HB 406 Testimony.pdf
Uploaded by: Amy Petkovsek
Position: FAV

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Advancing Human Rights and Justice for All

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MLSC

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United Way

March 29, 2022

The Honorable Guy Guzzone
Chair of the Budget and Taxation Committee
3 West
Miller Senate Office Building
Annapolis, Maryland 21401

RE: Maryland Legal Aid's Written Testimony in Support of HB 406 – Children in Out-of-Home Placements- Placements in Medical Facilities

Dear Chairman Guzzone and Committee Members:

Thank you for the opportunity to present testimony in support of HB 406, a bill that seeks to relieve children in foster care of the pain, frustration, and trauma of calling a hospital their home. Maryland Legal Aid (MLA) is a private, non-profit law firm that provides free legal services to indigent Maryland residents. From 12 offices around the state, MLA helps individuals and families in every Maryland county with many civil legal issues, including housing, consumer, public benefits, and family law matters. MLA also represents abused and neglected children and provides legal assistance to senior citizens and nursing home residents. This letter serves as notice that Amy Petkovsek, Esq. will testify on behalf of Maryland Legal Aid at the request of Delegate Kirill Reznik.

Medical hospitals and psychiatric facilities are safe places to heal from physical and mental health conditions. They are not, and should not be repurposed as, housing units for children in foster care whom the state has run out of placement options for. A lack of appropriate placements for foster youth in Maryland was an emerging crisis pre-pandemic, which has now been exacerbated by the closure of congregate care homes across the state and a decrease in open foster home beds. HB 406 would take a significant step forward in addressing this

escalating situation by setting clear guidelines for when a youth in foster care can remain placed in a hospital setting, and also by establishing a support fund and task force to remedy the continued practice of placing children in medical and psychiatric facilities.

Currently, MLA represents dozens of youth across Maryland who are medically and psychiatrically cleared for discharge but live in hospital facilities due to a lack of appropriate placement options. One youth refers to the rotation of hospital nurses as "his new family." Another hospital became frustrated with the lack of movement on any other placement, needed the bed free, and dropped MLA's client off at a homeless shelter. Yet another youth sits at a facility with no television, no opportunity to attend appropriate schooling, and no access to activities outside the four white walls of her room- not because of any psychiatric or behavioral need, but because there is no place for her to go. Even worse- she knows that. Beyond having a hospital turn into a de facto home, these children are given the clear message- no one wants you, there is no place for you. This is traumatic, inappropriate, and cruel. And in Maryland, it is becoming the new normal, rather than the exception.

Opponents of HB 406 may contend that removing extended and needless hospital stays as a placement option will increase the placement of foster children in motel settings. It is true that in 2021 and continuing in 2022, many local Departments of Social Services are so placement resource-strapped that they are placing children in local motels, with a support worker checking in on them. Just last month, a 14-year-old MLA client placed in a motel took too much of his prescribed medication and was then thrust into a potentially life-threatening situation. Motels are not a safe, appropriate, or kind place to house a youth in care. And neither is a hospital. Maryland needs to do better, and soon. HB 406 takes steps in that direction.

MLA appreciates the opportunity to provide testimony and urges this committee to dedicate the funds needed to give foster care residents a safe, appropriate place to live by giving HB 406 a favorable report.

Sincerely,

/s/ Amy Petkovsek

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HB406 - S - Hopkins - Support.pdf
Uploaded by: Annie Coble
Position: FAV

JOHNS HOPKINS
UNIVERSITY & MEDICINE
Government and Community Affairs

HB 406
Support

TO: The Honorable Guy Guzzone, Chair
Senate Budget and Taxation Committee

FROM: Annie Coble
Assistant Director, State Affairs, Johns Hopkins University and Medicine

DATE: March 30, 2022

Thank you for the opportunity to share our experiences leading Johns Hopkins to **support HB 406 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, prolonged hospitalizations, and prolonged emergency department stays due to insufficient community-based treatment and placement options.

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. Our Division of Child and Adolescent Psychiatry is an important part of this expert team, and is devoted to meeting the behavioral health needs of our young patients through a multidisciplinary approach to the assessment, treatment, and study of pediatric mental disorders.

Over the past several years, due to insufficient community-based treatment and placement options, our Child and Adolescent Psychiatry inpatient units and pediatric emergency department 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 such extended and unnecessary hospitalizations and emergency department stays, children have little to no access to ongoing education, outdoor recreational activities, or community and family engagement. Unnecessarily prolonged hospitalization is not only detrimental to the child, it is also a significant resource drain, limiting our ability to admit and treat the many vulnerable pediatric patients in mental health crisis who are increasingly presenting in emergency departments and other health care settings. Johns Hopkins Child and Adolescent Psychiatry inpatient services receives over 2,000 referrals and is only able to accept approximately 20% due to the unit being at capacity.

The cost to the hospital and the state is significant in both human and financial terms. Inpatient psychiatric services cost $2,109 per day. For the child hospitalized for 115 days beyond what is medically necessary, the calculated expense is $242,535. This is critical funding that could otherwise be dedicated to more efficient and appropriate treatment for multiple children. Our recent review suggests 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. In a retrospective review of three years of data looking at factors related to length of stay on the Child and Adolescent Inpatient Services, the most salient predictor of prolonged length of stay was need for out-of-home placement at the time of discharge. This troubling finding highlights the importance of inadequate out of home placement options as a driver of unnecessary days on pediatric psychiatry inpatient units and in emergency departments.

The relative lack of needed out of home placement options for Maryland youth has a profound ripple effect throughout an already overwhelmed system of acute psychiatric services for children and adolescents. Throughout the state there is a shortage of not only general acute inpatient psychiatric hospital beds, but also more specialized 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 without access to active interventions. An unfortunate consequence is that children who could have been successfully managed with prompt and appropriate acute psychiatric management may escalate to violence or self-harm, and may end up being placed out of state where they are separated from family and familiar surroundings.

The various channels of state government that are responsible for addressing the needs of these children are challenging to navigate for the social workers and clinical teams responsible for arranging safe, appropriate, and timely placement prior to discharge. The responsible agency often varies based on diagnoses or age of the patient, with coordination needed, but often lacking when more than one agency or department is involved. Johns Hopkins has a number of pediatric patients with psychiatric conditions in state custody awaiting placements outside the hospital and who have been here beyond what is medically necessary. The development of a standard multi-agency approach to finding and securing appropriate community-based care and living arrangement would dramatically improve the lives of these children.

This issue is not unique to Johns Hopkins hospitals; hospitals across the state and country 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.

HB406 is a huge step in the right direction by creating accountability for state agencies to find safe and timely placements for these children. Additionally, the creation of the Task Force to Examine the Placement of Foster Children in Emergency Departments is a crucial tool for creating long term successes. The issue of children being stuck in medical facilities has been a long-standing issue and will not see improvements until there is true investment in an integrated and forward-looking solution by the State, as seen by the creation of this task force. We would encourage the membership of the Task Force to be broadened to include clinical representation of hospital and community providers.

For these reasons, Johns Hopkins urges a favorable report of HB406.

HB 406- Children in Out-of-Home Placements- Placem

Uploaded by: Erin Dorrien

Position: FAV

Maryland
Hospital Association

House Bill 406 - Children in Out-of-Home Placements - Placement in Medical Facilities

Position: ***Support as Amended in the House***
March 30, 2022
Senate Budget & Taxation Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment in support of House Bill 406. Maryland hospitals care for everyone who comes through their doors, but too often patients are unable to access the level of care needed to transition back into the community.

Last fall, hospitals joined the Maryland Department of Health (MDH) to identify reasons behind discharge difficulties among children and adolescents who were identified as at risk for a delay, especially children involved with one or more state agencies. Foster youth, especially children and teens with complex medical needs, face many barriers to appropriate care.

Over an eight-week span, hospitals reported the number of youths in an "overstay," defined as being in the emergency department for longer than 48 hours or in an inpatient unit beyond medical necessity. An average of 39 hospitals reported weekly, with an average of 16 hospitals reporting at least one child meeting overstay criteria. In the average week, 25 youth met overstay criteria in the emergency department, and 25 youth met overstay criteria in inpatient units.

During this study, hospital staff offered additional context to understand the reason behind a discharge delay. While capacity issues were most cited for the delay, hospital staff identified a state agency process as a primary or secondary cause of delays for the majority of the overstays. These include:

- Unable to place in a group home
- No foster care placement identified
- No available therapeutic foster care placement
- Parents abandoned patient or passed away
- Guardian wants to relinquish rights
- Waiting on interstate compact approval

These findings reaffirm results of research MHA conducted prior to the COVID-19 pandemic, when hospitals wanted to understand the myriad reasons a patient may be difficult to discharge. In 2019 hospitals participated in two studies of discharge delays among behavioral health patients in both inpatient settings and emergency departments. These studies found:

- During the 90-day study of behavioral health inpatients, 3% of patients experienced a discharge delay[1]
- During the 45-day study of emergency departments, 42% of behavioral health patients experienced a delay[2]

It is clear these discharge delays clog up hospital resources and waste money. More important, it is vital that these vulnerable individuals receive the right care in the right place at the right time.

We thank the bill sponsor for recognizing this very important issue. As noted, there are multiple and complex reasons for these delays. Any sustainable solution will require a holistic approach that includes coordination among all state agencies responsible for meeting the health, custodial and social/emotional needs of foster youth.

The bill, as amended, requires the appointment of an individual to coordinate between MDH, the Department of Human Services, local agencies, and the courts. MDH indicated they are hiring a person to coordinate when patients are unable to be discharged from the hospital due to pending state action. It is imperative that any state coordinator or coordinating body be empowered to remove barriers to timely discharge. The dedicated staff at our hospitals work tirelessly with state and local agency counterparts to secure necessary placements for children and youth in need. Often, the system creates barriers beyond the control of any individual caseworker.

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 most foster youth remember each placement—good or bad.

Our foster youth deserve nothing less than 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:
Erin Dorrien, Vice President, Policy
Edorrien@mhaonline.org

[1] www.mhaonline.org/docs/default-source/resources/mha-report-jan-2019.pdf
[2] www.mhaonline.org/docs/default-source/resources/behavioral-health/behavioral-health-patient-delays-in-emergency-departments-study-2019.pdf

OPD Supplemental Expert Testimony HB406.docx.pdf
Uploaded by: Lindsey Balogh
Position: FAV

MARYLAND OFFICE OF THE PUBLIC DEFENDER

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SUPPLEMENTAL EXPERT TESTIMONY FROM AN OPD LCSW-C

BILL: HB406 – Children in Out-of-Home Placements – Placement in Medical Facilities

COMMITTEE: Budget & Taxation

FROM: Maryland Office of the Public Defender

POSITION: Favorable

DATE: 03/30/2022

The Maryland Office of the Public Defender respectfully requests that the Committee issue a favorable report on House Bill 406. This written testimony is intended to supplement the Maryland Office of the Public Defender's testimony in order to convey the substantial harms to youths who are held in hospital emergency departments.

Critical development takes place during childhood and adolescence, and youths require supportive caregiving, a stable environment, and opportunities for peer interactions in order to develop into functional adults. Most of our clients who are held in hospital settings beyond medical necessity are age 13-16. During this stage of development, significant changes occur as youths begin to learn abstract thinking, develop problem-solving skills, become concerned about the world around them, gain independence, and develop their identity, among other important development steps. In essence, this is the stage where youths start figuring out *how* to be an adult, the start of a decade-long journey into adulthood.

Youths are admitted to emergency departments for a variety of reasons pertaining to behavioral health, but in nearly every case, the youth is experiencing an acute psychiatric episode. The purpose of the admission to the emergency department is to stabilize the youth, as the episode they are experiencing is so severe that they cannot move forward in their development until the episode is resolved. Even the best psychiatric emergency departments cannot provide an appropriate setting for youth development. As such, when a youth remains at a hospital longer than is medically necessary, the negative impact of the hospitalization becomes dramatic.

It probably seems obvious to assume that a hospital is a safe place for a youth that cannot otherwise be placed by DSS, but this is categorically untrue. Youths are deprived of education, therapy, peer interactions, exercise, access to their own clothes and belongings, community engagement, privacy, and human contact outside of the staff members present during a given shift. Likewise, youths are exposed on a daily basis to adults experiencing delusions and hallucinations,

patients who expose themselves, situations where staff must physically manage aggressive patients, seeing other patients come and go, and overall, a generally high level of acuity among the other patients on the unit. The damage to vulnerable youths stuck in this situation cannot be understated. Youths are traumatized by the time spent in hospital overstays.

Years of research also demonstrates the harms of needless hospitalization on vulnerable youths. In the case of youths who are deemed aggressive, studies show that hospital overstays can actually increase aggressive behavior as a result of the stressful hospital conditions. Research also shows that the longer a youth stays in the hospital, the more they identify with negative beliefs about themselves and their abilities resulting in feelings of shame and inferiority; this is particularly damaging at an age when youths are try to define their identity. Lastly, research shows a clear positive relationship between the length of a youth's hospital stay and the likelihood that a youth will be readmitted.

Our own clients have described lengthy hospitalizations as more akin to a prison setting than a place of therapeutic recovery. The environment is dehumanizing, traumatizing, and dangerous, and it deprives youths of the ability to develop into the functional adults that we hope will one day contribute to our communities. Instead, it causes delays in development that can have lasting impacts on individuals who will, in several years, undoubtedly become adults in need of treatment.

For these reasons, the Maryland Office of the Public Defender urges this Committee to issue a favorable report on HB406.

Submitted by: Maryland Office of the Public Defender, Government Relations Division.
Authored by: Lindsey Balogh, JD, MSW, LCSW-C
Advanced Social Worker, Mental Health Division
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HB 406.Senate.DRMtestimony.ChildreninOOHPlacements
Uploaded by: Megan Berger
Position: FAV

Disability Rights Maryland

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SENATE BUDGET AND TAXATION COMMITTEE
TESTIMONY OF DISABILITY RIGHTS MARYLAND
HOUSE BILL 406 – Children in Out-of-Home Placements-Placement in Medical Facilities

March 30, 2022

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 located a safe placement for them. In many cases, these children remain hospitalized for months past their discharge date. **House Bill 406 recognizes the grave impact that excessive time in hospital and institutional settings has on youth with emotional and behavioral disabilities.** HB 406 also implements critical reforms and safeguards that ensure that children and youth are not needlessly warehoused in emergency departments and hospitals and are returned to community placements and settings as quickly as medically recommended. DRM cautions, however, that the true root of the grave hospital overstay problems that this bill addresses will not fully be remedied until 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. DRM is not opposed to the amendments that have been incorporated into the bill and we hope that future legislation will go even further toward protecting children's rights.

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 zero education services or 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 previous clients, "Frank," [1] a thirteen year-old young man in DHS custody, was cleared for medical discharge from a hospital but was forced to wait in the hospital for two-and-a-half months while an appropriate community placement was located. Prior to his hospital admission, 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 the two-and-a-half months. As a result of DRM's advocacy, he was finally 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 asked her when he would be able to "go home."

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

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

negotiations over who will accept responsibility for finding and funding a placement for the child. It is our conclusion that urgent changes are necessary to ensure that children and youth in DHS care and custody are discharged from the hospital at the earliest possible time and receive appropriate care and services in the community.

For the foregoing reasons, DRM supports HB 406.

Thank you for the opportunity to present this information to you today. For more information, please contact Megan Berger, Esq. at 410-727-6352 ext. 2504 or Megan.Berger@disabilityrightsmd.org.

Senate Budget & Taxation Committee HB 406 testimon

Uploaded by: Mitchell Mirviss

Position: FAV

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Testimony of Mitchell Y. Mirviss, Esq. before the Senate Budget & Taxation Committee
HB 406: Children in Out–of–Home Placements – Placement in Medical Facilities

Position: SUPPORT
March 30, 2022

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, regarding 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, for the past four years, BCDSS and other local departments of social services have been warehousing children in psychiatric hospitals, psych wards of other hospitals, and even in hospital E.R.s due to a statewide placement shortage now in its sixth year running. These illegal and grossly inappropriate placements can last weeks, months, or even a year or longer.

In 2021 alone, 49 or 50 different Baltimore City foster children had a total of 69 separate hospital overstays. ***The average length of hospitalization was 55 days.*** And Baltimore City accounts for less than half of the total foster care population in the State. As of December 31, ***eleven children*** were in hospital overstays statewide. As of March 18, 2022, ***nine Baltimore City children*** were in hospitals without medical cause. One Baltimore City child has stayed in a hospital for 483 days. All of these children have been warehoused in psychiatric hospitals or wards without medical justification or have been kept in emergency rooms of hospitals for extended periods of time without medical justification.

During 2019, the OPD represented one child who had been wrongly hospitalized on seven different occasions. One of the Baltimore children hospitalized last year was only *six years old*. He is the *second* six-year-old known to have been hospitalized without medical need since 2019. Some of the children have been hospitalized three or four times. As of today, there are several foster children who are stuck in a surreal, highly illegal *Cuckoo's Nest* world.

This is a disaster. In my 37 years of representing foster children in Baltimore, I have never seen anything this bad. That includes children sleeping in hard chairs in a DSS office building 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 the child does not meet the criteria for involuntary hospitalization but remain stuck in the hospital because the local DSS refuses to pick up the child, stating that no placement

is available. Juvenile court judges have resorted to ordering the placement of the child in a private psychiatric hospital 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 most congregate-care placements for foster children, yet here in Maryland we are using the very worst, the absolutely most restrictive placements—psychiatric wards and E.R.s—for our most vulnerable, highest need children. A psychiatric hospital or an E.R. 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. The literature confirms that over-hospitalized children are likely to regress and be further traumatized.

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. Unfortunately, DHS has failed to plan for the actual needs of its foster care population and to budget for services that would fix the problem. The State has been well aware of the problem for four years running now. A year ago, several advocates and I were preparing to sue but did not because the State announced plans to expand and create dozens of new placements and beds. That information turned out to be misleading (at best). New plans were announced last summer, but they will not solve the problem. As of today, ***only four new beds have been filled***, and these are (a) reserved for developmentally disabled children; and (b) located in Frostburg, far from Baltimore. DHS had an RFP for 60 new beds; ***it received only one proposal for only fifteen new beds***, which DHS admits is not enough.

Because the State has failed to curb these illegal placements and has no plan to do so, the General Assembly needs to step in and enact strong measures that will prevent DSS agencies from continuing to mistreat foster children in this way. HB 406 provides legal clarity and financial protection to hospitals. These are vital measures, even if they do not go far enough. Similar measures, such as HB 1032 (2020), have put DHS and MDH on clear notice that such provisions might be necessary if they did not create placements for these children.

HB 406 would at least be a start in addressing the crisis. No foster child should be warehoused in a psychiatric ward 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 maltreated children as if they were our own.

Respectfully submitted,

/s/ Mitchell Y. Mirviss

MPA Testimony 2022 - Support HB406 - Senate Heari
Uploaded by: Pat Savage
Position: FAV

MARYLAND
PSYCHOLOGICAL ASSOCIATION

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March 31, 2022

Senator Guy Guzzone, Chair
Senate Budget & Taxation Committee
Miller Senate Office Building
Annapolis, MD 21401

Bill: HB406 – Children in Out-of-Home Placements – Placement in Medical Facilities

Position: Support

Dear Chair Guzzone and Members of the Committee:

The Maryland Psychological Association (MPA), which represents over 1,000 doctoral-level psychologists from throughout the state, is writing in **SUPPORT** of **HB 406 – Children in Out-of-Home Placements-Placement in Medical Facilities**.

We applaud and support the purpose of the bill, to better manage the placement of children and adolescents into medical facilities/programs. We strongly support and thank the Sponsor for the inclusion of Psychologists as one of the mental health specialists uniquely qualified to evaluate the mental health status of children and adolescents.

The bill is a good start to building out a system of care that needs attention. For the Committee's consideration the MPA wanted to share these additional points:

1. Some flexibility could be helpful concerning the requirement that the evaluation be set for 48 hours prior to a court hearing. This may be difficult to meet for several reasons.

2. We appreciate the removal of the use of fines of local departments involved in this process, as originally included in the bill. This may have created the unintended consequence of conflict rather than encourage coordination between facilities and local childcare services.

3. The availability of out-of-home placements for children/adolescents in Maryland is sorely lacking. Additional legislation, in the form of establishing the funding for adequate numbers of out-of-home placements, would provide necessary resources to help fulfill the aims of this bill.

For these reasons, we urge a favorable report on HB 406. If we can provide any additional information or be of any assistance, please do not hesitate to contact the MPA Executive Director, Stefanie Reeves, MA, CAE at 410-992-4258 or exec@marylandpsychology.org.

Respectfully submitted,

Sincerely,

Linda McGhee
Linda McGhee, Psy.D., J.D.
President

R. Patrick Savage, Jr.
R. Patrick Savage, Jr., Ph.D.
Chair, MPA Legislative Committee

cc: Richard Bloch, Esq., Counsel for Maryland Psychological Association
Barbara Brocato & Dan Shattuck, MPA Government Affairs

HB 406 - Children in Out-of-Home Placements - Plac

Uploaded by: Pegeen A. Townsend

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HB 406 – Children in Out-of-Home Placements – Placement in Medical Facilities

Position: *Support*
March 30, 2022
Senate Budget & Taxation Committee
Senate Judicial Proceedings Committee

Bill Summary

HB 406 would require local departments of health and social services to find a placement for a child determined not to require hospitalization or pay a fine into a Foster Care Support Fund.

MedStar Health's Position

One of the most frustrating situations in caring for our communities is when a child with a disability, cognitive impairment, or behavioral health issue is brought to the emergency department, is treated and stabilized, and no longer needs acute care services but we cannot find an appropriate placement to discharge the child to. These children often spend days and weeks in the emergency department, and some spend months in our inpatient unit while we search for an appropriate placement. Some argue that because the child is in a safe environment, that child is not to be prioritized by the state for placement.

This is a disservice to the child who should be in a more appropriate setting. It is a disservice to the community when a bed is occupied by someone who does not need acute care services. And, it is a disservice to health care providers who need to care for acute patients.

It is clear the state does not have sufficient resources to properly care for these children. A survey last fall by the Maryland Hospital Association found that the weekly average for youth in hospitals meeting "overstay criteria" is 50 (25 youth in in-patient units / 25 youth in the emergency department). The average age for the youth meeting "overstay criteria" was 14, with an even split between males and females. Typically, these patients are waiting for Department of Social Services placement or waiting for inpatient psychiatric placement. Common reasons for discharge delays include: 1) aggressive behaviors; 2) developmental disabilities and/or autism with psychiatric features; 3) sexually relative behaviors, and; 4) age (too young/too old for available youth placement). These are some of the most vulnerable patients we care for and they should have access to the care they need in the most appropriate setting.

For the reasons listed above, we respectfully ask that you give HB 406 a ***favorable*** report.

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Uploaded by: Regan Vaughan
Position: FAV

CATHOLIC CHARITIES BALTIMORE

CHERISHING THE DIVINE WITHIN ALL

House Bill 406
Children in Out–of–Home Placements – Placement in Medical Facilities
House Appropriations Committee
February 15, 2021
Support with Amendments

House Bill 406 was introduced to address the issue of foster youth remaining in hospitals after discharge. Catholic Charities of Baltimore understands this issue and supports efforts to address the root causes and to be part of a solution that will also create accountability for those ultimately responsible.

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, including many in foster care, through school based behavioral health services, out-patient mental health clinics, a residential 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 other departments, most notably the Behavioral Health Administration in the Maryland Department of Health.

The issues we are dealing with are not new; children staying in hotels, sleeping at DSS offices, and being stuck in hospitals. The Baltimore Sun has documented all of these issues over recent decades. Most recently the MD Children's Cabinet published the "Interagency Plan: Developing Resources To Address the Complex Needs of Maryland Youth in Care Prepared By: State of Maryland Children's Cabinet April 2020". (The last public update to the plan was in February 2021.) This strategic plan is strikingly similar to the Interagency Strategic Plan created in 2008 under the prior administration.

The goal of any legislation should be to hold the State's Children's Cabinet and entire child-serving system accountable for implementing these strategies in a timely and robust fashion.

There are healthy discussions and efforts underway to address foster children stuck in hospitals, voluntary placements for children, crisis response systems for children, etc. The biggest mistake that we make is to treat these issues as separate and discrete. There is only one child-serving system, and it is housed across a number of agencies that must be accountable for working together to take care of all of Maryland's children.

The issues that exist are both long-term and short-term. There is an immediate need for youth crisis/treatment beds to alleviate the current stress on the system. There is a longer-term need for evidence-based preventative services to treat the behavioral health needs of Marylanders. The number one driver of entries to child welfare is behavioral health. Adult substance use is the number one driver of young children entering care. Youth and parent mental health issues are the primary driver of teens entering the system. The systems MUST come together. This isn't a political issue – the plan has already been written, multiple times, by consecutive republican and democrat administrations.

With this legislation, an oversight committee should be established that is responsible for urgently overseeing implementation of the above referenced Interagency Plan. The committee should have representatives from the legislature, DHS, MDH, local DSS, MARFY providers, attorneys for the youth, and other stakeholders. This Children's Cabinet should be required to provide the committee with regular progress reports. The youth and adults served by these programs deserve the very best our State can offer.

Thank you for your consideration of our views.

Submitted By: Kevin Keegan, Director of Family Services

Written Testimony.Senate. HB 406_B&T 3.30.22.pdf
Uploaded by: Sanjeev Varghese
Position: FAV

PAUL DEWOLFE
PUBLIC DEFENDER

KEITH LOTRIDGE
DEPUTY PUBLIC DEFENDER

CARROLL L MCCABE
DIVISION CHIEF MENTAL HEALTH

COMMITTEE: **Budget & Taxation**

FROM: **Maryland Office of the Public Defender, Mental Health Division**

BILL: **HB 406 – Children in Out–of–Home Placements – Placement in Medical Facilities**

POSITION: **Favorable with Amendments**

DATE: **03/30/22**

The Maryland Office of the Public Defender respectfully requests a favorable report from Budget and Taxation on HB 406. We are grateful to sponsor Delegate Kirill Reznik for facilitating collaboration among numerous stakeholders to arrive at the amended version. HB 406 is the first step toward accountability for the Departments and redressing the continuing harm perpetrated in cases where vulnerable foster children have been failed by the State.

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

1. Since at least 2017, children in local Department of Social Services (DSS) custody are languishing in emergency departments and inpatient psychiatric units after discharge or judicial release because DSS refuses to remove them, citing a lack of placements. The Department of Human Services (DHS) has failed to provide housing placements in the least restrictive setting, which these children are entitled to under state and federal law, as well as the U.S. Constitution.
2. DSS is currently keeping children in the *most* restrictive environment with the highest cost. HB 406 incentivizes DSS to provide outpatient placements and facilitates an implementation planning process.
3. Foster children needlessly occupy scarce inpatient psychiatric beds, causing children and adults who need these inpatient beds to suffer longer stays in emergency departments.
4. Prolonged hospital stays are extremely harmful to children who already are highly traumatized due to physical abuse, sexual abuse, or neglect.
5. Neither the hospitals nor the courts have been able to solve this issue.
6. 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.

Today, there are multiple foster children being held in hospital emergency departments and inpatient psychiatric units without medical need due to DHS' failure to ensure appropriate placements. This inhumane and illegal practice retraumatizes vulnerable children. The Mental Health Division of the Office of the Public Defender represents these children. Since 2018, OPD has represented over 100 children who were either bounced from emergency department to inpatient psychiatric unit to emergency department or who remained hospitalized in hospital emergency departments or inpatient psychiatric units after discharge or judicial release because

DSS refused to remove them. That number is not the total number of all foster children who remain hospitalized beyond medical need because OPD does not get notified of all of these cases where children are eligible for representation. Maryland law currently requires that OPD receive notice of a subset of those children—children who have been certified for involuntary civil commitment. This bill requires that OPD received notice of all foster children who are detained in emergency departments and inpatient psychiatric units beyond medical necessity—often after judicial release or discharge is ordered. As a result of HB 406, OPD will be able to provide these children with the representation to which they are entitled, which is the first step toward holding the Departments accountable for providing placements.

Since 2017, OPD has worked with hospitals around the State to address the issue of children remaining in emergency departments and involuntary inpatient psychiatric units after discharge or judicial release. After a number of unsuccessful attempts to resolve this issue in Maryland courts, OPD sought the assistance of two law firms—Venable and Brown, Goldstein and Levy—and Disability Rights Maryland 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. Now, despite being aware of the problem for years, the Departments continue to fail in their responsibility to care for the most vulnerable of our children. Detaining foster children in emergency departments and inpatient psychiatric units when they do not meet criteria for involuntary civil commitment or beyond medical necessity, regardless of the reason, violates their constitutional rights, and these children have actionable claims in federal court.

Foster children—who already suffer from trauma due to abuse and neglect—are devastated by prolonged involuntary hospital stays. Many of them have been abandoned by their biological parents and suffer behavioral difficulties derivative of trauma. These children 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, impacting their social development. Inpatient psychiatric units and hospital emergency departments are acute care units and not designed to provide long term care. Accordingly, these units typically do not provide educational programs or age-appropriate therapeutic activities available to foster children in appropriate long-term placements. The State is failing these vulnerable children who understand that they have been effectively abandoned after a physician or judge orders their release and DSS refuses to pick them up from the hospital.

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 it gives hospitals a statute to rely on when DSS abandons their wards despite a physician ordering discharge or a judge ordering release.

Additionally, children in need of inpatient beds suffer from Maryland's severe shortage. Children may stay for days or weeks in emergency departments waiting for beds in 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. For example, since October of 2021, the OPD represented a client who remained in a hospital ED for 95 days waiting for an inpatient bed, a client who remained in an ED for 36 days waiting for a bed, and another client who was in an ED for at least 90 days waiting for a bed. Many more individuals spent days or weeks in emergency rooms waiting for inpatient beds to open. Multiple studies have shown that ED boarding is harmful to child and adult patients.

In a Letter of Information to the Legislature in 2020, Johns Hopkins hospital advised that each day that a child is hospitalized in an inpatient psychiatric unit costs $2,109.00. Medical insurance does not pay the cost of hospital stays beyond medical necessity. HB 406 requires the Department of Health or Department of Humans Services to reimburse hospitals the prevailing Medicaid rate. Although this reimbursement rate is much less than the cost of care, the state is currently warehousing children beyond medical necessity without paying for care. OPD was recently made aware of 1 patient who remained hospitalized for a year after medical necessity because DSS refused to pick up the child when the child was ready for discharge. Using the 2020 rate, the cost for keeping that child in an inpatient psychiatric hospital was approximately $764,000.00. Another child at the same hospital remained for 6 months after medical necessity, costing approximately $380,000.00. The total cost of providing unnecessary inpatient treatment in a setting found to be harmful for those two children was over **One Million Dollars**. It is inconceivable that Maryland State agencies have not found the money to provide appropriate, less expensive, less restrictive placements.

HB 406 requires the Departments to provide placements, but it also facilitates the cooperation necessary to accomplish the task. The bill creates a Coordinator to ensure compliance and cooperation between the Departments, Courts, hospitals, and OPD. The bill also provides for more collaboration on placement solutions. The 2019 Post Acute Discharge Planning Workgroup Report detailed the barriers related to hospital discharge for adults and children with complex mental health needs and provides recommendations to address the shortage of robust community-based services. For example, the report recommended that BHA and DHS take the lead on evaluating the effectiveness of available in-home/respite care services to determine an effective model to address inappropriate hospitalization while also providing relief to caregivers. HB 406 requires a task force for further study on the issues and implementation.

We respectfully request a favorable report on HB 406 as a step toward government accountability, solving complex problems associated with housing placement, and providing for foster children as already required by law.

Respectfully Submitted,

Carroll McCabe
Chief Attorney, Mental Health Division
Maryland Office of the Public Defender
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UMMS - Katrina Escuro - HB406 Testimony - Favorabl
Uploaded by: Shane Sarver
Position: FAV

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CORPORATE OFFICE

House Bill 406
Children in Out-of-Home Placements – Placement in Medical Facilities
Position: Favorable
Budget & Taxation
March 30th, 2022

Dear Chairman Guzzone, Vice Chair Rosapepe, and Members of the Budget & Taxation Committee:

My name is Katrina Escuro, and I am a child and adolescent psychiatrist and medical director of the child and adolescent psychiatry inpatient unit at University of Maryland Medical Center. Thank you for providing this opportunity to express my support for this legislation on the behalf of the University of Maryland Medical System. We have seen a significant rise in the number of children who have been psychiatrically stabilized but remain in the hospital because they are awaiting placement by the Department of Social Services. In the past six months alone, we have cared for five children who collectively account for more than 200 days of hospital "overstay," or days in the hospital after the child was cleared for discharge. This is more than 200 days without fresh air or proper education. More than 200 days with only limited contact with family and friends. More than 200 days that these children cannot get back. Imagine spending 200 days without stepping foot outside or seeing your loved ones.

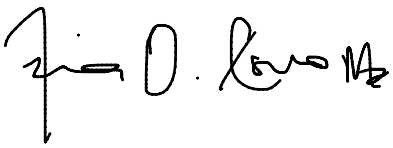
Whenever we have a child on our unit who needs placement outside of their home, our hospital treatment team arranges regular meetings with the child's DSS team to obtain updates on placement and determine if we can provide additional information to help secure placement. It is not unusual for us to find out during these meetings that the forms required for referral are outdated and focused on the child's behaviors prior to hospitalization, thus resulting in available placements declining to accept these children or even interview them once they are psychiatrically stable. The clinical updates that are requested of us are sometimes attached to these referrals, but rarely reviewed after reading the initial form. There are times where we have successfully advocated for these forms to be updated to reflect how these children are behaving after receiving treatment, but placements are often not willing to reconsider once they have already made a decision. Imagine always being judged solely by your worst behavior when you are in the middle of a crisis.

One child who was on our unit for almost two months after psychiatric stabilization was accepted to another facility, but her transfer required approval from Social Services Administration for out of state placement. It took over one month for SSA to review and approve the placement, despite this facility being identified several weeks beforehand. Meanwhile, this child often wondered aloud why no one wanted her. When asked if she needed anything, she replied "a home." Imagine your fate in someone else's hands, sitting on someone else's desk awaiting signature.

The delay in finding placement for these children has downstream effects as well. These children occupy beds that are subsequently unavailable to the dozens of children waiting in emergency rooms across the state for inpatient psychiatric admission. These beds occupied by children who are already psychiatrically stable represent over 200 days' worth of treatment that cannot be provided to children in crisis. Imagine watching your own child sleeping on a stretcher in the emergency room for over a week after a suicide attempt, because there are no beds available.

We fully recognize that funding and resources are limited, but we are asking for those responsible for placing these children to approach the process more creatively and look at alternate options in a more timely manner. We understand that DSS is charged with finding placement for many children out in the community, in addition to those in the hospital. Hospital treatment teams are often skilled in coordinating referrals to other treatment providers and willing to assist DSS in the placement search. We are asking that DSS collaborate with the various hospital teams to find placement for children in the hospital as soon as possible. The hospital may seem like a reasonable place for children to wait for placement, but they are at serious risk of decompensation once they have outgrown the acute crisis stabilization programming. Imagine passing legislation that can help these children heal from their past traumatic experiences and learn how to navigate life safely and successfully. Passing House Bill 406 can help make this a reality.

Sincerely,



Katrina Escuro, M.D.
Assistant Professor, Division of Child and Adolescent Psychiatry
Department of Psychiatry
University of Maryland School of Medicine
Medical Director, Child and Adolescent Inpatient Psychiatry Unit
University of Maryland Medical Center

UMMS - Megan Pearlman - HB406 Testimony - Favorabl
Uploaded by: Shane Sarver
Position: FAV

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House Bill 406
Children in Out-of-Home Placements – Placement in Medical Facilities
Position: Favorable
Budget & Taxation
March 30th, 2022

Good Afternoon, Chairman Guzzone and Committee Members, my name is Megan Pearlman. I am the Clinical Social Work Team Lead at the University of Maryland Medical Center for the inpatient psychiatric units. I want to first thank you for allowing me this opportunity to provide support for this legislation on the behalf of the University of Maryland Medical System. HB 406 would require more timely action amongst agencies and further protect the rights of the pediatric psychiatric patients who are inappropriately admitted to the inpatient psychiatric units or are unable to discharge due to the local Department of Social Services' inability to identify suitable out-of-home placements in a timely manner.

Our Child and Adolescent Inpatient Psychiatric Unit provides care for hundreds of kids each year who require acute psychiatric stabilization. The average length of stay is between 5 and 7 days. Now, I can share a lot of statistics with you, but one piece of data that underscores the plight of children on our unit who are in the custody of DSS is this: over the past 9 month, a total of 7 patients, or kids rather, in DSS custody, spent a total of 359 days in the hospital beyond what was deemed medically necessary and against their will. During this time of unnecessary overstay, these kids miss out on milestones such as attending their friends' birthday parties or even celebrating their own, taking their driver's license test, attending afterschool sporting events, celebrating Thanksgiving, Christmas, and the list goes on. And what is worse, while here,

awaiting placement, they often begin to regress, blaming themselves as if this is their fault for seeking help in the first place. It is difficult for most people to even comprehend the traumas and adversities these kids have already had to endure. To have to live in a locked psychiatric unit without the familiar faces of their family members and/or friends is unconscionable. No child should be forced to remain in a locked inpatient psychiatric unit simply due to the failings of the government agency that is charged with protecting and caring for them. While I imagine that the work of DSS is not easy, neither are the lives of these children. At the very least, it is incumbent upon DSS to work collaboratively with the hospital teams to find these children a suitable home.

In conclusion, for all these reasons, University of Maryland Medical Systems urges a favorable report of HB406.

UMMS - Sumr Farooq - HB406 Testimony - Favorable.p

Uploaded by: Shane Sarver

Position: FAV

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House Bill 406
Children in Out-of-Home Placements – Placement in Medical Facilities
Position: Favorable
Budget & Taxation
March 30th, 2022

Good afternoon,

My name is Sumr Farooq and I am a licensed social worker on the inpatient child and adolescent psychiatric unit at the University of Maryland Medical Center, here on behalf of the University of Maryland Medical System. I agree with everything that has been said in support of House Bill 406.

I would like to impress upon you today the human experience for children who are directly affected by the insufficiencies that exist in the current state of the placement process.

I recently cared for 9th grader whom I will call "Angel." Angel was just starting her first year in high school when she was admitted to our unit for an acute psychiatric admission. Angel had a history of significant trauma and at a young age, had been removed from her parent's care and custody by the court. After 21 days in our unit, Angel was medically ready for discharge; however, because she was under the custody of local DSS, she had to wait until DSS could find a placement for her. She spent the next 81 days waiting for them to find her a home.

During those 81 days, Angel spent her first semester of high school, Thanksgiving, Christmas, New Years, away from loved ones, and the comforts of simply being a kid. She would often make comments saying that it was her fault she was still here. She thought that she was being punished. She felt rejected and hopeless. One night, unable to express how she was feeling out loud, she wrote a note. It said, "I never said this before, I need my mom, I'm just not myself; I'm losing myself." This is the reality for these kids. They feel voiceless, unable to truly advocate for what they deserve. There is no end in sight for them. One of the hardest parts about my job was to meet with this child daily, just to tell her "I don't know where you are going", and to hear that she was unable to make contact with her DSS worker herself to ask why there were no updates. What is already one of the most traumatic experiences in their young lives, is exacerbated by the inability of local DSS to find suitable placement.

While she was hospitalized, our team tried to collaborate with local DSS, reaching out to them directly for status updates and implementing weekly treatment team meetings to provide our insights into her responsiveness to treatment.

Our team also offered to assist with the referral process. The only information that these placement agencies receive is an initial referral which contains some limited information about the patient. This is the only piece of information they have to decide whether to accept or reject a

placement. Although this child had experienced trauma and had triggered some negative behavior, those experiences are what cultivated a profound resiliency that allowed her to improve during her admission. These strengths and progress must be underscored to families and facilities she was being referred to. Unfortunately, we have no ability to make sure that this is being done.
We offered to contact placement agencies ourselves to follow-up, and were denied information on where referrals were sent. Week after week, we were informed that placements were denying her, with no feedback. When pressed for detail about why these placements were denying her, DSS would not provide us with this information.

In February, we ultimately took it upon ourselves to reach out to placement agencies directly in the hope that perhaps one agency would reconsider their prior denial. In doing so, we contacted one facility who stated that they had only received the referral the day prior. With careful and direct follow-up with these agencies, we were able to facilitate an interview with the child, which lead to her discharge the next day. In conclusion, had we not taken it upon ourselves to make this direct contact, this child would have been left to languish far beyond the 81 days she spent unnecessarily.

Thank you Chairman Guzzone and Members of the Committee.

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Uploaded by: Therese Hessler
Position: FAV

Maryland Association of
Resources for Families & Youth

March 30, 2022

House Bill 406
Children in Out-of-Home Placement - Placement in Medical Facilities
Budget & Taxation Committee

Position: SUPPORTS AS AMENDED IN HOUSE

The Maryland Association of Resources for Families and Youth (MARFY) is an association of private child caring organizations providing foster care, group homes, and other services through more than 200 programs across Maryland. The members of MARFY represent providers who serve Maryland's most vulnerable children who are in out of home placements due to abuse, neglect or severe mental health, and medical needs. We operate group homes, treatment foster care programs and independent living programs, primarily serving the foster care population as well as a juvenile services population.

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.

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.

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.

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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 youths 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.

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Maryland Association of
Resources for Families & Youth

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.
- While 14 counties in Maryland do have Mobile Crisis teams, not all of them serve children with Mobile Crisis. 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 regard 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.

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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, ensuring that all Maryland counties have Mobile Crisis that serve children and adolescents.
- 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.
- Align rates that support social workers/therapists' pay in line with schools and hospitals.

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- 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 breakdown in information sharing.

Resources to Implement Family First Prevention Services Act: While the concept is critical in regard 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.

MARFY recognizes the abundant challenges surrounding these issues and appreciates the effort of the Sponsor and the Committee to engage in meaningful conversation on solutions and we ask for a favorable report on HB406. Thank you.

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hb406 cpmc.pdf
Uploaded by: judith Schagrin
Position: FWA

THE COALITION TO PROTECT MARYLAND'S CHILDREN

Our Mission: To combine and amplify the power of organizations and citizens working together to keep children safe from abuse and neglect. We strive to secure the budgetary and public policy resources to make meaningful and measurable improvements in safety, permanence, and well-being.

Senate Budget and Taxation Committee
March 30, 2022

HB 406: OUT OF HOME PLACEMENTS – PLACEMENT IN MEDICAL FACILITY

Support with Amendments

When a child is in the state's custody, we assume a weighty responsibility for the child. Although one obligation is to do no harm, we are failing the children and youth whose trauma behaviors present a serious risk to themselves or others. For weeks and sometimes months, these youth are stuck in psychiatric in-patient units without education, age-appropriate socialization, or even treatment as these units are designed for crisis resolution. Shockingly, others may linger in emergency rooms for weeks and months when no community treatment setting or even an in-patient bed willing and available to accept the child.

We appreciate that HB 406 is shining a light on this troubling issue, the end result of decades of neglect by our state government. When multiple treatment programs closed and hundreds of beds disappeared, no plan was made for replacements. This has had disastrous consequences for the children and youth, leaving the local departments of social services without any option for those youth with high intensity needs. Placement providers have the right to say 'no' and they do.

Were the Maryland Department of Health to open 25 "no reject, no eject" psychiatric crisis respite beds, the overstay crisis would be immediately alleviated, and the children would have a safe and stable environment until a more long-term plan can be effectuated.

Some suggest that the children are stuck because caseworkers aren't doing their jobs. These people will share stories claiming that uncaring local departments "dump" children in the hospital and never look back, never even visiting. This is unfortunate, as maligning the workforce is simply a distraction from very real systemic failings.

HB406 offers a welcome start to addressing the shortage of treatment options, mandating that the Maryland Department of Health and Department of Human Services collaborate to provide sufficient capacity for the children – 'our' children - and we ask for your support.

2022 HB 406 Senate Side.pdf
Uploaded by: Scott Tiffin
Position: FWA

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NASW MARYLAND CHAPTER
National Association of Social Workers

Senate Budget and Taxation Committee
March 30, 2022

HB 406: OUT OF HOME PLACEMENTS – PLACEMENT IN MEDICAL FACILITY

Support with Amendments

'Stuck children' are those with high intensity behavioral health needs and/or developmental disabilities on overstay in psychiatric facilities or in hospital emergency rooms. Despite the Children's Cabinet claim that increasing placement options for specialized youth remains a top priority, existing resources and policies have failed to help children get un-stuck. We appreciate that HB 406 is shining a light on this troubling issue, the end result of decades of neglect by our state government.

HB 406 as amended appropriately puts the onus of responsibility on the Maryland Department of Health to provide the beds necessary to accommodate children's treatment needs. In fact, if 25 'no eject, no reject' psychiatric crisis beds were opened, every 'stuck' child would have a safe and stable treatment setting for discharge pending the next step. Enabling youth on overstay to discharge would open in-patient beds and reduce unconscionable waits in the emergency rooms.

There are those who suggest that these children are stuck because caseworkers aren't doing their jobs. These people will share stories with you about uncaring local departments who "dump" children in the hospital and never look back, never even visiting. This is unfortunate, as scapegoating the workforce is simply a distraction from very real systemic failings.

A deeper dive to understand the real driver of 'stuck children' readily uncovers a crumbling placement system only worsened by COVID-related staffing shortages. In recent years, roughly 450 beds for children with complex needs have closed without no plans for replacement. As a reminder, DSS's are reliant on private providers for youth with high intensity and complex needs. Private providers have limited bed spaces, the right to say no to admission, and the right to require a child be removed from a program.

Along with children and youth on overstay in hospitals, local DSSs are now so desperate that staff are hoteling children for lack of alternatives.

What is hoteling? Youth with high intensity needs for whom ***all placement options have been exhausted*** (typically 40 to 60 rejections) are housed in hotels as an act of desperation. The DSS purchases 1:1 supervision, and provides the 1:1 aide with gift cards to purchase the child's food, and laundry is done at the laundromat. The caseworkers aren't lazy, uncaring, or otherwise shirking their responsibilities – they simply have no alternative. This is not the sort of parent Maryland intends to be.

The authority responsible for licensing behavioral health programs to meet the treatment needs of those 'stuck' in the hospital rests with the Maryland Department of Health. Moreover, the Children's Cabinet, to whom the Interagency Placement Committee reports, claims to be the entity with responsibility for identifying in-state placement needs.

What is most significant about HB406 is that it represents an important step forward to addressing the acute crisis in treatment settings for children and youth with high intensity behavioral health needs. Requiring that Maryland Department of Health, the agency with the authority to approve behavioral health treatment settings, authentically share responsibility with the Department of Human Services for a full continuum of treatment and placement options represents the start of a solution.

We ask for the following amendments:

On Page 10 insert on Line 17: "(One) representative of the National Association of Social Workers - Maryland Chapter" with knowledge and experience in extended hospital overstays for foster children.

This will enable the backing of an organization with a collective of knowledge and experience in the delivery of public child welfare services.

We also ask that Lines 9 through 14 be deleted on Page 7, a section referencing multiple notifications to the Mental Health Division of the Public Defenders Office by the local department with responsibility for the children.

Hospital staff are mandated by Md. Health-General Code 10-625 to notify the Mental Health Division in the Office of the Public Defender whenever children are hospitalized by certification. Furthermore, HB406 requires the appointment of a coordinator who will also be required to notify the OPD at prescribed intervals. For DSS to do so would be redundant and has no utility for the children.

In addition to the above amendments, we believe the following steps would go a long way to help address the very serious issues facing Maryland foster children:

1. Mandate that the Governor appropriate $100 million to create a full continuum of care for children with behavioral health needs, including additional Residential Treatment Centers and other residential settings to assure these valuable resources exist and are financially sound.

2. Require MDH to develop 25 "no reject, no eject" psychiatric respite beds for children and youth as an appropriate alternative to overstay in hospitals or 'boarding' in an emergency room.

3. The Interagency Placement Committee, who reports to the Children's Cabinet, claims responsibility for developing in-state placement resources. The Children's Cabinet has indicated that increasing placement options is its top priority. Until a more comprehensive report can be completed, request an update from the Children's Cabinet on the status of overall capacity and the plan for a meaningful expansion of resources that can provide immediate and long-term relief.

4. We understand there was an early February 2022 deadline for an RFP issued by DHS to create 35 new "Diagnostic, Evaluation Treatment" beds and 25 psychiatric respite beds. Did any providers bid on a contract? If not, the reasons need to be urgently explored.

5. Support the Behavioral Health System Modernization Act (SB 637/HB 935) to develop a more robust continuum of behavioral health services for children and prevent the need for Out of Home Placement.

6. Review data related to emergency room 'boarders' to determine demographics of long-stayers and distinguish between children waiting for a foster care placement and those certified for placement and awaiting a hospital bed. The solutions for these children are entirely different and data will help identify what's needed.

7. Rate reform for providers, already many years in the making, has once again been put off, now until 2026. Until that work is complete, add funding to the budget for providers to expand services and eliminate the need to purchase outside 1:1 or 2:1 services. The roughly $10 million spent currently on 1:1 staffing could be re-routed to the programs to strengthen services instead of hire outsiders.

8. After the many changes in Child Welfare over the past two decades, mandating a holistic review of children's needs and available options like that completed in Oregon, "Identifying Capacity Needs for Children within the Oregon Child Welfare System," couldbe illuminating and offer a roadmap forward.

NASW Maryland is committed to Maryland's children and child welfare system and stands ready to facilitate discussions that lead to action to address this long-standing crisis.

Judith Schagrin, LCSW-C
Legislative Committee Chairperson

Mary Beth DeMartino, LCSW-C
Executive Direct

ADDITIONAL BACKGROUND

- The issue of hospital overstays and shortage of placements for high intensity youth with complex needs dates back decades but became especially acute in recent years, after we lost roughly 450 placement beds in residential treatment centers, therapeutic group homes,and DDA approved programs. The high intensity psychiatric respite beds developed duringthe last acute placement crisis also closed.

- No plan was made to replace any of these beds, in part because group homes have fallen into disfavor and also because of the optimistic claim of well-intended child welfare advocates that every child could be successfully served in family homes.

- What triggers an overstay? The answer is simple - not having a placement for a youth on discharge from the hospital. As many as 40 to 50 referrals may have been sent out, and no provider had space or all have said “no” to admission. Child Welfare relies on private providers to care for children with complex needs, who have the right to refuse admission or to require removal from a program.

- Data indicates that roughly 25% of entries into Out of Home Placement each year are the result not of maltreatment but because parents are unwilling or unable to provide care to their children – largely older youth – because of the intensity of behavioral health needs and/or developmental disability.

- These needs are characterized by self-injurious behaviors that may include swallowing glass and other objects; self-mutilation; and multiple suicide attempts as well as incidents of aggression and threatening behavior towards others and against property. These are also the youth who sexually offend against others in the family, including siblings and caregivers as well as family pets. Finally, behaviors may also have resulted in legal charges for gun possession, assault, car theft, robbery, breaking and entering, and other delinquent behaviors.

- Child Welfare is reliant on a partnership with private placement providers; a business environment and rate setting process that attracts and supports quality providers who can meet the needs of children with complex needs is imperative.

- For the local departments, the scarcity means long, tense hours pleading with placement providers for a bed, including offering funding for additional staffing. Roughly ten million dollars ($10,000,000) are being spent to buy outside 1:1 or sometimes even 2:1 staffing foryouth in placements that can’t meet their needs. These staff are typically untrained and purchased simply for the purpose of additional supervision.

- While the Local Care Team is well-intended, by the time a family comes to the attention ofthe local department, caregivers are drained and desperate. Rarely do LCT partners haveresources to recommend that weren’t exhausted long ago.

- The Interagency Placement Committee, which reports to the Children’s Cabinet, claims responsibility for developing in-state placement needs. However, the “Interagency Plan: Developing

Resources to Meet the Complex Needs of Children in Care" relies heavily on new policies and procedures - more bureaucracy – and its progress developing residential resources has not been responsive to the urgency of the need.

- Finally, despite having responsibility for the children, the voice of public child welfare social work professionals is notably absent. A peculiarity of large public service bureaucracies is that those administrators with the least contact with children and families have the greatest access to shaping policy. We can change that.

hb406amend.pdf
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Position: UNF

MARYLAND JUDICIAL CONFERENCE
GOVERNMENT RELATIONS AND PUBLIC AFFAIRS

Hon. Joseph M. Getty
Chief Judge

187 Harry S. Truman Parkway
Annapolis, MD 21401

MEMORANDUM

TO:	Senate Budget and Taxation Committee
FROM:	Legislative Committee Suzanne D. Pelz, Esq. (410-260-1523)
RE:	House Bill 406 Children in Out-of-Home Placements – Placement in Medical Facilities
DATE:	March 23, 2022 (3/30)
POSITION:	Oppose

The Maryland Judiciary continues to oppose House Bill 406 as amended.

The Judiciary remains opposed to provisions of the bill that pertain to the administrative law judge (ALJ) which were not amended. The bill states that the court may not commit a child for inpatient psychiatric care if an ALJ has made a determination that the child does not require such treatment. This limits the court's discretion and authority and prevents the court from effectively making a decision that is in the best interest of the child.

The bill also mandates that the findings of an administrative law judge are admissible as evidence in a hearing under this subtitle. Because the Department is not permitted to have a representative attend the hearings before the ALJ, admitting the findings as evidence limits the court's ability to hold a full evidentiary hearing and raises concerns of *ex parte* communications.

cc. Hon. Kirill Reznik
Judicial Council
Legislative Committee
Kelley O'Connor

HB406 - Letter of Information.pdf
Uploaded by: Cameron Edsall
Position: INFO

CHANGING Maryland FOR THE BETTER

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March 30, 2022

Chair Guy Guzzone
Senate Budget and Taxation Committee
3 West
Miller Senate Office Building
Annapolis, Maryland 21401

Chair William C. Smith, Jr.
Senate Judicial Proceedings Committee
2 East
Miller Senate Office Building
Annapolis, Maryland 21401

RE: HB 406: Children in Out–of–Home Placements – Placement in Medical Facilities

Dear Chair(s) Guzzone, Smith, and Members of the Respective Committees:

The Governor's Office of Crime Prevention, Youth, and Victim Services is submitting this letter of information on behalf of the Children's Cabinet regarding HB 406: Children in Out–of–Home Placements – Placement in Medical Facilities. The Children's Cabinet includes the secretaries from the departments of Budget and Management; Disabilities; Health; Human Services; and Juvenile Services; as well as the State Superintendent of Schools for the Maryland State Department of Education. The Governor's Office of Crime Prevention, Youth, and Victim Services serves as Chair and provides staff support to the Children's Cabinet.

This proposed legislation seeks to change the circumstances under which a court may commit a youth for inpatient psychiatric care; establishing requirements and procedures for the placement of certain children in medical facilities; authorizing a hospital, an emergency facility, or an inpatient facility to petition a court to compel a local department to remove a child from the hospital, emergency facility, or inpatient facility under certain circumstances; requiring the Maryland Department of Health (MDH) or the Department of Human Services (DHS) to provide beds and ensure placement for certain children and be subject to certain remedies for failure to provide beds; requiring a certain facility to ensure that a child is placed in a certain environment; providing that a certain facility may not be liable for certain federal violations under certain circumstances; requiring the Governor to appoint a certain individual to coordinate the carrying out of certain provisions of this Act; establishing the Foster Child Support Fund as a special,

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nonlapsing fund; and establishing the Task Force to Examine the Placement of Foster Children in certain psychiatric treatment providers.

The issue of overstaying psychiatric necessity within an Emergency Department (ED) or hospital is extremely complex and involves multiple systems of care, each with its own policies and procedures. In an effort to decrease the number of youth experiencing a stay in an ED or hospital past medical necessity, the Children's Cabinet worked collaboratively to develop an Interagency Plan to Address Youth with Complex Needs[1].

Since the development of this plan, the following has been accomplished by Cabinet agencies:

1. Development of Psychiatric Residential Treatment Facility (PRTF)-Level Beds
    - In FY 21, the Governor provided $5 million in funding via a Notice of Funding Availability through MDH for providers that will develop programming targeted at the population experiencing overstays.
    - One provider is operational in Western Maryland. As of 3/28/2022, five youth that were in an active overstay have been placed into this program. A second provider is building its operation and is anticipated to start receiving youth in summer 2022.
2. Financial Support to Current Residential Treatment Centers (private RTC providers)
    - MDH updated the rate methodology effective FY 21 to increase the daily rate cap to $750, eliminate the rolling base year, and rebase rates based on FY 19 expenditures, as well as increased training regarding retrospective rate adjustment under Medicaid rules.
    - MDH received a $15M appropriation in Supplemental Budget No. 4 - Fiscal Year 2023 (M00Q01.10) to implement a tiered rate payment structure to match reimbursement to the level of service needed by the child for RTCs.
    - $7M + distribution from ARPA Federal block grant funding to private RTC providers regarding COVID related losses which will make whole for prior losses and allow providers to re-expand staff to full licensed bed capacity.
3. Community-Based/Respite Placements
    - MDH provided funding to staff nearly 40 specialty inpatient psychiatric beds (that were unavailable due to the increased staff costs during the pandemic) in partnership with Sheppard Pratt.
    - 49 specialized high-intensity group home beds were created in 2020 through DHS.
    - A Statement of Need was issued in December 2021 by DHS to obtain 60 community-based beds for psychiatric respite care.
4. Mobile Crisis and Stabilization

[1]The Children's Cabinet Interagency Plan to Address Youth with Complex Needs can be found here: http://goccp.maryland.gov/wp-content/uploads/Childrens-Cabinet-Interagency-Hospital-Overstays-Plan.pdf

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- MDH secured $4.8 million from an emergency COVID grant dedicated to child and family specific model for mobile crisis response and stabilization training (MRSS), technical assistance, implementation, and direct services.
- MDH is dedicating $1.57 million out of BHA's COVID-related Mental Health Federal Block grant dedicated to development, implementation and ongoing quality monitoring of a child and family specific model for mobile crisis response and stabilization services (MRSS.) These services will help to support youth returning to and remaining in home and community settings.
- MDH is dedicating $9 million out of BHA's COVID-related Substance Use Disorder Federal Block grant. These funds are earmarked to support and expand mobile crisis response and stabilization services (MRSS), care coordination efforts, training, monitoring, and oversight.
- MDH (BHA and Medicaid) applied for and received a CMS technical assistance grant for almost $800,000 which is being used to engage Health Management Associates to assist the state in the process of including mobile crisis services into a revised state plan amendment in order to fully access the 85% Federal match opportunity under the American Recovery Plan Act (ARPA).
- On March 18, 2022, MDH announced ongoing initiatives and the progress on mobile crisis and stabilization services.[2] The model currently operating in Harford County and the greater Mid-Shore region—will expand into Allegany, Garrett, Washington, Frederick, St. Mary's, Calvert and Charles Counties over the next three months. All jurisdictions are receiving technical assistance and readiness assessments, and additional phases of expansion are scheduled over the next year.
- Through Project Bounce Back, to address social-emotional learning, MSDE is implementing a statewide Maryland School Mental Health Response Program to assist local school systems and provide technical assistance for accessing behavioral health services for students.

5. Build-out of Evidence-Based Practices (EBPs)/1915i
    - Maryland already has the capacity to access enhanced rates for certain EBPs under existing State Plan Amendment and Medicaid waivers (1915b and 1915i).
    - These areas are also under exploration for future expansion options through a technical assistance contract under grant funds primarily targeting crisis services, as these EBPs are an essential component of high intensity stabilization services for youth and families.
    - Based upon a prior independent audit affiliated with the last Medicaid 1915b waiver renewal, the state recognizes the need to increase both the provider pool (Care coordination providers and 1915i service providers) as well as the

[2] https://health.maryland.gov/newsroom/Pages/Maryland-Department-of-Health-expands-child-and-adolescent-behavioral-health-crisis-services,-peer-recovery-services.aspx

utilization of both of these services. Goals include building out the availability of these EBPs and exploring barriers to families accessing these services.

6. Public Awareness Efforts/Relationship Building - State and Local, Public and Private
    - MDH (BHA) is developing training for law enforcement on engagement with mobile crisis teams in a collaborative partnership that supports developmentally appropriate engagement only when absolutely necessary.
    - Strong relationship building continues with the Maryland Hospital Association to partner in identifying possible overstays and coordinating a team to assist in putting a service plan in place.
7. State Level Coordination
    - MDH is establishing an overstay hotline to provide a central registry for discharge planners in hospital emergency departments across the state to call and register a patient that no longer meets medical necessity for an emergency department.
8. Local Care Team (LCTs) Revitalization
    - The Children's Cabinet approved protocols directly linking hospitals with LCTs to open up the communication flow for youth in or at risk of an overstay. The Maryland Hospital Association helped develop those discharge protocols and implementation is underway.
    - The Children's Cabinet dedicates $1.8 million in funding yearly for every Local Care Team to employ a Local Care Team Coordinator to facilitate the work.
    - Additional staff time support at the local Core Service Agency / Local Behavioral Health Agency are being supported on a county by county basis to the limit of funding availability.

Finally, the Children's Cabinet collaborated in the preparation of the FY 2021 Out-of-Home-Placement Report[3] which showed improvement in the population experiencing inpatient hospital care.

- 629 placements were identified as either a medical or psychiatric hospital stay which is a 23.4% decrease from FY 2020.
- 9% decrease in all out-of-home placements from FY 2020.

Please feel free to reach out to the Office if any additional information is needed.

Sincerely,

Yesim Karaman
Chief of Staff
Governor's Office of Crime Prevention, Youth, and Victim Services

[3] The Children's Cabinet FY 21 Out-of-Home Placement Report can be found online here: http://goccp.maryland.gov/wp-content/uploads/2021-OOHP-Report.pdf

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HB 406 - B&T-JPR - Letter of Information.pdf
Uploaded by: Mark Luckner
Position: INFO

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Room 336 • Annapolis, Maryland 21401
Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Edward J. Kasemeyer, Chair – Mark Luckner, Executive Director

March 30, 2022

The Honorable Guy Guzzone
Chair, Senate Budget and Tax Committee
Room 3 West, Miller Senate Office Building
Annapolis, MD 21401

The Honorable William C. Smith
Chair, Senate Judicial Proceedings Committee
Room 2 East, Miller Senate Office Building
Annapolis, MD 21401

Re: House Bill 406 – Children in Out-of-Home Placements – Placement in Medical Facilities

Dear Chair Guzzone and Chair Smith:

The Maryland Community Health Resources Commission (CHRC) respectfully submits this letter of information for House Bill 406 – Children in Out-of-Home Placements – Placement in Medical Facilities (HB 406). The Commission appreciates the intent of this bill and commends the sponsor for his commitment to this important issue.

HB 406, as amended by the House, would accelerate the removal of Children in Need of Assistance from medical facilities into suitable alternative placements. The bill also establishes a new Foster Care Support Fund (the Fund) to be administered by the CHRC, as well as a Task Force to Examine the Placement of Foster Children in Emergency Departments that will study this topic and make a number of policy recommendations.

Since its inception in 2005, the CHRC has awarded over 600 grants to serve vulnerable populations throughout the state, but we have limited experience in grants that specifically serve children in the foster care system. For this reason, the CHRC would respectfully request that the bill be amended to remove the designation of the CHRC as the Fund's administrator. Instead, we request that the bill instruct the Task Force to make recommendations as to which state agency is best suited to administer the Fund.

The Commission appreciates your concern for the unmet needs of children in our state's foster care system and looks forward to working with you on this important legislation.

Sincerely,

Mark Luckner
CHRC Executive Director
cell (410) 299-2170

cc: The Hon. Kirill Reznik, Maryland General Assembly
The Hon. Edward J. Kasemeyer Chair, Maryland Community Health Resources Commission
Heather M. Shek, JD, MS, Director, Office of Governmental Affairs, Maryland Department of Health