A LIFEBRIDGE HEALTH GROUP
CENTER FOR HOPE
Advancing hope, healing and resilience

HB762 Child Advocacy Centers- Providers
House Judiciary Committee – February 26, 2023
Testimony of Adam Rosenberg, Executive Director, LifeBridge Health Center for Hope
Position: **OPPOSE**

Center for Hope opposes HB762. It is unnecessary and legally flawed. The bill seeks to introduce unprecedented and unworkable notice provisions on Maryland's child advocacy centers as well as any health care provider affiliated with a child advocacy center (CAC).

I am a former board member of the National Children's Alliance (NCA), the Maryland Children's Alliance (MCA), and the executive director of the Baltimore Child Abuse Center for over a decade before we joined LifeBridge Health and created Center for Hope three years ago. In my 15 years of national experience, I am not aware of any widespread or systemic problems with continuity of care issues or notice in the child advocacy community in Maryland, or elsewhere among the 900 CACs nationwide. Despite allegations to the contrary**, I have never supported this bill in any form.**

Child advocacy centers are nationally accredited. Center for Hope, a subsidiary of LifeBridge Health, is a comprehensive violence intervention program that provides trauma-informed crisis intervention and prevention services to over 6,000 patients and community members each year who have experienced child abuse, domestic violence, elder abuse, and community gun violence in the Baltimore region. Our services include Maryland's first nationally accredited child advocacy center that provides an evidence-based multidisciplinary team response to abuse and trafficking. Formerly known as the Baltimore Child Abuse Center, our team has helped over 40,000 children and families since inception. We employ over 100 employees, many of whom are healthcare providers. With six fulltime mental health therapists on staff, including a manager of our mental health and clinical director, we have one of the largest mental health teams of any child advocacy center in the state. As a subsidiary of LifeBridge Health, we are subject to rules and policies governing healthcare agencies. As a child advocacy center, we are required every five years to meet national accreditation standards from the National Children's Alliance, which are incorporated by reference in the very law this bill seeks to change, Md. Code Criminal Procedure §11-928. All of Maryland's accredited centers are also required to meet the same standard updated and put forth every five years. Maryland CACs received training and technical assistance in meeting these standards via NCA's state chapter, the Maryland Children's Alliance.

Center for Hope, like many CACs, has internal detailed procedures in place for notifying clients and providing or referring to new providers in the event any of our therapists leave, die, cannot provide service or in the rare instance when one is terminated. The internal policy at Center for Hope for the unexpected termination of a therapist, or if a therapist quits unexpectedly, is that the manager, or their immediate director, directly informs the clients and families via telephone or written correspondence, preferably immediately.

Current policies, regulations, and standards help keep kids safe. There are several policies in place governing continuity of care and notice at CACs. The provisions promoted by this bill are unnecessary.

1. National accreditation standards for CACs are incorporated by reference into Md. Crim Proc §11-928 - these include standards on mental health and organizational capacity.
2. Ethical standards governing providers such as social workers, professional counselors and psychologists address continuity of care procedures and govern the action of board-certified clinical supervisors. Under these rules, for example, a licensed health care provider may not terminate her health care staff without exposing her own license to censure.
    a. See, e.g. Board of Social Work Examiners, Code of Ethics- Responsibilities to Clients 10.42.03.03.03 (3) Notify the client promptly and seek the transfer, referral, or continuation of service in relation to the client's need or preference if the licensee anticipates the termination or interruption of service; (4) Prepare and disseminate to an identified colleague or record custodian a written plan for the transfer of clients and files in the event of the licensee's incapacitation, death, or termination of service
    b. American Psychological Assoc. Ethical Principle 3.12 Interruption of Psychological Services "Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations."
    c. Board of Professional Counselors and Therapists, Chapter 10.58.03. Code of Ethics A counselor shall: …(9) Make arrangements for another appropriate professional to act in the event of an absence of the counselor.
3. Health providers and agencies could be civilly liable for the tort claim of "abandonment" if a provider inappropriately and abruptly discontinues care to a patient. Further, MD Code, Health Occupations, § 14-404 provides that a licensee can be disciplined if she/he "Abandons a patient."

The bill is vague on its face, creates an untenable standard, and is unenforceable. The bill mandates that "CHILD ADVOCACY CENTERS SHALL PROVIDE WRITTEN NOTIFICATION WITHIN 48 HOURS TO THE CHILD AND THE CHILD'S PARENT OR GUARDIAN WHEN THERE IS A CHANGE IN THE CHILD'S BEHAVIORAL, MENTAL, OR OTHER HEALTH CARE PROVIDER… [AND] THE NOTIFICATION…SHALL INCLUDE THE NAME AND CONTACT INFORMATION OF THE NEW AND PREVIOUS PROVIDERS."

This language fails for multiple reasons.

1) **The bill contradicts Md. Code, Health Gen. §20-103 and §20-104** which provide that parental notification is at the discretion of the health care provider for some minors' mental health care and medical treatment.

2) **The bill includes <u>all</u> health care providers** – Child advocacy centers (CACs) are multidisciplinary teams that include a variety of medical, mental health, and other disciplines, as specified in Crim Proc. §11-928. Most of Maryland's CACs are run by local government with State Department of Human Services employees as managing staff. Many CACs do not even employ their own therapy team and often make a voluminous number of referrals This bill's language "other healthcare providers" includes this vast range of licensed professionals who are part of supporting their CAC, including physicians, nurse practitioners, medical staff, forensic interviewers, family advocates, and other staff who are licensed social workers or "health care providers" within the meaning of Health Occupations or Health General codes. These professions have their own policies and procedures, such as those of promulgated by child abuse medical providers (CHAMP), as authorized by MD Code, Health - General, § 13-2203.

3) **The term "the child's… provider" – is impermissibly vague.** As written, the bill could pertain to those employed by a child advocacy center, contracted with a child advocacy center, or even serving the child from another agency. Our child advocacy center is part of LifeBridge Health, and our clients may be served by medical professionals from within our hospital and healthcare system. "Previous providers" is also vague, as it is unclear how previous that is meant to be.

4) "Change in …provider" is broad and burdensome. The bill does not specify what it means by "change" and is unenforceable on its face. Furthermore, it would be difficult to comply if all changes in all healthcare personnel, for any reason, temporary or permanent, require notice. Most CACs in Maryland refer some or all of their clients to external behavioral health providers and medical providers in an effort to give access to much needed continuing care. Once the referral is made and accepted, the professional therapeutic engagement with the CAC ceases, and due to various privacy provisions, the CAC is not privy to the client's ongoing care with an external therapist. However, this bill creates the ill-informed requirement to pierce that privacy and makes the CAC responsible for therapeutic relationships it has no control over.

5) **There is no enforcement mechanism.** The bill does not specify the enforcement mechanism for failure to comply. It arguably creates a civil remedy and private cause of action for patients to sue a child advocacy center, thus channeling claims to the courts, and not a licensing or regulatory agency under the Department of Health.

48 hours is an unrealistic window to provide a new provider in some cases. The bill requires that child advocacy centers provide the name of "the new provider" within 48 hours. This is not feasible. It is Center for Hope policy to offer, whenever possible, an internal transfer to another Center for Hope therapist if a therapist leaves or has an absence. This of course depends on space or program capacity. It is Center for Hope policy to provide at minimum three referrals to other behavioral health resources that the client would independently engage if we cannot accommodate the client internally. We are not able to guarantee external continuity of care for

a variety of reasons and cannot immediately provide the name of "the new provider" as that choice would be at the discretion of the client and availability of the provider. Additionally, a 48-hour window may be unrealistic as many of our clients experience serious housing instability and do not have reliable addresses. Many are also in crisis because of the allegations and must relocate for safety reasons, sometimes multiple times.

There exists a shortage of qualified and available mental health providers, made even more acute by the highly skilled nature of trauma-informed mental health professionals. Simply put, there are not enough providers doing this work, not enough providers willing to accept new patients at rates which centers can afford, and a greater shortage of providers especially after the pandemic. Our own mental health team receives more requests for services than we can deliver, and our therapy team is at capacity. Furthermore, CACs can only hire new staff as our funding streams allow. For example, due to instability in federal funding streams for victims of crime (VOCA), we had to freeze hiring of mental health staff in FY20. This coincided with the pandemic, and thus we had to ask current staff to increase and, in some cases, double their caseloads. Other agencies did the same and still have high volumes related to pandemic caseloads. We partner with and refer to several other agencies, many of whom are also at or near capacity.

We oppose this bill's efforts to expose our agency, staff, and the behavioral health field to liability for provider shortages outside of our control.

The bill's 48-hour notice provision meets no known industry standard. As the bill's legal defects suggest, the arbitrary 48-hour notice provision meets no industry standard. The continuity of care notice provisions that the bill seeks to impose on child advocacy centers do not seem to appear in any health care statute or COMAR regulation of which we are aware. Also, the bill seeks to impose its unprecedented healthcare standard via the Criminal Procedure article, not Health General, Health Occupations or any regulatory agency or licensing board. The vetting process that the bill's proponents have chosen for its arbitrary suggested healthcare standard is through members of the House Judiciary Committee and the Senate Judicial Proceedings Committee. Md Crim Proc §11-928, codifies the necessary components (forensic interview, medical, mental health, law enforcement, child welfare) that make up a multidisciplinary response to child abuse. It does not and should not outline internal policies or internal best practices for the inner workings of healthcare providers.

The bill contradicts and confuses Maryland's current whistleblower provision. Healthcare providers at Center for Hope and LifeBridge Health are already covered under Maryland's whistleblower provision MD Code, Health Occupations, § 1-502. This bill seeks to create a new standard with different rules, but place it in the Criminal Procedure Article, thus having two competing statutes. It also includes "health care providers working with child advocacy centers." This is impermissibly vague without defining what "working with" means: this can range from providers who are contracted, employed by, consulted with, or even refereed to.

Redundantly, staff at every child advocacy center are already covered under federal whistleblower protections that are part of our grants received through the National Children's

Alliance, as well as any other federal dollars received via VOCA or other federal grants.

Disputed facts should not make bad law. Upon information and belief, the incident that gave rise to this particular bill was rare and isolated. It stems from a personnel matter within the Montgomery County CAC and is reportedly part of ongoing litigation, as well as a public inquiry by the Office of Inspector General of Montgomery County in November 2020. There is evidence in the public record (pp. 14-15 of the OIG report, excerpt attached) that children did receive notice and care after their therapists were fired, which these therapists dispute. Regardless, this ongoing factual dispute among litigants should not subject the state's child advocacy centers to liability for failing to comply with an unworkable and unenforceable proposed continuity of care standard that exists in no other law or regulation governing any provider.

This bill does not meet its purported purpose to assist children in need. Maryland's child advocacy centers proudly strive to meet and exceed national standards of accreditation and provide the best care in the most difficult of circumstances. This bill's language appears as a personal reaction to an isolated incident which is still in dispute. CAC staff and its network of health providers are a wide mix of partner agency staff, State of Maryland employees, county employees, contract positions, grant funded opportunities, as well as volunteer and in-kind support. Each of Maryland's CACs are staffed and structured differently, yet follow a wide set of local, state, and national best practices. Many tools and levels of support ensure continuity of care. In the rare absence of continuity, there are many existing remedies available.

Rather than imposing an obscure set of very specific restrictions for a still to be litigated incident, focus should instead be placed on Maryland's need to support, promote, and sustainably fund its CACs to meet the current increasing demand for services for children impacted by sexual and physical child abuse.

For all these reasons, Center for Hope asks for an UNFAVORABLE report.

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