing the unique needs of justice and child welfare involved youth through implementation of the Crossover Youth Practice Model (CYPM).

CYPM is a partnership with DJS, DHS, Georgetown University, and the Maryland Judiciary. This effort aims to better serve this unique population by removing barriers to cross-systems collaboration, reducing unnecessary system involvement, ensuring access to diverse set of supports and treatment interventions, and avoiding duplication in service provision.

After piloting in Montgomery County and Prince George's County, the CYPM is now in place in Western Maryland (Allegany, Washington and Frederick Counties), Central Maryland (Carrol, Harford and Howard Counties), and most recently launched in Baltimore City and Baltimore County. Further, a CYPM toolkit will be launched in 2020 to lay the groundwork for a statewide rollout.

Multidisciplinary Case Planning, Intervention, and Review

DJS will continue to participate in multidisciplinary team meetings with other agencies and stakeholders to coordinate efforts, leverage resources, and jointly case plan and identify appropriate interventions to support youth. Additionally, DJS regularly engages with agency stakeholders to review difficult cases to better assess youth needs, service provisions, and gaps in the treatment-service continuum.

Explore Additional Placement Resources for Youth that have Highly Specialized Behavioral Needs

DJS has implemented a continuum of placement resources that provide a diverse array treatment services and supports at different security levels. DJS, in coordination with the licensing agency, is reviewing current placement resources to determine if available capacity could be re-purposed to accommodate youth that are connected to a human service agency, but also have juvenile justice system involvement. Re-purposing current treatment resources will provide additional placement options to ensure youth are able to access appropriate behavioral health support interventions in the least restrictive environment.

Contact: James A. Johnston, DJS Legislative Director 410-262-6694 (c) james.johnston@maryland.gov

Increase Maryland's Shared Community Evidence Based Service Continuum

DJS is partnering with DHS to build-out the Evidence Based Service (EBS) continuum in Baltimore City and around the State. Evidence-based programs are designed to provide intensive level treatment for youth that are at risk of being placed out-of-home in either a DHS or DJS placement. Both agencies are working with the Innovations Institute at the University of Maryland to support current EBS services, identify needs to expand EBS services, and develop plans to sustain the valuable programs in our communities.

DJS is committed to identifying new resources to build upon Maryland's continuum of care, leveraging all current resources, and creating systems for meaningful multi-agency collaborations to improve youth and family outcomes.

HB 1382_MHA_INO_Jane Krienke
Uploaded by: Krienke, Jane
Position: INFO

Maryland
Hospital Association

February 27, 2020

To: The Honorable Maggie McIntosh, Chairman
House Appropriations Committee

From: Jane Krienke, Former Foster Youth & Legislative Analyst, Government Affairs
Maryland Hospital Association

Re: Letter of Concern- House Bill 1382- Children in Out-of-Home Placement- Placement in Medical Facilities

Dear Chairman McIntosh:

On behalf of the Maryland Hospital Association's (MHA) 61 member hospitals and health systems, we appreciate the opportunity to comment on House Bill 1382. Maryland's hospitals care for everyone who comes through our doors, but too often patients are unable to access the level of care needed to transition back into the community. Foster youth, especially children and teens with complex medical needs, face many barriers to appropriate care. In too many cases, these children stay in hospitals when they no longer require medical care due to discharge delays and a lack of space in more appropriate settings. This is harmful to the children, the hospital, and the state. We thank the sponsors of the bill for recognizing this very important issue.

Last year a comprehensive study of Maryland's hospitals found 42% of behavioral health emergency department patients were delayed during discharge or transfer. Delays for children and teens were often twice as long as adults. The top causes of delays—accounting for more than half— were lack of capacity or delays in processing referrals.[i]

The Department of Human Services' 2020 report on hospital stays for foster youth revealed the average length of stay in acute care hospitals was 23 days and 16 days for youth in inpatient psychiatric care settings. Three youth remained in hospitals beyond medical necessity for nearly a combined 950 days. These extremely long stays were reportedly due to waiting lists at residential treatment centers and youth requiring higher levels of care than what was available.[ii]

While well intentioned, HB 1382 contains several concerning provisions that would contradict federal guidelines that direct how hospitals discharge and evaluate patients.[iii] HB 1382 would prevent a hospital from keeping a minor, who is in the custody of a local department of social services, longer than 30 hours even if an appropriate alternative placement is unavailable. Maryland hospitals care for these children until care can be appropriately and safely transitioned, and this limitation creates an artificial timeline that does a disservice to these children and puts them at risk. We encourage the committee to consider the importance of finding the right placement instead of the first one that may come available under the pressure of a ticking clock.

The bill also restricts a hospital from admitting a minor if he or she is not exhibiting new behavior and has been recently discharged from another emergency facility or inpatient psychiatric facility. At the core of Maryland's hospitals is a mission to care—no matter the circumstances. A recent discharge from any facility would not—and should not—restrict a child from receiving care.

Instead of considering this bill for passage, Maryland's hospitals strongly urge the committee to view HB 1382 as an opportunity to engage in conversation and develop a real, sustainable solution that ensures foster youth are cared for and placed in the most appropriate setting in a timely manner. This should occur regardless of the jurisdiction or which dedicated social worker is assigned to the child. We need consistency and assurance that foster youth will no longer languish in our hospitals.

Over the past year, the Maryland Department of Health convened a diverse group of stakeholders to study the issue of post-acute care placement for adults and youth. The goal is to identify barriers and create protocols to discharge patients. A subgroup is focused on children and transition age youth.[iv] We strongly recommend that the Maryland General Assembly review these recommendations and implement them as appropriate. The 2019 recommendations released by this work group include actionable steps and identify areas where additional help is needed. Given the unique needs of foster youth, the state should consider consulting this group of experts and leaders to develop an action plan to ensure all foster youth have smooth and timely transitions out of hospitals and into appropriate placements.

When we craft policies that impact foster youth, it is imperative to remember our responsibility to ensure they have every opportunity to thrive and lead healthy, happy lives like their peers who are not in the care of the state. We must remember these experiences shape childhood memories and that most foster youth remember each and every placement—good or bad. On behalf of Maryland's hospitals, we extend our gratitude to Del. Lierman, Del. Reznik and the Appropriations Committee for bringing this issue into the public arena. Our foster youth deserve nothing less than the commitment from the state, hospitals and other stakeholders to work together to address this issue and ensure they have access to the care and support they need.

For more information, please contact:
Jane Krienke
Legislative Analyst
Maryland Hospital Association
Jkrienke@mhaonline.org

Erin Dorrien
Policy Director
Maryland Hospital Association
Edorrien@mhaonline.org

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[i] Dillion, Kristin, Thomsen, Darcie and Bloomgren, B. (September, 2019). *"Behavioral Health Patient Delays in Emergency Departments:Results from the Maryland Hospital Association Behavioral Health Data Collection".*
[ii] Department of Human Services.(January 1, 2020). *"2019 Joint Chairmen's Report- Report on Hospitals Stays by Youth in Out-of-Home Placements.*
[iii] Centers for Medicare & Medicaid Conditions of Participation. 42 CFR § 482.43
[iv] Health Management Associations. (September 30, 2019). "*Post-Acute Discharge Planning Workgroup."*

HB1382_MASSB_MASSB
Uploaded by: MASSB, MASSB
Position: INFO

children and youth remain stable after discharge and do not return to a hospital setting. Viable solutions require child- and family-serving public agencies (e.g., MDH, BHA, DDA, DJS, etc.) and providers (e.g., congregate care, psychiatric hospitals, therapeutic or treatment foster care, etc.) across the state to share responsibility and collaborate together to build an appropriate and sufficient array of placement settings, primarily family-based, that can provide safe, stable and nurturing homes in a timely manner for children and youth demonstrating this specialized set of needs.

Children and youth in psychiatric hospital settings, particularly beyond medical necessity, typically present with a chronic history of severe and complex behavioral and mental health issues that have resulted in the youth having experienced multiple placement changes as well as severe instability in their social, home and community functioning. Many states are grappling with accessing mental health services for this high-risk population. However, what we know is that without adequate, individualized, and well-coordinated services, these children are more likely to remain in highly restrictive environments reducing the likelihood of timely reunification or permanency despite reasonable efforts.

Children who have been placed in psychiatric hospitals engage in behavior that is unsafe for themselves and for the communities. The behaviors demonstrated are indicative of pervasive exposure to trauma, violence, substance use and other adverse childhood experiences, which is displayed as episodic acute crisis. The children and youth requiring have emotional and intellectual disabilities, sexually reactive and sexualized behaviors, co-occurring disorders (high aggression and low IQs), and self-injurious and assaultive behaviors. The children and youth are victims of extreme abuse and neglect, toxic stress, and lack of sufficient early intervention. Based upon the description, when they are ready for discharge there are few placement providers willing to accept a child with a history of intense behavioral and/or mental health challenges, most of whom have inconsistently received appropriate treatment within a therapeutic milieu.

HB 1382 undermines the complexity of these overstay cases, and the legislation is not curative of the underlying problem—a deficiency in placement resources across the State. We appreciate the opportunity to share this information with the Committee. We hope this information will be seriously considered during Committee deliberations.

Warm regards,

Paul Stearns, MASSB President

MASSB Foundation
103 Market Street Annapolis, MD 21401
Phone 443.756.1116
trustee@massbfoundation.org
www.massbfoundation.org

Maryland Association of Social Services Boards

DATE: February 26, 2020

BILL NUMBER: HB1382

COMMITTEE: Appropriations

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

POSITION: Letter of information

House Office Building
Annapolis, Maryland 21401

Dear House Appropriations Committee,

The Maryland Association of Social Services Board (MASSB) respectfully submits this this letter of information regarding House Bill 1382 (HB1382). HB 1382 is intended to solve a serious problem. Currently, children in foster care who have complex needs and behaviors may experience a hospital "overstay," if an appropriate placement cannot be secured by the time the child is ready for discharge from the hospital. It is important that as we go forward in identifying a solution to this problem, we remain focused on what is in the best interest of the children we serve. 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 child; renders any previous findings of an Administrative Law Judge (ALJ) absolute
3. Prohibits the Local Departments of Social Services 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 of Human Services to reimburse the hospital for any costs associated with the child's stay beyond medical necessity. It should be noted, the Department of Human Services currently provides the hospital compensation in the event of an overstay.

MASSB recognizes the urgency of addressing the number of children and youth who remain in acute settings beyond medical necessity. The issue of child welfare-involved children and youth remaining in hospitals and psychiatric institutions beyond medical necessity is highly complex. This problem requires a comprehensive, multi-disciplinary and collaborative approach to increase the availability of clinically appropriate and well-supported placements for youth to both prevent hospitalization and respond holistically so they can discharge when ready. Additionally, a robust and high functioning placement and service array would be able to ensure

HB1382_MASSB_MASSB
Uploaded by: MASSB, MASSB
Position: INFO

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Children who have been placed in psychiatric hospitals engage in behavior that is unsafe for themselves and for the communities. The behaviors demonstrated are indicative of pervasive exposure to trauma, violence, substance use and other adverse childhood experiences, which is displayed as episodic acute crisis. The children and youth requiring have emotional and intellectual disabilities, sexually reactive and sexualized behaviors, co-occurring disorders (high aggression and low IQs), and self-injurious and assaultive behaviors. The children and youth are victims of extreme abuse and neglect, toxic stress, and lack of sufficient early intervention. Based upon the description, when they are ready for discharge there are few placement providers willing to accept a child with a history of intense behavioral and/or mental health challenges, most of whom have inconsistently received appropriate treatment within a therapeutic milieu.

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Warm regards,

Paul Stearns, MASSB President

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Maryland Association of Social Services Boards

DATE: February 26, 2020

BILL NUMBER: HB1382

COMMITTEE: Appropriations

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

POSITION: Letter of information

House Office Building
Annapolis, Maryland 21401

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HB1382_QAC Board
Uploaded by: QAC, QAC
Position: INFO

Advisory Board for
Queen Anne's County Dept of Social Services
125 Comet Drive, Centreville, Maryland 21617

DATE: February 27, 2020

BILL NUMBER: HB1382

COMMITTEE: Appropriations

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

POSITION: Letter of information

House Office Building
Annapolis, Maryland 21401

Dear House Appropriations Committee,

The Queen Anne's County Department of Social Services Advisory Board (QAC Board) respectfully submits this letter of information regarding House Bill 1382 (HB1382), which is intended to solve a serious problem. Currently, children in foster care who have complex needs and behaviors may experience a hospital "overstay," if an appropriate placement cannot be secured by the time the child is ready for discharge from the hospital. It is important that as we develop solutions to this problem that we consider all potential ramifications of this legislative action. HB 1382 makes the following changes to current law:

1. Limits the amount of time a child may remain in the hospital beyond medical necessity to 30 hours and prohibits the medical facility from keeping the child more than 30 hours for evaluation after discharge from acute level of care - even if the child has no appropriate place to go;

2. Prohibits a court from requiring a hospital to keep a child beyond medical necessity, even if the child has no appropriate place to go and discharge is not in the best interest of the child and renders absolute any previous findings of an Administrative Law Judge;

3. Prohibits the Local Departments of Social Services from taking a 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;

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5. Requires the Department of Human Services to reimburse the hospital for any costs associated with the child's stay beyond medical necessity. (Note that the Department of Human Services currently provides the hospital compensation in the event of an overstay.);

The QAC Board recognizes the urgency of addressing the number of children and youth who

remain in acute settings beyond medical necessity. The issue of child welfare-involved children and youth remaining in hospitals and psychiatric institutions beyond medical necessity is highly complex. For that reason, this problem requires a comprehensive, multi-disciplinary and collaborative approach that increases the availability of clinically appropriate and well-supported placements for youth. Such steps are needed to prevent hospitalization as well as to respond holistically so they be discharged only when they are ready (and have somewhere safe and appropriate to go).

Any robust and high functioning placement and service array would ensure that children and youth remain stable after discharge and do not return to a hospital setting. Viable solutions require child- and family-serving public agencies (e.g., MDH, BHA, DDA, DJS, etc.) and providers (e.g., congregate care, psychiatric hospitals, therapeutic or treatment foster care, etc.) across the state to share responsibility and to collaborate together to build an appropriate and sufficient array of placement settings (primarily family-based) that can provide safe, stable and nurturing homes in a timely manner for children and youth demonstrating this specialized set of needs.

Children and youth in psychiatric hospital settings, particularly beyond medical necessity, typically have a history of chronic, severe, and complex behavioral and mental health issues that have resulted in them undergoing multiple placement changes as well as severe instability in their ability to function in home, at school, and in the community. Many states are grappling with identifying and accessing mental health services for this high-risk population. However, we know that without adequate, individualized, and well-coordinated services, these children are less likely to arrive in stable and supportive environments despite reasonable efforts.

Children who have been placed in psychiatric hospitals often engage in behavior that is unsafe for themselves and for communities. These behaviors reflect pervasive exposure to trauma, violence, substance use and other adverse childhood experiences: collectively known as episodic acute crisis. Such children and youth often have emotional and intellectual disabilities, are sexually reactive and display sexualized behaviors, have co-occurring disorders (high aggression and low IQ), as well as self-injurious and assaultive behaviors. These children and youth are victims of extreme abuse and neglect, toxic stress, and lack of sufficient early intervention. Based upon these factors, few placement providers are willing to accept a child with such a history of intense behavioral and/or mental health challenges, most of whom have received inconsistent levels of appropriate treatment within a therapeutic milieu.

HB 1382 understates and undermines the complexity of such overstay cases, and the legislation is not curative of the underlying problem - a deficiency in placement resources across the State. We appreciate the opportunity to share this information with the Committee. We hope this information will be seriously considered during Committee deliberations.

Warm regards,

Alison Davis

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Alison F. Davis, PhD, Chair, on behalf of the QAC Board

HB1382_QAC Board_LOI
Uploaded by: QAC, QAC
Position: INFO

Advisory Board for
Queen Anne's County Dept of Social Services
125 Comet Drive, Centreville, Maryland 21617

DATE: February 27, 2020

BILL NUMBER: HB1382

COMMITTEE: Appropriations

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

POSITION: Letter of information

House Office Building
Annapolis, Maryland 21401

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Warm regards,

Alison Davis

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Alison F. Davis, PhD, Chair, on behalf of the QAC Board

HB1382_MD Dept of Health_INFO
Uploaded by: Shek, Heather
Position: INFO

Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

February 27, 2020

The Honorable Maggie McIntosh, Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

RE: HB 1382 – Children in Out-of-Home Placement-Placement in Medical Facilities – Letter of Information

Dear Chair McIntosh and Committee Members:

The Maryland Department of Health (Department) respectfully submits this letter of information for HB 1382 – Children in Out-of-Home Placement-Placement in Medical Facilities.

The Department is working closely with our sister agencies, the Maryland Department of Human Services (DHS) and the Maryland Department of Juvenile Services (DJS) on addressing this complex issue. The Department is committed to the following:

- Assistance in identifying adolescents currently in extended hospital stays or in danger of losing community/RTC placement due to behavioral issues;
- Assistance in developing plans for at-risk adolescents to preempt hospital placements;
- Providing expedited evaluation services to determine behavioral/developmental needs;
- Assistance in identifying existing capacity in RTC beds system-wide and determine appropriate placements based on acuity/disposition (court involved, developmentally disabled, etc.);
- Providing leadership level support to implement an interagency process to expedite/determine proper placements;
- Assistance in developing/expanding current RTC bed capacity through MOU's with private providers.

I hope this information is useful. If you would like to discuss this further, please contact Deputy Secretary of Operations, Gregg Todd, at 410-767-4557 or gregg.todd@maryland.gov or Director of Governmental Affairs, Webster Ye, at (410) 260-3190 or webster.ye@maryland.gov.

Sincerely,

Robert R. Neall
Secretary