

November 16, 2015

Kevin McDonald, Chief
Certificate of Need
Maryland Health Care Commission
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Offices In
Maryland
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Re: **Adventist Healthcare Behavioral Health & Wellness Services
Interested Party Comments in Opposition to
Seasons Residential Treatment Program, LLC
Docket No. 14-16-2367**

Dear Mr. McDonald:

Adventist Healthcare Behavioral Health & Wellness Services ("Adventist") operates a behavioral health care facility with 107 Special Hospital-Psychiatric beds and 82 residential treatment center ("RTC") beds in Rockville, and a behavioral health care facility with 15 Special Hospital—Psychiatric beds and 59 RTC beds in Cambridge. As such, Adventist is an existing provider of health care facilities in the same service area identified by the applicant in the above-captioned certificate of need ("CON") review.

Under COMAR 10.24.01.01B(20)(e), Adventist is a person who will be adversely affected, as that term is defined under COMAR 10.24.01.01B(2), by the establishment of a new RTC as proposed by the applicant.

Adventist believes the proposed project is not needed and fails to comply with applicable CON review criteria. Hence, Adventist opposes the CON application of Seasons Residential Treatment Program, LLC, and through undersigned counsel, seeks recognition as an Interested Party by submitting comments in the attached Opposition to Seasons Residential Treatment Program, LLC.

Sincerely,



Howard L. Sollins

HLS
Enclosure

Kevin McDonald, Chief
Certificate of Need
Maryland Health Care Commission
November 16, 2015
Page 2

O B E R | K A L E R

cc: Suellen Wideman, Asst. Atty. General
Ms. Tyeaesis Johnson
Pamela B. Creekmur, Health Officer
Thomas C. Dame, Esq.
Ms. Ruby Potter

BEFORE THE MARYLAND HEALTH CARE COMMISSION

IN THE MATTER OF

SEASONS RESIDENTIAL TREATMENT
PROGRAM, LLC

Docket No. 14-16-2367

**Adventist Behavioral Health & Wellness Services
Opposition to Seasons Residential Treatment Program, LLC**

Adventist HealthCare Behavioral Health & Wellness Services (“Adventist”) opposes the CON application of Seasons Residential Treatment Program, LLC (“Seasons RTP”) and seeks recognition as an Interested Party.

Seasons RTP Proposal

Seasons RTP has applied for a CON to establish a 72-bed residential treatment center (“RTC”) to be located in Prince George’s County, to serve all of the State of Maryland. The Application proposes that Seasons RTP will:

- meet applicable licensing and certification requirements;
- seek approval to be a Psychiatric Residential Treatment Facility (“PRTF”) under the federal rules and regulations governing such institutions;
- house and treat adolescent girls ages 13 to 18, including a female RTC unit with 18 beds;
- house and treat adolescent boys ages 13 to 18, including a male RTC unit with 18 beds;
- house adult males ages 18-21 in a separate unit;
- have two diagnostic units consisting of 10 beds each for the male and female population;
- serve 13 to 21 year olds with a DSM-V diagnosis, refractory behaviors and co-morbid substance abuse;
- Ensures that all admitted adolescents will have a mental health diagnosis and a clinical history of behavioral challenges due to mental illness.

Seasons RTP claims that, in addition to treating Maryland residents 13 to 21 years of age, it will also treat adolescents from the District of Columbia that need placement in a RTC.

Under the Office of Health Care Quality's RTC licensing regulations at COMAR 10.07.04.01A, an RTC "means a related institution as defined in Health-General Article, Title 19, Subtitle 3, 'Hospitals and Related Institutions' Annotated Code of Maryland and shall include a residential treatment center for emotionally disturbed children or adolescents with overnight accommodations for two or more non-related individuals who are referred for admission on the recommendation of a physician." Seasons RTP proposes to treat adults up to age 21 in an RTC. It has not been established that adults may receive services in a state-licensed RTC. As such, Seasons' RTC programs, volumes and operations appear incompatible with licensing standards.

Adventist Behavioral Health

Adventist Behavioral Health ("Adventist") currently operates Adventist HealthCare Behavioral Health & Wellness Service (Potomac Ridge) in Rockville, and Adventist HealthCare Behavioral Health & Wellness Services (Eastern Shore) in Cambridge.

The Adventist RTC programs offer psychiatric treatment for adolescents 12 to 18 years of age who have a history of mental illness and severe emotional or behavioral challenges. Residents of the RTCs are supported by a team of psychiatrists, nurses, social workers and therapists providing care and supervision 24 hours-a-day in a staff-secure environment. Typical residents admitted to the RTC programs display patterns of disruptive behavior, including aggressiveness towards others, suicidal ideations, truancy and self-injurious behaviors.

Contrary to erroneous allegations by Seasons RTP, Adventist's RTCs are also federally certified Psychiatric Residential Treatment Facilities (each a "PRTF").

Therapies included at the Adventist RTCs include: comprehensive behavioral health and substance abuse assessment; on site special and general education by approved staff; equine therapy at the Cambridge facility; expressive therapy such as art, music and dance; individual and group therapy; pastoral care; pet therapy; relapse prevention and aftercare transition.

In addition to RTC programs, the Adventist facilities provide acute inpatient psychiatric services, a partial hospital program, an intensive outpatient program, group home living, and an outpatient wellness clinic.

II. Background

a. **Residential Treatment Centers and Psychiatric Residential Treatment Facilities in Maryland**

Seasons RTP suggests it will offer a level of care as a Psychiatric Residential Treatment Center (“PRTF”) that is not available in Maryland. This is patently incorrect.

“Under Maryland statute, ‘residential treatment center’ (‘RTC’) means a ‘related institution’ . . . that provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbance or mental illness who require a self-contained therapeutic, educational and recreational program in a residential setting whose length of stay averages between 12 and 18 months. . . . Residential treatment centers focus on maximizing a child or adolescent’s development of appropriate living skills. *An RTC is a very intense level of care and should only be provided when therapeutic services available in the community are insufficient to address the child or adolescent’s needs.*”¹ (emphasis added) (Exhibit 1).

Seasons RTP is not proposing to offer any level of care or licensure category that is not already available within Maryland at multiple facilities.

¹ Maryland Health Care Commission, An Analysis and Evaluation of the CON Program. (2001). (Exhibit 1).

Seasons RTP's application reveals that it does not have a thorough or accurate understanding of the Maryland mental health system, the licensed and recognized levels of care and how its proposed facility fits into these levels of care. The application's flawed assumptions and lack of clarity in terms of the services it proposes to offer will be detailed in these comments (the "Comments").

b. Types of Placements in Maryland RTCs

RTCs serve patients referred by the private and public sector. Private referrals can be made by private psychiatric hospitals and psychiatrists. Public referrals come through a number of agencies including the Department of Juvenile Services (DJS), the Department of Human Resources (DHR), the Behavioral Health Administration (BHA) (formerly known as the Mental Health Administration), the Department of Developmental Disabilities (DDA)², and the Maryland State Department of Education (MSDE). Seasons RTP claims that it will serve residents redirected to its facility from all of these above agencies. However, Seasons never explains how it will properly care for, treat and house these various patient types that require multiple levels of care and different types of accommodations (e.g., staff secure versus hardware secure environments.) There are inconsistent descriptions of the level of security that will be provided particularly in relation to the types of residents the applicant claims will receive services.

Seasons RTP seems most focused on the need for staff secure and hardware secure services. These are types of facilities defined by DJS.³ DJS recognizes the following levels of care:

² Seasons does not propose to serve developmentally disabled patients so discussion of this patient category has not been included in these Comments.

³ See Maryland Department of Juvenile Services, Gap Analysis p. 13. (Attached to Seasons RTP application).

Figure 2. DJS Residential Program Levels and Subtypes

Security Level	Residential Program Subtype
Level II – Staff Secure	<ul style="list-style-type: none"> - Intermediate Care Facility for Addictions - Behavioral Program (e.g., Youth Center) - Group Homes and Therapeutic Group Homes with Schools on-site
Level I – Community-based	<ul style="list-style-type: none"> - Foster Care, Treatment Foster Care - Group Home/High Intensity Group Home - Therapeutic Group Home - Alternative Living Unit - Independent Living Program - Transitional Living Program
Mental Health Residential Placements	<ul style="list-style-type: none"> - Residential Treatment Center - Diagnostic Unit - High Intensity Psychiatric Respite - Psychiatric Hospital

Level II and Level III facilities identified by DJS are not classified as Mental Residential Placements. However, it does not appear that Seasons RTP recognizes the differences in these levels of care and program types. As presented by DJS, Level II and Level III facilities do not appear to be RTCs. Yet it appears Seasons RTP is seeking to obtain a CON and to license an RTC to provide a type of service that is not delivered in an RTC. As shown below⁴, (Exhibit 3) except for one facility, all Level II and Level III facilities appear to be operated by the State. None of the following Level II and Level III facilities, which are akin to what Seasons RTP proposes to establish, are listed as an RTC. It is apparent that Seasons is wrongly seeking a CON for an RTC by describing a facility that is not an RTC.

CAPACITY, ADP, AND SECURITY TYPE FOR STATE-OPERATED COMMITTED FACILITIES, FY 2014

Facility	Rated Capacity	ADP	Security Type
Backbone Mountain YC	48	35.3	Staff
Green Ridge Mountain Quest	10	9.3	Staff
Green Ridge YC	30	25.5	Staff
J. DeWeese Carter Center	14	10.9	Hardware
Meadow Mountain YC	40	37.8	Staff
Savage Mountain YC	36	31.7	Staff
Victor Cullen Center	48	45.3	Hardware
Wm. Donald Schaefer House	19	14.1	Staff
Total	245	209.9*	N/A

*Averages may not add to totals due to rounding.

⁴ See Maryland Department of Juvenile Services, Data Resource Guide, Fiscal Year 2014, p. 123, provided by the applicant with its filings. (Exhibit 2). http://www.djs.state.md.us/docs/2013_GAP%20analysis.pdf

III. Analysis of the CON Review Criteria

COMAR 10.24.01.07 (A)(1) requires a proposed new health care facility to submit a formal Certificate of Need application, which Seasons RTP has done.

According to COMAR 10.24.01.08 (G)(3) - "Criteria for Review of an Application for Certificate of Need," Seasons RTP' application for a new Residential Treatment Center in Maryland is required to address all of the factors listed and discussed below.

- a. State Health Plan. An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies and criteria.**

Adventist notes at the outset that the State Health Plan is outdated and does not provide a viable quantitative need analysis based on use rates and population demographics.

Seasons RTP claims it will meet the behavioral, clinical, safety, and mental health needs of male and female patients requiring Mental Health Residential Placement (MHRP) as a psychiatric hospital. Seasons RTP has, however, not applied to be a psychiatric hospital. (Application page 29). The Acute Psychiatric Chapter of the State Health Plan at COMAR 10.24.07 states, on page AP-52: "Each applicant proposing a new facility shall agree in writing to apply for JCAHO accreditation and Medicaid certification as soon as permissible after opening and be jointly licensed as a Special Hospital-Psychiatric Facility (COMAR 10.07.01) and as a Residential Treatment Center (COMAR 10.07.04)." Yet, nowhere does the Seasons RTP CON application comply with the applicable requirements to establish a Special Hospital-Psychiatric facility.

- b. **Need. The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.**

In order to document need, the applicant must at a minimum identify the population to be served; the extent to which these populations are served by existing providers; any remaining unmet needs the population has or will have in the future; and how the proposed project will meet those needs. Seasons RTP's application fails to accurately reflect and document these items and thus fails to demonstrate need for the project as discussed in detail below.

i. Population to be Served

Seasons RTP is proposing to establish a 72-bed RTC/PRTF for adolescent boys and girls and a separate unit for adult males 18-21, but never presents any population data, utilization data, or demographic statistics to show the number of adolescents and adults that are currently not able to receive the level of care that Seasons RTP is claiming it will provide. Given that Seasons RTP is proposing that its RTC/PRTF will be located in Maryland, it would only be appropriate that it plans to serve a majority of Maryland patients. However, this is not the case. In its last submission to the State, dated September 3, 2015, Seasons RTP provides a breakdown of the patient base it will obtain from different referral sources. For 2018, Seasons RTP claims its patient base will be (a) 32% from Maryland MHA or DJS governmental entities; (b) 55% from DC governmental entity referrals; (c) 5% from Virginia referrals; and (d) 5% from West Virginia referrals. (The remaining 3% of projected utilization is 2% from Tricare (military dependents) and 1% from Self pay/third party commercial insurance patients).

Accordingly, Seasons RTP expects that only 32% of its patients will come from Maryland in 2018. The same results hold true for Seasons RTP's projections of future years

2019-2021. Maryland's goal in approving RTCs in the state is to treat and provide appropriate healthcare to Maryland residents - not citizens of the District of Columbia, Virginia or West Virginia. So, not only does Seasons RTP fail to identify a population base that is not receiving appropriate care in Maryland, it is trying to impose a burden on Maryland by housing and treating youths from neighboring jurisdictions. It is particularly noteworthy that Seasons RTP claims a benefit of its facility is that it would avoid placement of Maryland residents out of state, yet the entire premise and financial foundation of its project is that other states will not have a similar interest in providing services locally and will prefer to send individuals out of state to Maryland. This is a fundamentally inconsistent and conflicting premise.

Additionally, Seasons RTP claims that it will be pulling patients from a 150-mile radius from its proposed location in Maryland. Again, there is no identification of a population that is not receiving care in this expansive service area, and no evidence that there is a lack of RTCs or PRTFs in Maryland such that Maryland adolescents and youths in need of care cannot obtain the services necessary. The 150-mile radius includes southern Pennsylvania, Delaware, and part of New Jersey. However, Seasons RTP does not propose to receive and treat any patients from these areas. In fact, Seasons RTP neglects to note that Pennsylvania has over 40 RTC facilities.

As well as not identifying an overall patient base for Maryland and surrounding states that need these services, Seasons RTP fails to present any data to quantify the number and types of patients to be served in the various programs it claims it will offer. There is no data to document the incidence rates or use rates for these adolescents and adults and their projected demand for RTC/PRTF services.

Next, it is unclear that within the patient base that Seasons RTP proposes to serve - female adolescents up to 18; male adolescents up to 18; and adult males up to 21 - how these

patients will be treated and housed. For instance, Seasons RTP claims that it will treat trauma and related mental illnesses, but then states that it will also house and treat violent offenders. It is unclear whether these populations will be allowed to commingle, or be separated into units. It is not clinically responsible to mix patient types in this manner, and there is a complete void in Seasons RTP’s application as to how Seasons RTP is planning to house, treat and keep these adolescents safe.

ii. Existing RTC/PRTF Providers In Maryland

The chart below provides a list of the RTC/PRTF facilities in Maryland licensed by the Behavioral Health Administration, formerly the Mental Hygiene Administration. There are two RTCs (one privately run by Adventist Behavioral Health and one state operated) in Montgomery County, the Region in which Seasons RTP is planning to build its new facility. Seasons RTP has produced no data or supporting documentation stating these facilities are not accessible to patients in Regions V and VI, or are not capable of providing quality care or sufficient services to those patients in need. Within 50 miles of Seasons RTP’s location, there are over 160 available beds for Maryland patients needing non-community residential treatment care.

Additionally, between 50 and 70 miles from Seasons RTP’s location there are 5 private RTCs (including Chesapeake Treatment Center for sex offenders) and one state operated facility. As well, approximately 89 miles away is another Adventist facility with 59 beds. There is more than a sufficient number of RTCs and bed capacity at the current facilities.

Maryland RTC Locations

Facility	County/Region	Age of Patients	Beds	Miles from Proposed
Chesapeake Treatment Center	Baltimore (Region I)	16-20	29	67
Good Shepherd	Baltimore (Region I)	13-21	105	63
Berkeley and Mann	Baltimore (Region I)	12-18 coed	68	57
St. Vincent’s Villa	Baltimore (Region I)	5-13 coed	95	71
Woodbourne Center	Baltimore (Region I)	12-18 males	48	62

Maryland RTC Locations

Facility	County/Region	Age of Patients	Beds	Miles from Proposed
Regional Institute Baltimore (State)	Baltimore (Region I)	12-18 co ed	45	54
Adventist Eastern Shore	Dorchester (Region IV)	12 to 17	59	89
Jefferson School	Frederick (Region III)	12 to 17	50	72
Potomac Ridge (Adventist)	Montgomery (Region VI)	13 to 18	83	46
John Gildner Regional (State)	Montgomery (Region VI)	11-18 coed	80	46

Source: Maryland Department of Juvenile Services Data Resource Guide, Exhibit 2.

iii. Utilization Reported by Department of Juvenile Services for RTCs

Another source of referrals to RTC/PRTFs is DJS. The exhibit below summarizes utilization reported by DJS for placements in RTCs from 2011 to 2014. There has been a tremendous decline in placements during this time period. Statewide the overall decline was 12.7%.

Seasons RTP does not quantify the number or type of referrals/placements it expects to receive from DJS, or for that matter how this population will be separated from other patient types, demand for patients of this type and from this referral source have declined dramatically.

Residential Treatment Centers (Maryland) - Average Daily Placement from DJS							
Facility	County	Beds	2011	2012	2013	2014	Change ADP 2011-2014
Chesapeake Treatment Center	Baltimore	29	18.1	19.7	18.5	23.2	28.2%
Good Shepherd	Baltimore	105	25.4	33.7	26.9	11.6	-54.3%
Berkeley and Mann	Baltimore	68	5.8	5.6	8	8.4	44.8%
St. Vincent's Villa	Baltimore	95	1.6	1.3	4.3	3.8	137.5%
Woodbourne Center	Baltimore	48	26.6	27.4	27.2	30.6	15.0%
Regional Institute Baltimore (State)	Baltimore	45	7.8	4.5	4.8	8.1	3.9%
Adventist Eastern Shore	Dorchester	59	17.1	14.5	12.9	12.7	-25.7%
Jefferson School	Frederick	50	12.1	17.9	17.3	11	-9.1%
Potomac Ridge (Adventist)	Montgomery	83	15.7	11.5	11.6	13.3	-15.3%
John Gildner Regional (State)	Montgomery	80	3.8	2.1	1	2	-47.4%
Adventist Anne Arundel	Anne Arundel		8.8	5.6	0	0	-100.00%
Total		662	142.8	143.8	132.5	124.7	-12.7%

***Highlighted in Yellow are Providers Closest to Seasons RTP Proposed Location*

Source: Department of Juvenile Services, Data Resource Guide, Exhibit 2.

Maryland has seen a sharp decline in the number of juvenile cases referred to DJS intake in recent years, and this has begun to trickle down to placements in RTCs. Over the period

2009-2014 there has been an average decline of 1.5% in RTC/PRTF placements. Department of Juvenile Services, Data Resource Guide 2011 to 2014 at pp. 45, 50.

iv. DJS Referrals to Secure Facilities

Seasons RTP suggests that it will fill a gap in demand for DJS placements of committed male youth in a hardware secure environment. However, Seasons RTP never identifies how many placements it will accommodate or how it will architecturally provide for this level of care and how this plan is consistent with RTC services as compared to the types of facilities serving a committed population. Seasons RTP claims that it will have technologically advanced systems and construction for the population that needs a hardware secure setting. However, Seasons RTP provides no documentation on how it will develop its facility to provide for these adolescents and how it will separate this population from the other populations that Seasons RTP claims to serve. Moreover, in its completeness response, in describing its proposed Physical Plant, Seasons RTP claims it will provide a “home-like” environment that will be “secure” and keep residents and the community “safe” but will not have bars or fences. It claims it will have a “high staff to resident ratio” yet will move from 1:3 to 1:6 staffing as census increases i.e. more residents means fewer staff. (As noted below, Seasons RTP has substantially underfunded its 1:3 staffing.) The application is internally inconsistent. Based on all of the submissions that Seasons RTP has provided the State over the last year, it appears that Seasons RTP wants to serve all types of populations, but never addresses how it plans to tackle the needs of these diverse populations to promote their recovery and to keep them safe.

Moreover, DJS classifies secure facilities separately from the RTCs classified as Mental Health Residential Placement (MHRPs) facilities.⁵ The chart below lists the secure facilities and their overall utilization. Regardless of Seasons RTP’s statements and intentions, for all intents

⁵ Department of Juvenile Services, Gap Analysis, p. 11-12. (Attached to Seasons RTP application).

and purposes, it is seeking to become an RTC/PRTF in Maryland, and will compete for patients with Adventist and other privately operated RTCs, but is basing its application on a model that does not fit the type of facility it is seeking to establish.

The Level III, hardware secure facilities in Maryland are all operated by DJS - they are not private sector units and as such Seasons RTP would not be legally permitted to treat these patients in its proposed RTC.

As for Level II facilities, all but one facility is operated by DJS. A staff secure facility is a residential program in which the movement of the youth is controlled by staff supervision rather than restrictive architectural features. MHRPs include facilities such as Adventist that serve patients referred by DHR and MHA. Level II, staff secure, facilities are declining in utilization, as shown below. Once again, Seasons RTP wants to take patients that are best suited for MHRP level facilities, but also take patients that are more appropriately placed in hardware secure settings. However, Seasons RTP never addresses how it will house these populations and whether it will mix groups to the detriment of all the adolescents that Seasons RTP proposes to serve.

State Operated Committed Facilities	Location	Security	Beds/	ADP 2012	ADP 2013	ADP 2014	Increase (Decrease) in ADP	Change ADP 2012-2014	Change ALOS 2012-2014
Backbone Mountain Youth Center	Region III Western	Level II-Staff Secure	48 Males	47.1	42.2	35.3	-11.8	-25.05%	-17.60%
Green Ridge Mountain Quest	Region III Western	Level II-Staff Secure	10 Males	9.5	9	9.1	-0.4	-4.21%	-2%
Green Ridge Youth Center	Region III Western	Level II-Staff Secure	30 Males	29.5	29.7	23.7	-5.8	-19.66%	-30%
Meadow Mountain Youth Center	Region III Western	Level II-Staff Secure	40 Males	39.9	38.6	37.8	-2.1	-5.26%	9%
Savage Mountain Youth Center	Region III Western	Level II-Staff Secure	36 Males	35.5	35.3	31.7	-3.8	-10.70%	-7.50%
William Donald Schaefer House	Region I Baltimore	Level II-Staff Secure	19 Males	13.1	15.1	14.1	1	7.63%	60%
J. Deweese Carter Center	Region IV Eastern	Level III- Hardware	14 Females	9.8	12.2	10.9	1.1	11.22%	-21.50%
Victor Cullen Center	Region III Western	Level III- Hardware	48 Males	41.9	47.1	45.3	3.4	8.11%	0.40%
Private Provider Silver Oak Academy	Keymar MD	Level II-Staff Secure	96 Males	47.8	46.8	60.7	12.9	26.99%	-10.40%
Total Placements in Secure Facilities Operated by DJS				274.1	276	268.6	-5.5	-2.01%	

Source: DJS Data Resource Guide (Exhibit 2).

v. DJS Out of State Placement

Seasons RTP argues that Maryland youth are being removed from Maryland and sent to facilities far away from their homes. However, Seasons RTP fails to recognize that the level of care that DJS identifies is not the same as the RTC/MHRP facilities. Level II and Level III secure facilities are separately classified throughout DJS’s gap analysis that Seasons RTP relies on to support its claim of need. It is DJS that places Maryland youth out of state in Level II and Level III facilities. Seasons RTP will most likely not be permitted to treat and house these adolescents; and likely will not be capable of doing so. Regardless, out of state placements for RTCs/MHRPs were only 1.9% of total placements for fiscal year 2014.⁶

vi. Utilization Reported by Child Welfare Services (Department of Human Resources)

One source of referrals for RTC care is through DHR. The following exhibit summarizes the utilization trend for RTC placements (census) at year end for the last 6 years. DHR placements to Maryland RTCs have declined by 37.8 percent, demonstrating the shift in focus to providing care in less restrictive and less costly community based settings.

While Seasons RTP does not quantify the number or type of referrals/placements it expects to receive from DHR, or for that matter how this population will be separated from other patient types, it is clear that demand for patients of this type and from this referral source have declined dramatically. There is not an unmet need for these RTC services.

RTC Census as of December 31, 2009-2014 for DHR Referrals

One Day Census	2009	2010	2011	2012	2013	2014	Percentage Change
Maryland RTC Totals	286	231	182	199	183	178	-37.8%

Source: Maryland Department of Human Resources, Advocates for Children and Youth, Baltimore, Maryland (Attached to Seasons RTP application.)

⁶ DJS 2014 Data Resource Guide, Section IV, page 142. (Exhibit 2).

Moreover, the Governor’s Office for Children notes that Maryland’s Department of Human Resources (DHR) can also place adolescents in RTC/PRTFs. Over the 5-year period 2009-2014, DHR’s placements have seen an average 5.6% decrease to RTCs, further indicating a decline in or lack of need for additional services of this type.

vii. Referrals from Behavioral Health Administration

The largest number of RTC referrals comes from the Maryland BHA. The following exhibit summarizes the utilization trend for these placements from 2009 to 2014.

RTC Placements from MHA							
	2009	2010	2011	2012	2013	2014	Percent Change
MHA RTC Placements	534	482	440	371	393	418	-21.7%

Source: Governor’s Office for Children’s Services, Fiscal Year 2014 (Attached to Seasons RTP application)
 (1) One day census on January 1st of each respective year.

These referrals have experienced a 21.7% decline in placements over this time period. Utilization increased slightly in 2014 because a waiver demonstration project ended. Maryland has amended its State Health Plan to continue providing the community based service under waiver retroactive to October 1, 2014.⁷ Maryland’s BHA concluded that RTC/PRTFs should only be used when community placements are not available. The Demonstration Waiver project showed that community based support and other types of less restrictive care than RTC/PRTFs are less costly and have better outcomes. The BHA noted that BHA placements to RTC/PRTFs declined in utilization by 4% from 2009 to 2014. See Maryland’s Governor’s Office for Children’s 2014 release, p. 71. The BHA has recommended that:

“The current capacity of residential treatment centers in Maryland appears adequate to meet the needs of Maryland youth for this level of care for the foreseeable future, based on vacancy rates

⁷ Governor’s Office for Children, Out of Home Placement Plan, page 72. (Attached to Seasons RTP application.)

for the in-state RTCs and plans to serve youth in the community via the 915(i) State Plan amendment.” See *Id.* at p. 76.

According to the BHA, not only has there been a decrease in admissions to RTC/PRTFs over the years 2009-2014, the average length of stay (ALOS) has decreased as well over the last five years. See *Id.* at p. 72. “This has been due primarily to an MHA effort to have children move from the RTCs to community treatment as their clinical needs can safely be met at a lower level of care. MHA has accomplished this through both a process of monitoring their progress in the RTC and providing technical assistance in discharge planning.” *Id.*

viii. Maryland State Government Placements and Private Placements

Data is limited that captures the full range of types of referrals to RTCs (particularly by facility). However, the total RTC placements by referral source is available and is presented in the chart below. These data show that the number of placements to RTCs in Maryland is declining remarkably - whether the placements are private placements or placements through the State’s juvenile court services, the DHR, BHA or other state entities tasked with caring for Maryland youth in crisis. Maryland’s state placements have decreased by almost 27% in the last 5 years, for an annual decrease of 6%. As the BHA concluded in its recommendation to the Governor’s Office for Children’s Services, there is sufficient capacity in Maryland and there is no need for additional RTCs, especially in light of Maryland’s plan to implement permanently the RTC waiver program that had proven so successful. *See Maryland’s Governor’s Office for Children’s Services, 2014 release.*

Maryland Historic State Placements ⁽¹⁾ to RTCs 2009-2014 - All Sources							
Placement Type ⁽²⁾	2009	2010	2011	2012	2013	2014	Percent Change
DHR RTC Placements	251	239	184	193	183	183	-27.1%
DJS RTC Placements	156	156	180	155	153	141	-9.6%
MHA RTC Placements	534	482	440	371	393	418	-21.7%

Maryland Historic State Placements ⁽¹⁾ to RTCs 2009-2014 - All Sources							
MSDE RTC Placements	47	37	22	0	0	0	-100%
Statewide Placement Trends	988	914	826	719	729	722	-26.9%

Source: Governor's Office for Children's Services, Fiscal Year 2014(Attached to Seasons RTP application)

(1)One day census on January 1st of each respective year.

(2)DHR: Department of Human Resources; DJS: Department of Juvenile Services; MHA: Mental Health Administration; MSDE: Administration for Special Education

For all Maryland State Agency placements to RTC/PRTFs, there has been an average decline of 5.9%, indicating there is certainly no need for an additional RTC with 72 beds within 50 miles of existing RTCs that have available capacity. *Id. at p. 19.* It is important to note that DJS referrals to RTCs are declining as well, since these populations appear to be a focus of Seasons RTP, although Seasons RTP has not projected how many DJS patients they will serve and at which level. Seasons RTP claims it will provide (1) staff secure resident care, (2) hardware secure levels of care and (3) short stay diagnostic unit for male and female adolescents. Seasons RTP claims that there is a need for Level III hardware secure care for adolescent boys, yet Seasons RTP does not clearly document how it will serve this need. The facility design and description provide no evidence that it will have fences, locks, and bars that are characteristics of such services.

ix. Utilization of Adventist's RTC Facilities

There is more than sufficient capacity at the existing RTCs/PRTFs in Maryland. There is no need for an additional facility. This is evidenced by the historical occupancy of the Adventist facilities. There is clearly sufficient capacity at the Adventist facilities, which have been operating at less than 50% occupancy for 2012-2014. Given these facilities' close proximity to Seasons RTP's proposed site location, it would make for poor health planning for Maryland to approve another RTC/PRTF in the region that will also be underutilized.

Rockville (Potomac Ridge) Utilization 2012-2014

	Rockville 2012	Rockville 2013	Rockville 2014
Total Beds	83	83	83
Total Possible Days	30,295	30,295	30,295
Resident Days	10,453	10,216	9,390
Admissions	30	46	53
Occupancy	34.50%	33.72%	31.00%
ALOS	348	222	177
Average Daily Census	28.64	27.99	25.73
DJS Reported ADP	11.5	11.6	13.3
Estimated ADP From Other Sources	17.14	16.39	12.43

Eastern Shore (Dorchester County) Utilization 2012-2014

	Eastern Shore 2012	Eastern Shore 2013	Eastern Shore 2014
Total Beds	59	59	59
Total Possible Days	21,535	21,535	21,535
Resident Days	7,857	10,244	9,043
Admissions	27	46	27
Occupancy	36.48%	47.57%	41.99%
ALOS	291	223	335
Average Daily Census	21.53	28.07	24.78
DJS Reported ADP	14.5	12.9	12.7
Estimated ADP From Other Sources	7.03	15.17	12.08

x. Placements from the District of Columbia

Seasons RTP relies on the purported needs of the youth of the District of Columbia to justify its proposed project. This reliance is flawed.

Seasons RTP relies heavily on the 2009 report “Out of State, Out of Mind - The Hidden Lives of DC Youth in RTCs,” which was submitted in its latest submission to the State. However, this report in no way supports Seasons RTP’ claim that there is a need for an additional RTC/PRTF in Maryland. Rather, the report concludes, among other things, that DC over relies on RTCs and that there needs to be reform in institutionalizing adolescents. The report further concluded that (1) a new local RTC will not correct the problems in the system; (2) DC must commit to investing in quality local service; (3) other modalities should be utilized,

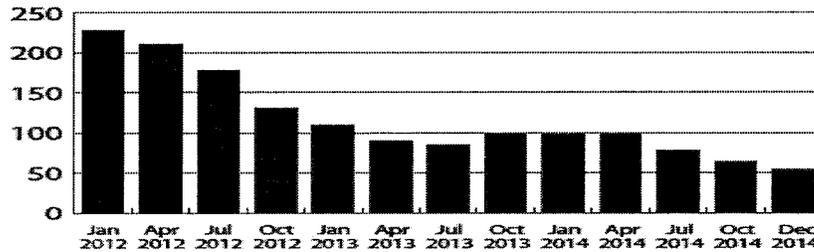
such as therapeutic foster care or creating flexible funding for wrap initiatives; and (4) there should be a vesting of control and oversight responsibility for RTCs in DC in a single DC agency. Never is there mention in the report that DC needs to rely on Maryland RTC/PRTF facilities to house its adolescents, or that a new RTC/PRTF, wherever located, would address the problems faced in DC.

There is no documented evidence that DC patients have needs that are not being met. While Seasons RTP touts its “contract” with the District of Columbia to provide short term assessment and housing of DC juvenile offenders, the document is not an enforceable contract for service - rather, it is entitled “Human Care Agreement” and in no way commits DC to send a single patient to Seasons RTP’ facility. A submitted letter from the DC Department of Youth Rehabilitation Services simply says that some DC RTC patients are placed a distance away. Other persons submitting letters of support for Seasons RTP’ project are under the misconception that there are no PRTFs in Maryland--not recognizing the fact that RTCs and PRTFs in Maryland are one and the same. Adventist RTCs are PRTFs. With regard to whether Seasons RTC plans on serving committed patients coming from the DC Department of Youth Rehabilitation Service or through private RTC placements as alluded to by the letter of support from the Psychiatric Institute of Washington, there is confusion and the situation is unclear.

In reality, the percentage of patients leaving DC for care is seriously declining suggesting, there is not additional need for RTC/PRTF services in DC. See Exhibit 3 (Exhibit 9 to Seasons RTP’s Application) showing 2012 decrease in out of state RTC placements for DC youth. See also Chart below from the 2014 Agency Progress Report for DC Youth Rehabilitation Services, (Exhibit 4) showing the decrease in out of state RTC placements from

2012-2014. According to the Report, in December 2014, there were only 60 committed DC youth placed in out of state treatment facilities.

DYRS Youth in Out-of-State Residential Treatment Facilities: 2012-Present



In any event, whether DC patients have a need for additional services, these non-Maryland patients do not justify the need for additional RTC beds in Maryland and is not a valid basis for a Maryland Certificate of Need.

xi. Seasons’ RTP Projected Utilization

Seasons RTP provides no quantitative basis for its projected utilization. In fact, its projected utilization is inconsistent with numerous trends and factors identified elsewhere in its application. The application is absolutely devoid of supporting data such as: (a) population of its service area and demographic trends; (b) use rates for the conditions projected to be served; and (c) number of patients and census of patients by program including the numerous programs Seasons RTP projects it will serve (i.e., traditional RTC; staff secure and hardware secure RTC; short term diagnostic services; patients requiring psychiatric hospital level care; and day students, where the level of care is unknown).

xii. Staffing Model

In its latest submission to the State, Seasons RTP presents its staffing model. Adventist believes that Seasons RTP has seriously understaffed its 72-bed facility that will need separate units for (1) adolescent boys 13-18 for diagnostic purposes; (2) adolescent girls 13-18 for

diagnostic purposes; (3) a RTC unit for males 13-18; (4) a RTC unit for females 13-18; and (5) a unit for adult males 18-21. This does not even include staffing for separate units for those needing a hardware secure environment versus a staff secure environment. Also, Seasons RTP states that it will have an outpatient program to educate adolescents. For all of these programs, units and services, Seasons RTP only anticipates the following staff: RN staffing - 4 FTE; LPN staffing - 2.5 FTE; Therapist - 4.5 FTE; Discharge Planner - 1 FTE; Special Education Teacher - 3 FTE; General Education Teacher - 3 FTE; Teacher Assistant - 1.5 FTE; and IEP Coordinator - 1.5 FTE.

The facility, even if approved and operational, will be understaffed and provide security concerns as well as concerns for the health and well being of the adolescents being treated there. With 5 separate units identified, 24 hour staffing (3 shifts, 7 days per week) with 1 nurse (RN or LPN) would require 21 nursing FTEs. Even just one nurse for the day shift, 7 days per week would require 7 FTEs compared to the 6.5 nursing FTEs proposed.

Similarly, there are other staffing areas that appear to be undercounted. For example, there are 6 FTE direct care staff (a little more than one per unit) on a 24/7 basis. Also, Seasons RTP claims to provide security with high staffing levels yet there are only 1.5 FTEs for contract security guards, which again will not cover the facility 24/7 (three shifts, 7 days per week). Also, there is no staffing for evening and night shift house supervisors, which would, if properly documented, would add an additional 3.08 FTEs (1.4 FTE's evening and 1.4 FTE's for night and then 0.28 FTE's projected 10% paid time off documented). Finally, there is discussion of day programs including education programs. There is no documentation to show there is sufficient staff to cover the day programs and day school programs in addition to the inpatient residents of the facility.

In addition, Seasons RTP has significantly under budgeted for its staffing expense. Attached as Exhibit 5 is an analysis of the application's proposed staffing in its completeness response, based on Table 5, i.e. the Seasons RTP manpower information, answers to Question 13 regarding Table 2 and the Table 4 revenue and expenses. The attached exhibit details the applicant's staffing information by service line. The analysis looks at the cost of staffing projected, but taking into account that staff will be needed 365 days per year, 7 days per week, also accounts for estimated paid time off. This also confirms that the applicant used a 1:3 staffing ratio. Looking at the sum of all staffing, for all units and the need for this full time coverage, one can derive the number of productive FTEs. Looking at the Seasons RTP projected salary and benefits, it becomes readily evident that the applicant has not projected a sufficient staffing cost to pay for its projected manpower. For 2018, this shortfall is \$827,364. The exhibit then provides a year by year comparable analysis that adjusts the staffing to take into account projected census increases per service line. The deficit in funding staff worsens, year by year from 2018 where the shortfall grows to \$1.6 million, \$2.2 million and then \$2.3 million in each year through and including 2021.

Seasons RTP states in its completeness response that it will initially staff at 1:3, but will then move to 1:6 staffing. This is inconsistent with the completeness response to Question 13. As the attached chart indicates, information supporting a 1:6 ratio was not provided.

Not only does Seasons RTP show it will underfund staff at a 1:3 ratio, a decrease below that staffing level will not be permitted based on the applicant's claim that it will receive PRTF referrals from West Virginia. The attached West Virginia rules (Exhibit 6) indicate that West Virginia regulators extend their oversight to out of state facilities receiving such referrals. Those regulations also require 1:3 staffing during day and evening hours so Seasons RTP will not be

changing that staff level unless it will not receive referrals from West Virginia on which it is relying. Thus, its underfunded staffing problem will continue.

- c. **Availability of More Cost-Effective Alternatives. The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.**

As discussed in detail above, there are sufficient existing RTC facilities operated in both the public and the private sectors that Seasons RTP has not considered. Many of these facilities have significantly high levels of unoccupied beds. Use of these existing facilities is far more cost effective than an expenditure of over \$16 million to construct a new facility when so many alternatives have bed capacity.

Seasons RTP has failed to show that an additional RTC/PRTF is necessary in Maryland, and thus the approval of such a project where there is no need is not cost effective. Seasons RTP claims that not only will it be an RTC/PRTF, but that it will be a Level III hardware secure provider for Maryland and District of Columbia youth who have been processed through the respective court systems and need to be assessed for placement. However, Seasons RTP fails to present any evidence how it will house and provide support and care for all of these populations given its current architectural scheme, financial documentation and staffing model. Seasons RTP has in no way shown Maryland that it can safely and adequately treat any or all of the patients it claims to serve. Most critically, Seasons RTP fails to consider community placement as an alternative to RTC services and the national and statewide trends towards less institutionalization and more community based services, which are often less costly.

- d. Viability of the Proposal. The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.**

As explained above, Seasons RTP claims that it will treat adolescents in a RTC/PRTF, but that it will also provide Level III hardware secure services to Maryland and DC youth. However, Seasons RTP has not shown any architectural diagrams, staffing models, and financial documentation to show how it would house and effectively treat all of these patients. For this reason, it is questionable whether Seasons RTP has included sufficient capital and/or operating costs in its project to provide for both hardware secure and staff-secure environments.

Given the declining need for RTCs in Maryland, as established above, the viability of Seasons RTP new RTCs is in serious doubt; there are 11 RTCs in Maryland - all with available capacity.

In considering the District of Columbia as a significant source of patients, while Seasons RTP touts its "contract" with the District of Columbia to provide short term assessment and housing of DC juvenile offenders, the document is actually entitled "Human Care Agreement" and in no way commits DC to send a single patient to Seasons RTP' facility. As Seasons RTP' presents in its application, the Department of Youth Rehabilitation Services in DC has seen a significant decrease in youth being placed out of state. Between January 2012 and December 2012, there was an overall 51% reduction in DC's out of state RTC placement (See Exhibit 5). See also Chart included above showing decline in out of state RTC placements for DC youth from 2012-2014. Given that Seasons RTP estimates that over 50% of its utilization will come from the District of Columbia, these factors cast doubt on the viability of its project.

In considering referrals from other States, we note there are a multitude of PRTFs in Pennsylvania, as well as RTCs in Virginia (which does not regulate this service); DC youth are just as likely to be sent to one of these states for assessment as they would be to Seasons RTP's proposed location in Maryland. Given the existence of RTCs in Virginia, why would Virginia adolescents travel to Maryland for RTC care? Seasons RTP claims that 5% of its patient base will come from Virginia - this is questionable, and no evidence supporting the statement has been provided. Given the existence of RTCs in Virginia, as well as West Virginia, it is not realistic that Seasons RTP's new facility will obtain 5% of its patient base from West Virginia.

Seasons RTP has not shown that it has an actual contract, or agreement, or business relationship with any acute care psychiatric facility in Maryland, or any Maryland state agency, that could potentially provide Seasons RTP with adolescents who need the Level II RTC care that Seasons RTP is claiming that it will provide.

- e. **Impact on Existing Providers and the Health Care Delivery System. An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, occupancy, on costs and charges of other providers, and on costs to the health care delivery system.**

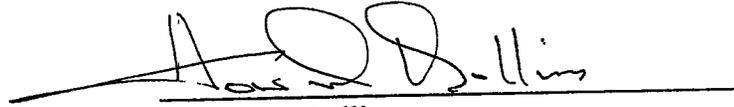
Existing providers have sufficient capacity, and given declining utilization for RTC/PRTFs in general, a new RTC is not necessary and would certainly have a detrimental effect on the existing providers. This is especially true with Adventist (Potomac Ridge) in Montgomery County. This facility has low utilization and is the closest facility to Seasons RTP's proposed project, located in the adjacent county. Given that Seasons RTP has not forecasted demand much less growth in demand for RTC services, there is no basis to assume that existing RTC beds in Maryland are insufficient in capacity to meet the needs for the foreseeable future. As a result the only way in which Seasons RTP can meet its projected

utilization is to take patients from existing providers including Adventist's facilities, which would be significantly harmed by the loss of patient volume. The cost of providing care would be spread over a fewer number of patients and with declines in reimbursement for services, the long term viability of Adventist's facilities would be threatened by Seasons RTP's proposal.

“An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, occupancy, on costs and charges of other providers, and on costs to the health care delivery system.” Seasons RTP has not complied with this regulation - only stating with no evidentiary or statistical support that the Maryland area and the region around Seasons RTP's proposed location has a need for an additional RTC/PRTF.

The Seasons RTP application should be denied. There is no need for the additional RTC. The staffing is flawed and underfunded. Not only is this project not needed in Maryland but it is also essentially a facility that is predicated on the unsupported and inappropriate assumption that other states lack RTC capacity and do not wish to keep their own residents closer to home for services, preferring instead to send them out of state to Maryland. There is no assured source of out of state referrals and the alleged contract with DC government assures no referrals at all, particularly given the design of the facility. The project is internally inconsistent in relation to its claims about the types of residents to be served in comparison to the design and staffing of the facility. In essence, this is an application that describes a plan and a mission that is inconsistent with the project being developed. Once developed, this RTC would simply duplicate ample existing capacity in Maryland.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Howard L. Sollins", is written over a horizontal line. The signature is stylized and cursive.

Howard L. Sollins
John J. Eller
Ober, Kaler, Grimes & Shriver
100 Light Street
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CERTIFICATE OF SERVICE

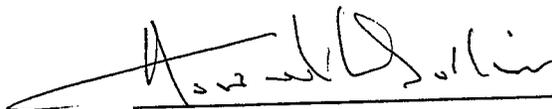
I HEREBY CERTIFY THAT, on this 16th of November, 2015, a copy of the foregoing Adventist Behavioral Health Opposition to Seasons RTP Residential Treatment Program, LLC was served via e-mail and first class mail, postage prepaid, to:

Suellen Wideman, Esq.
Assistant Attorney General
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Ms. Tyeaesis Johnson
1101 30th Street, NW
4th Floor
Washington, DC 20007

Pamela B. Creekmur, Health Officer
Prince George's County Department of Health
1701 McCormick Drive
Largo, Maryland 20774

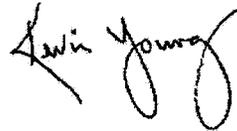
Thomas C. Dame, Esq.
Gallagher Evelius & Jones LLP
218 N Charles Street
Suite 400
Baltimore, Maryland 21201



Howard L. Sollins

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Opposition to Seasons Residential Treatment Program LLC are true and correct to the best of my knowledge, information and belief.

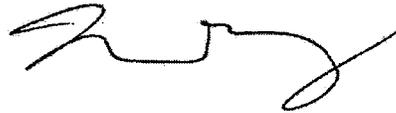
A handwritten signature in black ink that reads "Kevin Young". The signature is written in a cursive style with a large, looped "Y" at the end.

Date: November 16, 2015

Kevin Young, President
Adventist HealthCare Behavioral Health
& Wellness Services

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Opposition to Seasons Residential Treatment Program LLC are true and correct to the best of my knowledge, information and belief.



Date: November 16, 2015

Michael Tang, Associate Vice President of Fin.
Adventist HealthCare Behavioral Health &
Wellness Services

Exhibit List

Adventist Behavioral Health
Opposition to Seasons Residential Treatment Program, LLC.
Docket No. 14-16-2367

Exhibit No.	Description
1.	Maryland Health Care Commission, An Analysis and Evaluation of the CON Program (2001)
2.	Maryland Department of Juvenile Services, Data Resource Guide, Fiscal Year 2014, P. 123 and 142
3.	Exhibit 9 to Seasons RTP's Application
4.	DC Youth Rehabilitation Services, Agency Progress Report, 2014
5.	Analysis of Season's Proposed Staffing to Patient Ratio Calculations
6.	531.1 Psychiatric Residential Treatment Facility, BMS Provider Manual – State of West Virginia

EXHIBIT 1

Chapter 6

Inpatient Psychiatric Services and Residential Treatment Centers for Children and Adolescents

Inpatient Psychiatric Services And Residential Treatment Centers for Children and Adolescents: Overview and Definitions

Inpatient psychiatric care of children and adolescents addresses disabling symptoms including impaired sense of reality, disordered or bizarre behavior, psychosis, depression, anxiety, hysteria, phobias, compulsion, insomnia, and eating disorders. This excludes primary diagnoses of alcohol and drug abuse, mental retardation, and organic brain syndrome. The State Health Plan defines children as up to 11 years old, and adolescents as ages 12-17 years. The variability of individuals and their manifestation of psychiatric conditions may mean that some children may be treated in an adolescent unit, while some adolescents may be appropriately treated in either a child or adult unit. For most children and adolescents, quality of care is enhanced when they are treated in separate units, since they have different therapeutic needs from adults, require specialized educational and recreational programs, and tend to experience longer inpatient stays. Each distinct age group is best served in a discrete unit designed to meet its special needs.¹

Under Maryland statute, “residential treatment center” (“RTC”) means a “related

institution,” as defined in Health-General Article §19-301 *et seq.*, Annotated Code of Maryland and licensed under COMAR 10.07.04, that provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbance or mental illness who require a self-contained therapeutic, educational, and recreational program in a residential setting whose length of stay averages between 12 and 18 months. RTCs typically also offer outpatient day treatment services and schooling for children and adolescents who are unable to live at home.² Residential treatment centers focus on maximizing a child or adolescent’s development of appropriate living skills. An RTC is a very intense level of care and should only be provided when therapeutic services available in the community are insufficient to address the child or adolescent’s needs. Discharge planning is considered prior to placement in an RTC, and plans are actively reviewed throughout the treatment process³.

¹ State Health Plan, COMAR 10.24.07, Supp. 14, AP-2, Revised June 30, 1997.

² Ibid.

³ Ibid.

Supply and Distribution of Inpatient Psychiatric Services and Residential Treatment Centers for Children and Adolescents

Inpatient child and adolescent psychiatric services are provided in acute general hospitals, private psychiatric hospitals, and State psychiatric hospitals. Over the last five years, two private psychiatric hospitals that provided inpatient psychiatric hospital care for children and adolescents have closed: Gundry-Glass Hospital in southwestern Baltimore City closed on October 14, 1997, and Chestnut Lodge in Rockville (Montgomery County) closed on April 27, 2001.⁴

There are 235 child and adolescent inpatient psychiatric beds licensed to operate in Maryland. As Table 6-1 shows, child and adolescent psychiatric beds may be found in all regions of the State, except for Southern Maryland.

⁴ Sheppard Pratt Health Systems purchased the inpatient beds from both of these facilities. Sheppard Pratt has relinquished the 14 adolescent psychiatric beds remaining from the closed Gundry-Glass Hospital, and is presently in discussions with Montgomery County officials regarding the relocation of the 30 child and adolescent psychiatric beds from the now closed Chestnut Lodge to another site within Montgomery County.

Table 6-1
Child and Adolescent Psychiatric Hospital Facilities: Maryland,
October 2001

Hospital	Jurisdiction	Beds*	Hospital Type
Finan Center	Allegany	18	State Psychiatric
Brook Lane Psychiatric Center	Washington	28	Private Psychiatric
Carroll County General	Carroll	12	Acute General
Sheppard Pratt	Baltimore	56	Private Psychiatric
Franklin Square	Baltimore	6**	Acute General
Johns Hopkins	Baltimore City	15	Acute General
University of Maryland	Baltimore City	12	Acute General
Taylor Manor	Howard	20	Private Psychiatric
Potomac Ridge	Montgomery	25	Private Psychiatric
Laurel Regional	Prince George's	5	Acute General
Dorchester General	Dorchester	5	Acute General
Chesapeake Hospital	Dorchester	15	Private Psychiatric
Total		217	

* Includes all licensed beds, regardless of whether currently staffed and operating.

**This figure modifies bed capacity information presented in Chapter 5, which shows Franklin Square Hospital Center as having 24 adult beds, and no child or adolescent beds. The hospital had not indicated on its annual licensure form that 6 of its psychiatry beds had been approved to be designated as child beds.

Source: Maryland Health Care Commission files and Office of Health Care Quality Licensure Reports, October 2001

In addition, seven acute general hospitals, listed at Table 6-2, treat a significant number of adolescents in their adult psychiatric units, but have not identified on their license any of their general hospital beds as serving an adolescent population. These hospitals treated 689 adolescents in calendar year 2000. The reasons for these increased admissions include a growing number of referrals from area emergency rooms and Department of Juvenile Justice facilities, closure of private psychiatric hospitals and day treatment programs, and, anecdotally, increasingly restrictive utilization decisions by Maryland Health Partners⁵ in approving

outpatient rehabilitation and other services for the “gray area” population.⁶

⁵ Maryland Health Partners, a subsidiary of Magellan Behavioral Health, is the Administrative Service Organization (“ASO”) that holds the contract to

administer Maryland’s public mental health system for its Medicaid and gray area populations.
⁶ The “gray area” population is defined as earning up to 300% of the Consumer Poverty Index (“CPI”). Services to this population will be reduced in the upcoming fiscal year due to the existing and projected budget deficit for the Maryland Mental Hygiene Administration and the mental health “carve-out”.

**Table 6-2
Acute General Hospitals Providing Adolescent Psychiatric Care
in Adult Psychiatric Beds: Maryland, Calendar Year 2000**

Facility Name	Jurisdiction	CY 2000 Child/Adol Discharges ⁷	CY 2000 Adult Discharges	Pct. Child/Adol.	Licensed Adult Beds
Calvert Memorial	Calvert ⁸	110	355	23.66	13
Suburban	Montgomery ⁹	77	789	8.89	24
Montgomery General	Montgomery ¹⁰	91	991	8.41	27
Washington Adventist	Montgomery	113	1453	7.22	40
Southern Maryland	Prince George's ¹¹	105	811	11.46	25
St. Joseph's	Baltimore	94	483	16.29	34
Howard Co. General	Howard	99	466	17.52	14
Total		689	5348	11.41	177

Source: Maryland Health Care Commission, October 2001

⁷ Based on 70 or more discharges.

⁸ The facility has a psychiatric daycare licensed for adolescents and adults, and is receiving increasing referrals from Anne Arundel County.

⁹ Increased referrals are coming from area emergency rooms. Closure of Chestnut Lodge day treatment decreased support of outpatient rehabilitation for the gray-area population.

¹⁰ Increased referrals are coming from area emergency rooms.

¹¹ Increased referrals from the Department of Juvenile Justice's Cheltenham facility have increased adolescent admissions.

Residential Treatment Centers

Maryland has 765 residential treatment center beds for children and adolescents throughout the State, as shown in Table 6-3.¹²

**Table 6-3
Maryland Residential Treatment Centers: October 2001**

Facility Name	Jurisdiction	Number of Beds
Edgemeade at Focus Point	Anne Arundel	26
Regional Institute for Children/Adolescents-Baltimore	Baltimore City	45
Woodbourne Center Inc.	Baltimore City	54
Good Shepherd Center	Baltimore City	105
Berkeley & Eleanor Mann Residential Treatment Center	Baltimore	17 (+ 17*)
Villa Maria	Baltimore	95
Chesapeake Youth Center	Dorchester	49
The Jefferson School	Frederick	50
Adventist Behavioral Health System of Maryland	Montgomery	83
Taylor Manor Residential Treatment Center	Howard	17
Regional Institute for Children/Adolescents-Rockville	Montgomery	80
Edgemeade at Upper Marlboro	Prince George's	61
Regional Institute for Children/Adolescents-Southern Maryland	Prince George's	40
Chesapeake Treatment Center at The Hickey School	Baltimore	26
Total		748 (765*)

Source: Maryland Health Care Commission Data; Office of Health Care Quality, DHMH Licensure Reports, October 2001

*17 RTC beds once operated at Rose Hill Center in Rockville were acquired by Sheppard Pratt, received CON approval in November 2001 for relocation to its Towson campus, and will be licensed at the Mann RTC in early 2002.

¹² In a one-day snapshot census, on October 15, 2000, 24 children and adolescents were receiving residential treatment in out-of-state facilities, according to the State Coordinating Council.

Only one RTC is dedicated to the care of children: Villa Maria in Baltimore County. The State's RTCs are further subdivided by the following types of population they serve:

- “Lisa L” population¹³ – those children or adolescents at risk for over-staying in inpatient facilities, including hospitals and respite care;
- The “seriously emotionally disturbed delinquent youth” (“SEDDY”) population – adjudicated by the court and committed to the Maryland Department of Juvenile Justice;
- Juvenile sex offender population – committed by the courts to the Maryland Department of Juvenile Justice with a principal offense of sex offender;
- General RTC population – not requiring a specialized program, either by court order or medical necessity.

The Commission has adopted a State Health Plan chapter that addresses the sex offender

¹³ The so-called “Lisa L” case was a federal class action lawsuit brought in 1987 against the Maryland Department of Health and Mental Hygiene (DHMH), Department of Human Resources (DHR) and Department of Juvenile Justice, (formally the Department of Juvenile Services) (DJS), alleging that children and adolescents been held in Maryland's State psychiatric and private psychiatric hospitals after the time they are ready for discharge, as determined by the hospital treatment team, or had been discharged to placements in which they did not receive the services recommended by the hospital staff. An Interim Settlement Agreement, which required the State to implement discharge plans within decreasing timelines, went into effect in May 1990.

and “Lisa L” populations, at COMAR 10.24.07 F. and G., respectively¹⁴.

Other special populations have been identified as needing separate and distinct RTC units and other resources to meet the needs of particular children and adolescents,¹⁵ including children and adolescents with co-occurring disorders of mental illness and mental retardation, and adjudicated youth who require a higher level of care than that currently provided in the units for seriously emotionally disturbed delinquent youth (“SEDDY”).

Respite Care

The respite level of care provides rehabilitation support and active treatment for children and adolescents.¹⁶ Respite care for children and adolescents essentially means long-term psychiatric hospitalization, as opposed to the more usual connotation of a brief stay to spell other caregivers. There are five separate and distinct respite care units in three facilities in Maryland that serve children and adolescents; these are located at Sheppard Pratt Hospital in

¹⁴ The SHP permits an additional 12 RTC beds for the “Lisa L” population to be approved and implemented, if needed. The Subcabinet has requested that the Commission not consider proposals to implement these beds, until analysis of utilization data can determine if additional capacity is needed. The SHP at COMAR 10.24.07.07 identifies an additional 26 RTC beds as needed for treatment of adjudicated adolescent sex offenders, but the Commission has not scheduled a CON review for this bed capacity, pending further analysis and advice from DJJ.

¹⁵ *Report of the Out-of-State Placement Workgroup: Resources for Maryland Youth in Out-of-State Institutional Placements*, Maryland Health Resources Planning Commission, March 20, 1998

¹⁶ COMAR 10.21.27

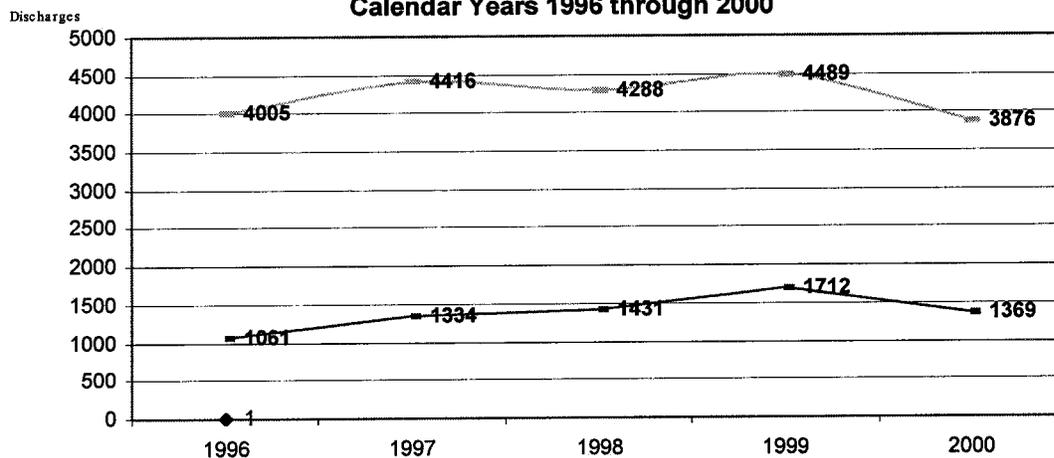
Baltimore County, Brook Lane Psychiatric Center in Washington County, and Taylor Manor Hospital in Howard County. The Sheppard Pratt facility has two units, one each for children and adolescents, with a total of 26 beds. Brook Lane Psychiatric Center’s unit is called Stonebridge, and serves youth between the ages of 11 and 14. Taylor Manor has two units, one providing a higher intensity of care than the other. At any given time, over 60 youth are awaiting RTC placement in these respite care facilities. About half remain in respite care placements for more than 90 days. While the Commission does not regulate respite care, it is an integral part of the full continuum of care, and directly affects the availability of RTC and hospital services.

Trends in the Utilization of Hospital and Residential Treatment Center Services by Children and Adolescents

Figure 6-1 below illustrates the overall trends in inpatient admissions of children and adolescents, over all three hospital settings, acute general hospitals, private psychiatric hospitals, and State hospitals.

Figure 6-1

**Child and Adolescent Inpatient Psychiatric Discharges All Hospital Settings
Calendar Years 1996 through 2000**



Source: Maryland Health Care Commission, October 2001: Based on data from MHCC Hospital Discharge Abstract and data provided by the Mental Hygiene Administration.

Utilization Trends in Maryland Acute General Hospitals

In CY 1996, 527 children 11 years old or younger were discharged from

general hospitals in Maryland. In CY 2000, there were 740 discharges for this age group, an increase of 40 percent. For the adolescents during this same time period, CY 1996 saw 1,414 discharges, and 1,557

discharges in CY 2000, an increase of 10 percent. During the same time period, however, the average length of stay for children decreased 28.7 percent, from 12.6 to 8.99 days, while the average length of stay for adolescents decreased by 16.1 percent, from 7.51 to 6.3 days. (See Appendix 6-1.)

Data provided in Appendix 6-1 also shows that Johns Hopkins Hospital, University of Maryland Hospital, and Franklin Square Hospital Center treated 95 percent of the children receiving inpatient services in CY 2000: 773 of the 813 discharges that year. A broader range of hospitals in the State treat adolescents; this includes the seven acute general hospitals with adult psychiatric services, identified in Table 6-2, that treat a substantial number of adolescents, but do not have designated adolescent units.

Utilization Trends in State Hospitals

The Mental Hygiene Administration, of the Department of Health and Mental Hygiene, operates two 18-bed adolescent units, one at Crownsville State Hospital in Anne Arundel County, and the other at the Finan Center in Allegany County.¹⁷ Between CY 1996 and CY 1999, adolescent discharges from State psychiatric hospitals decreased by 22.47 percent, from 227 in CY 1996 to 176 in CY 2000. Patient days decreased significantly at these two facilities between 1996-2000, from 6,784 to 5,438, a decline of 19.8 percent. The average length of stay

¹⁷ The State of Maryland does not operate a hospital-based facility for children ages 0-11; however, a few children are treated briefly at state hospitals. Between CY 1996 and CY 2000, no more than ten children, ages 0-11, were treated in State hospitals. Source: Mental Hygiene Administration, Data and Analysis Unit, October 16, 2001.

remained fairly stable over this time period, an average stay of 29.9 days in 1996, compared to 30.9 days in 2000.¹⁸

Utilization Trends in Private Psychiatric Hospitals

The number of child discharges from private psychiatric hospitals has increased 18.3 percent from CY 1996 to CY 2000 -- from 531 to 628. The number of adolescent discharges has decreased during this same period by 9.3 percent, from 2,364 to 2,143. The average length of stay for children in private psychiatric hospitals has decreased in the period CY 1996-CY 2000 from 16.63 to 14.58 days, a decrease of 12.3 percent. However, during this same period, adolescents discharged from private psychiatric hospitals showed a more significant decrease in average length of stay, from 24.31 to 8.61 days, a 64.6% decrease. Total charges for the combined age groups fell precipitously: from \$44,624,874 to \$19,889,109, a drop of \$24,735,765 [in current dollars], or 55.4 percent, between CY 1996 and CY 2000.

The data presented in Table 6-4 below combines the experience of acute general and private psychiatric hospitals for the five calendar years examined, and provides separate child and adolescent utilization trends by age and year for discharges, patient days, total charges, average length of stay, average charge, and per diem, according to that breakdown. Between calendar years 1996 and 2000, the number of inpatient child psychiatric discharges has increased by 29%, from 1,058 to 1,368 discharges. Between 1996 and 2000,

¹⁸ Source: Mental Hygiene Administration, Data and Analysis Unit, October 16, 2001

discharges of adolescents from general and private psychiatric hospitals experienced a 2% decline, from 3,778 to 3,700; however, during the intervening years the number of adolescent discharges has fluctuated. The combined total of child and adolescent

psychiatric inpatient discharges decreased during the period examined by 15 percent, from 5,957 to 5,080, but it is unclear whether the number of community-based services for children and adolescents has increased to a corresponding degree.

**Table 6-4
Summary Data for Child and Adolescent Inpatient Psychiatric Discharges: All Hospital Settings, Calendar Years 1996 through 2000**

HOSPITAL TYPE	AGES DESC.	TOTAL CASES	PATIENT DAYS	TOTAL(*) CHARGES	AVG. ALOS	AVG. (*) CHARGE	PER(*) DIEM
1996							
Total 0-11	0-11	1,061	15,487	\$11,720,318	14.60	\$11,078	\$758
Total 12-17	12-17	4,005	74,856	\$46,189,475	18.69	\$12,226	\$679
TOTAL	0-17	5,066	90,343	\$57,909,793	17.83	\$11,975	\$693
1997							
Total 0-11	0-11	1,334	18,393	\$13,260,417	13.78	\$10,015	\$730
Total 12-17	12-17	4,416	77,654	\$40,350,270	17.58	\$9,851	\$566
TOTAL	0-17	5,750	96,047	\$53,610,687	16.70	\$9,891	\$600
1998							
Total 0-11	0-11	1,431	18,345	\$13,808,159	12.82	\$9,704	\$754
Total 12-17	12-17	4,288	53,939	\$31,557,131	12.58	\$8,018	\$676
TOTAL	0-17	5,719	72,284	\$45,365,290	12.64	\$8,465	\$698
1999							
Total 0-11	0-11	1712	22550	\$20,907,194	13.17	\$12,226	\$927
Total 12-17	12-17	4489	49494	\$39,958,750	11.03	\$9,409	\$807
TOTAL	0-17	6201	72044	\$60,865,944	11.62	\$10,218	\$845
2000							
Total 0-11	0-11	1369	15816	\$12,216,300	11.55	\$8,930	\$773
Total 12-17	12-17	3876	33702	\$21,238,476	8.70	\$5,740	\$751
TOTAL	0-17	5245	49518	\$33,454,776	9.44	\$6,601	\$759

Note: (*) Total charges, average charge, and per diem charges computed for general and private psychiatric hospitals only. INA – Information Not Available

Source: Maryland Health Care Commission, adapted from Maryland Hospital Discharge Abstract and Maryland Hospital Information System, October 2000

For children, the average length of stay has experienced a significant decrease from 14.62 days in CY 1996 to 11.56 days in CY 2000, or 21%. The average length of inpatient stay for adolescents decreased 57.6 percent between CY 1996 and CY 2000, from 18.02 to 7.64 days. The overall length of stay for the combined age groups dropped almost 50 percent from 17.28 to 8.70 days. Similarly, total charges for the combined age groups dropped from \$57,909,793 to \$33,454,776, a decrease of \$24,000,000 [in current dollars], or 42 percent.

Utilization Trends in Residential Treatment Centers

A key to analyzing RTC issues is to understand that each of Maryland's 14 RTCs is a unique facility, with its own distinct combination of the variables that affect the utilization, financing, and management of all of Maryland's RTC facilities. These variable influences include:

- the populations served (age, sex, "Lisa L", seriously emotionally disturbed delinquent youth, violent juvenile sex offenders);
- geographic regions;
- the facility's corporate structure (i.e., non-profit, for profit, or State-operated);
- funding streams (i.e., Medicaid, State general funds, education funds, county jurisdictional funding, philanthropic funds);
- the entity controlling admissions (the court systems, Department of Juvenile Justice; the Multi-Agency Review Team; the State-contracted Administrative Service Organization, Maryland Health Partners);

- the facility's admission criteria; and
- the availability of appropriate community-based services.

With all of these variables continually in flux, different and conflicting trends emerge. Commission Staff contacted several RTCs in the State, inquired about their historic utilization and current trends, and learned that some RTCs are experiencing a significant number of empty beds for the first time in several years, while other RTCs are experiencing full occupancies with waiting lists, including in their respite programs.¹⁹ Those facilities experiencing reduced utilization mention several factors influencing their current downward trend in occupancy. There have been marked decreases in the number of admissions from child serving agencies to these facilities. Part of the overall decrease may be due to direct instruction to the State-operated Residential Institutes for Children and Adolescents ("RICAs") from the State Mental Hygiene Administration to reduce lengths of stay to nine months. One RICA has taken this a step further, and is seeking to discharge patients as soon as they begin to improve, which often results in a reduced length of stay. In addition, some RICAs are not staffed to their license RTC capacity.

Some RTCs note that the new seclusion and restraint regulations adopted by the federal Centers for Medicare and Medicaid ("CMS")²⁰, formerly the Health Care

¹⁹ Telephone contacts with RTCs by Commission Staff, October 11, 2001. The following discussion reflects the views of these providers.

²⁰ Medicaid Program; Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals under

Financing Administration, have added direct and indirect costs to the treatment of children and adolescents. Therefore, children and adolescents needing this type of care are either not admitted, or are discharged more quickly from the RTC to another type of facility. However, other RTCs have formulated inventive strategies to contend with the issues of staffing coverage, funding, and sharing of resources that result from the implementation of this rule.

Another factor cited by child mental health professionals in the declining utilization at some RTCs is the difficulty of obtaining the required documentation along with patient medical and educational evaluations from some local social services agencies, which often requires an inordinate amount of professional staff time, and is a pre-requisite to admission. Others contend that school districts in the state are responding to a financial disincentive to place children and adolescents into RTCs, thereby causing the downturn in admissions to some RTCs. Some school districts will not refer students to RTCs, because they have to bear the increased costs in education and therapy. The “inclusion” model adopted by these districts has, in fact, reduced the flow of referrals to RTCs.

Another factor affecting utilization of RTCs is the closure, or the potential closure, of some child and adolescent outpatient/day treatment programs. Without these community-based services, the condition of some children may deteriorate to the point that RTC placement or even inpatient admission becomes necessary. At least

eight outpatient/day treatment sites for children and adolescents have closed due to lack of profitability in recent months.²¹ The outpatient providers as well as some RTC administrators attribute their financial troubles to the decisions of the State’s Administrative Service Organization-mandated reimbursement policies, citing failure to make timely payments (some RTCs are facing deficits of \$2 million or more); retrospective utilization reviews that deduct funds from payments previously approved by the ASO; and a system that does not provide payment to an RTC until a patient has been a resident for at least six weeks. The RTC providers interviewed attribute much of their negative cash flow problems to these practices by the ASO.

The Commission is limited, in its ability to evaluate the impact of reimbursement and agency policies on the utilization of RTCs, and to determine if the appropriate number of such facilities is available to serve Maryland’s children, by the continued lack of a reliable, readily available, and comprehensive database, which could collect and aggregate RTC information into one single source. This crucial information is not currently obtainable for the entire RTC population in Maryland.

Some organizations do maintain fragmented and partial data sets. For example, the Mental Hygiene Administration, in its management information system, does

Age 21; Final Rule 42CFR Parts 441 and 483, January 22, 2001

²¹ These closures include VESTA, Prince George’s County; Affiliated Sante, Charles County; Edgemeade, Charles County; Woodbourne, Baltimore City; Prince George’s County Health Department; Granite House, part of the Sheppard Pratt Health System, at both St. Agnes Hospital in Baltimore City and Stoneridge in Randallstown, Baltimore County.

collect data for the Residential Institutes for Children and Adolescents in Rockville, Southern Maryland, and Baltimore. MHA also receives information on utilization from an *ad hoc* RTC Coalition. The Maryland Health Partners data collection system, known as the Crystal System, collects data based upon claims and authorizations. Since the State of Maryland contracts with Maryland Health Partners only to administer payment for Medicaid recipients who receive mental health treatment, these claims data do not reflect patient days not reimbursed by Medicaid. Specific information from Maryland Health Partners regarding RTC utilization is not readily available to public agencies, and has only recently become available to the Mental Hygiene Administration on a limited basis. The limited data produced by the Crystal System indicate that from July 1, 1997 through September 27, 2001 there were 2,152 discharges from all RTCs in Maryland. Of the 2,152 discharges:

- 15.1 percent (324) were for RTC stays of less than 90 days;
- 14.5 percent (313) were for stays from 91 to 180 days;
- 35.6 percent (766) were for stays from 181 to 365 days;
- 22.0 percent (433) were for stays from 366 days to 1½ years; and
- 12.8 percent (276) of the discharges were for stays longer than 1½ years.

These data, while an interesting detail about Medical Assistance utilization at RTCs, are by definition not comprehensive—yet they represent the most complete data available on RTC use. The absence of a comprehensive, non-duplicated database with which to analyze RTC utilization

across the State prevents the kind of definitive projection of bed need that the Commission issues for other facility-based health care services.

Utilization of Out-of-State RTC Providers

Maryland children and adolescents have historically received treatment in three out-of-state residential treatment centers: Devereux facilities in Florida and Georgia, and The Pines in Virginia. Twenty-seven Maryland children and adolescents were treated in these facilities during FY1999; this dropped to nineteen in FY 2000, and rose again to twenty-six in FY 2001. These figures represent significant progress in meeting a legislatively-mandated goal of minimizing the number of Maryland children sent out-of-state for RTC care.²²

Factors Affecting the Utilization of Child and Adolescent Mental Health Services

- **Increased prevalence**

According to a 1999 report by the United States Surgeon General, 20 percent of U.S. children and adolescents (15 million), ages 9-17, have diagnosable psychiatric disorders. Further, the Center for Mental Health Services estimated that 9 to 13 percent of U.S. children and adolescents, ages 9 to 17, meet the definition of “serious emotional disturbance” and 5 to 9 percent of U.S. children and adolescents, “extreme

²² Telephone contact with Jean Clarren, State Coordinating Council, Office of Children, Youth, and Families, Oct. 16, 2001.

functional impairment.”²³ National data indicate that only about 20 percent of emotionally disturbed children and adolescents receive some kind of mental health services, and only a small fraction of them receive evaluation and treatment by child and adolescent psychiatrists.²⁴

- **Impact of Managed Care**

With the “carving out” of mental health services from the Medicaid managed care system, and the creation of the Public Mental Health System in 1997,²⁵ it was anticipated that admissions of children and adolescents to inpatient psychiatric facilities would be restricted and lengths of stay would be curtailed. It was also anticipated that the Department of Health and Mental Hygiene’s Mental Health Administration (“MHA”) would receive a 1915c Medicaid Waiver that would encourage alternatives to inpatient care. However, as noted above, while inpatient hospital admissions of children and adolescents have decreased, length of stay in RTCs has increased since the public system began operation. Despite the increase in utilization and capacity of RTCs, there is anecdotal evidence that children and adolescents are not receiving the appropriate inpatient hospital services as evidenced by long stays in hospital emergency rooms before these individuals

are either admitted, referred to another service, or returned home.

- **Reimbursement Issues**

The public system’s administrative organization, Maryland Health Partners, has strongly encouraged shorter lengths of stay in hospitals, resulting in reports of higher recidivism rates for mentally ill children and adolescents seeking inpatient placement at acute general inpatient hospitals. There, hospital administrators -- fearing the impact on their position relative to length-of-stay and cost targets imposed under the Health Services Cost Review Commission’s rate-setting system -- have begun to discourage admission of difficult cases, whose progress and length of stay is difficult to predict. In comments submitted on the working paper that formed the basis of Chapter 5 of this report, Michael J. Kaminsky, M.D., Clinical Director of the Johns Hopkins Department of Psychiatry and Behavioral Sciences, noted this phenomenon: “[a]ny psychiatric patient with a significant co-morbidity is diverted from general psychiatric units, typically to a state hospital or private hospitalization just because of an overt need for a longer length of stay From there, when their medical conditions require it, they are transferred back to the general hospital’s medical units and so, ping-pong back and forth.”²⁶ The reluctance to admit a difficult case is exacerbated for psychiatric patients with co-existing developmental disability. Commission staff worked during 2001 with HSCRC staff and representatives of the Mental Hygiene and Developmental Disabilities Administrations to encourage

²³ Department of Health and Human Services, *Report of the Surgeon General’s Conference on Children’s Mental Health: A National Agenda, December 1999*

²⁴ American Academy of Child and Adolescent Psychiatry Work Force Fact Sheet, at www.aacp.org/training/workforce.htm

²⁶ Michael J. Kaminsky, M.D., letter to Barbara G. McLean, [then] Interim Executive Director, Maryland Health Care Commission, August 13, 2001

the treatment of such patients, through a change in HSCRC's rate setting methodology that minimizes the financial disincentive to hospitals to admit them.

Financial problems also beset the private psychiatric hospitals, which projected losses of \$7 million in 2001. To forestall the likelihood that any of the remaining private hospitals would close, the State of Maryland applied for and received a waiver from the federal Center for Medicaid and Medicare Services ("CMS") that will allow for a retroactive rate increase as of July 1, 2001, in the amount of \$9 million in Medical Assistance funds for FY 2001. Private psychiatric hospitals will receive, on average, 84% of the HSCRC's approved rates for both commercially-insured and Medical Assistance patients.

- **Systemic Factors**

Developing a Consensus on RTC Bed Need

RTC beds provided for in the State Health Plan as potentially needed for the for "Lisa L" population (12 beds) and adjudicated juvenile sex offenders (26 beds) have not been reviewed or approved by the Commission for Certificate of Need, and no reviews for these beds are currently scheduled. The Commission raised the question with representatives of the agencies included in the Governor's Subcabinet for Children, Youth, and Families as to whether the original 24 (subsequently a total of 34, through bed creep at the two sites) as well as the additional "Lisa L" beds, in particular, were needed. These RTCs, as noted above, are restricted to admissions referred by a

"Multi-Agency Review Team" comprised of representatives of these agencies.

In the fall of 2000, the Subcabinet convened a workgroup in response to these questions, and in compliance with a State Health Plan requirement²⁷ that it provide periodic reports to the Commission on the utilization of and continued need for the "Lisa L" beds. The workgroup also determined to examine the overall question of need for RTC bed capacity in the State. Along with the State's overall need for residential treatment center beds. The workgroup's recommendations included the following:

- that the 34 "Lisa L" beds currently in use be continued, based on regular full occupancy of the beds and a continued waiting list for the beds for an additional two years;
- that the beds continue to be considered temporary, as they are designated by the Plan, with a re-evaluation of the need for these beds at the end of the two-year period;
- that efforts continue to promote funding for use of community-based services for those children who can be served in placements that are less restrictive than the RTC level of care;
- that a decision about the use of the 12 additional beds be deferred until the larger, more complex issues [about bed need for the entire RTC-appropriate population] are addressed by the workgroup.²⁸

²⁷ COMAR 10.24.07G.6(a).

²⁸ Recommendations to the Maryland Health Care Commission from the Subcabinet Regarding Residential Treatment Center Bed Need, December 12, 2000

Subsequent to the December 12, 2000 release of these recommendations, the Office of Children, Youth, and Families issued a report in response to an item in the 2001 Report of the Joint Budget Chairmen²⁹ that identified “serious problems” with basic data collection, in the provision of mental health services to children and adolescents who are the responsibility of one or more of the Subcabinet agencies. This report acknowledged that, because no comprehensive database on these children exists, several questions posed by State legislators about the number of children awaiting RTC placement, and the length of the wait for placement, could not be answered. However, the Subcabinet indicated that its member agencies have initiatives in process to address these types of important data requests. They include the reactivation and improvement of the “Lisa L” database; a Request for Proposal (“RFP”) to conduct a statewide needs assessment of children and adolescent services, including RTCs, to be issued in the fall of 2001; and a proposal to develop two inter-related, human services database systems and a resource development directory, for which a contract is to be awarded November 1, 2001. The Subcabinet has committed to respond fully to the General Assembly’s questions by January 2, 2003.

- **Lack of Coordinated Data Base for Planning Purposes**

This problem, discussed above, was recognized and discussed at length by the Subcabinet workgroup, which in July 2001 conducted a survey of the State child-

serving agencies to determine the extent and adequacy of current agency data collection regarding RTC placements. The survey found that:

- Fragmentary and partial data are currently maintained separately by each child-serving state agency;
- Data are manually reported and aggregated, and not electronically stored;
- Data may be available from individual RTCs; however, the counts of children awaiting placement are not necessarily unduplicated, and the service status of the children is unknown.
- In addition, there is a lack of integration of databases among the involved state agencies. There is no formal interconnect or transfer of information from inpatient psychiatric hospitals to RTCs, to respite care, or to any community-based services. The lack of an up-to-date, integrated statewide database prevents the agencies that serve children from determining what children and adolescent psychiatric services are needed
- **Lack of Availability of Child and Adolescent Inpatient Care**

The closures of Gundry-Glass Hospital and Chestnut Lodge, two of the larger providers of child and adolescent inpatient psychiatric services in Maryland, leaves fewer options for child and adolescent psychiatric inpatient services, and has contributed – with other factors – to occasionally critical shortages of inpatient placements. As the *Baltimore Sun*

²⁹ Joint Chairmen’s Report on Residential Treatment Center Bed Need, September 2001

reported in February 2000,³⁰ the number of children treated at Johns Hopkins Pediatric Emergency Department for behavioral or emotional problems has nearly doubled since 1995 to 730 a year. The University of Maryland Hospital's Pediatric Emergency department is also swamped, to the point where it has considered opening a walk-in clinic for children and adolescents with psychiatric problems.

³⁰Diana K. Sugg, "A Hospital Crisis: Children in Need of Psychiatric Care," [The Baltimore Sun](#), February 13, 2000

- **Lack of Specialty Programs in RTCs and Hospitals for any of the Following Populations: Mentally Ill/Developmentally Disabled; Seriously Emotionally Disturbed Children; Sex Offenders; Seriously Emotionally Disturbed Delinquent Youth**

Providers report that RTCs are serving a patient population with more severe conduct disorders, lower IQs, more chronic sex offenders, co-morbid conditions (mental illness, substance abuse, developmental disabilities and mental retardation, and other medical conditions), and more persistent mental illness. While there are some RTC providers who focus on some of these special populations – and indeed, State Health Plan sections to address two of them, the “Lisa L” and adjudicated sex offenders - - no separate continuum of care has been developed to treat youth with these more focused and intense special needs. For example, only one RTC in Maryland, Villa Maria in Baltimore County, treats seriously emotionally disturbed children ages 5 to 11. As noted above, Southern Maryland has no child psychiatric hospital resources; the Maryland counties in the Washington Metropolitan Area rely upon Children’s National Medical Center in Washington, D.C. and Dominion Treatment Center in Virginia to provide inpatient child psychiatric services.

- **Maryland’s Community Access Planning Process and *Olmstead vs. L.C.***

Well-established differences in approach to providing health care services for children

and adolescents in need of inpatient hospital or residential treatment services will be addressed in the context of Maryland’s community access planning process, developed in response to the Supreme Court’s *Olmstead* decision. With Governor Parris N. Glendening’s July 26, 2000 Executive Order marking the tenth anniversary of the Americans with Disabilities Act, the State of Maryland became further engaged in a planning process to enhance the State’s solid progress in efforts to serve persons with disabilities in well-integrated community-based settings. The Community Access Steering Committee was created to make recommendations to the Governor to enhance community-based services for individuals of all ages with disabilities, and, of course, to respond to *Olmstead v. L.C.*, 527 U.S. 581 (1999). This case addresses important questions regarding the obligations of individual states to meet the needs of persons with disabilities under Title II of the Americans with Disabilities Act (“ADA”). *Olmstead* is a landmark decision in the ongoing effort to allow all citizens to more fully participate in those programs that support community access and integration³¹.

Government Oversight Of Inpatient Child And Adolescent Psychiatric And Residential Treatment Center Services

Government oversight of both inpatient child and adolescent psychiatric and RTC services in Maryland—including facilities, staff and program operation—is the responsibility of both federal and State

³¹ Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, pages 9-11.

government entities. Although this working paper focuses on responsibilities of the Maryland Health Care Commission, it is also important to consider how child and adolescent inpatient psychiatric services and RTCs are regulated by other government agencies, particularly when considering a potential alternative to the current framework of Certificate of Need review.

Federal Agencies

Centers for Medicare and Medicaid Services (“CMS”). The Centers for Medicare and Medicaid Services (“CMS”), formerly the Health Care Financing Administration (“HCFA”), within the United States Department of Health and Human Services (“DHHS”) is the federal agency that administers Medicare, Medicaid, and the State Children’s Health Insurance Program (“SCHIP”). CMS provides health insurance for over 74 million Americans through Medicare, Medicaid, and SCHIP. In addition to providing health insurance, CMS also performs a number of quality-focused activities including regulation of laboratory testing, surveys and certification of health care facilities (including inpatient psychiatric hospitals and RTCs, and provides to beneficiaries, providers, researchers, and State surveyors information about these and other activities related to quality of care improvement.

Office of the Inspector General. The Office of the Inspector General (“OIG”) within the federal DHHS is composed of the Office of Audit Services, Office of Investigations, the Office of Evaluation and Inspections, and the Counsel to the Office of Inspector General. The OIG works with CMS to develop and implement recommendations to correct systemic

vulnerabilities detected during OIG/HHS investigations of care provided in health care facilities such as inpatient psychiatric facilities and RTCs.

State Agencies

Department of Health and Mental Hygiene. The Maryland Department of Health and Mental Hygiene (“DHMH”) develops and oversees public health programs with the goal of protecting the health of Maryland residents. DHMH agencies with primary responsibility for regulating child and adolescent inpatient psychiatric services and residential treatment centers are the Mental Hygiene Administration, the Office of Health Care Quality (OHCQ), and the Maryland Medical Assistance Program. DHMH is a member of the Subcabinet for Children, Youth, and Families, and the Multi-Agency Review Team for “Lisa L” youth.

Mental Hygiene Administration. The Mental Hygiene Administration has as one of its responsibilities the oversight of the inpatient child and adolescent psychiatry and RTC services provided in State-funded facilities. This responsibility was significantly increased in 1997, when MHA assumed responsibility for Medical Assistance funds for mental health services, in the “carve out” that created the Public Mental Health System. In that year, mental health care for Medicaid recipients was “carved out” from the remaining array of Medicaid medical (and substance abuse) services, which were restructured, pursuant to Maryland’s 1115 (c) Medicaid Waiver, into managed care organizations, or “MCOs.” In Maryland, the program is known as HealthChoice. MHA assumed responsibility for the combined State-Only and Medical Assistance funding for mental

health services to Medicaid recipients and the resulting system also began to develop programs that included Medicaid recipients who were ineligible for the waiver MCOs, as well as the so-called “gray area” patients who, due to income, were deemed ineligible for Medicaid.

MHA, in collaboration with the county-level Core Services Agencies, manages the public mental health system, both its inpatient psychiatric segment (including inpatient child and adolescent services) and the system of community-based services. The Core Service Agencies are the local mental health authorities responsible for planning, managing and monitoring public mental health services at the local level. CSAs exist under the authority of the Secretary of the Department of Health and Mental Hygiene and also are agents of the county government, which must approve their organizational structure.³² CSAs may develop comprehensive community-based plans to divert children and adolescents from hospital or RTC placement.

To carry out its responsibilities, MHA contracts with an administrative service organization (“ASO”); the current contractor is Maryland Health Partners, a subsidiary of Magellan Behavioral Health, Inc., which is responsible for determining eligibility and access to services, utilization review, the development of a management information system [the Crystal System], claims processing, and system evaluation. Both Medical Assistance and State general funds for the PMHS are part of the Mental Hygiene Administration budget. This includes funding for services offered by the PMHS such as outpatient clinics and

psychiatric rehabilitation, as well as inpatient psychiatric hospitalization, residential treatment center placement, services rendered by individual practitioners, mental health-related Early and Periodic Screening, Diagnosis, and Treatment (“EPSDT”) services, and laboratory services.

In FY 2001, the latest data available, the Maryland legislature appropriated a total of \$637.5 million for MHA. Of this amount, \$396.2 million (\$310.4 million of Medicaid funding) was for community services, \$235.9 million was for State-operated institutions, and \$5.4 million was for program administration. Federal grants to MHA included a Federal Block Grant, Projects for Assistance in Transitioning from Homelessness (“PATH”), Shelter Care Plus, and other grants through the Center for Mental Health Services, which account for an additional \$8.9 million in federal funding to Maryland citizens. Sixty-one percent of expenditures were for community services. Table 6-5 shows the number of children aged 17 and under with mental illness receiving public mental health services in FY 2000. The number of children and adolescents receiving inpatient or outpatient, community-based services increased from 7,500 in 1977 to 31,920 in 2001. The majority received services in the community, as a result of MHA’s emphasis on prevention and early intervention.³³

³² Source: www.dhmh.state.md.us/mha/pmhs

³³ Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, p. 18.

Table 6-5
Medicaid Recipients and Uninsured Aged 17 and Under With Mental Illness
Receiving Services, by Age³⁴: Maryland, Fiscal Year 2000

Children Ages 17 and Under			
Service Type	M.A. + Uninsured	Medicaid	Uninsured
Case Management	638	587	51
Crisis	48	45	3
Inpatient	2,302	2,295	7
Mobile Treatment	189	178	11
Outpatient	27,741	26,689	1,105
Partial Hospitalization	236	236	0
Psychiatric Rehabilitation	3,656	3,559	99
Residential Rehabilitation	26	26	0
Respite Care	24	24	0
Residential Treatment	937	932	6
Supported Employment	10	9	1
FY 2000 Subtotals	35,807	34,580	1,283

Source: Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, p.20.

³⁴ Based only on Medicaid claims paid through March 31, 2001. These children and adolescents may have received more than one service; therefore, this is not an unduplicated count of children and adolescents served. (Source: Ibid., page 20)

Office of Health Care Quality. The Department's Office of Health Care Quality is mandated by State and federal law to determine compliance with the quality of care and life safety standards for a wide variety of health care facilities and related programs, including child and adolescent inpatient psychiatric services, whether free standing or as units in a general hospital. OHCQ issues the "special hospital" license to all private psychiatric and State hospitals, and, in the case of acute general hospitals, "deems" them to meet State licensure standards, by virtue of their accreditation by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). RTCs have a separate State licensure category. OHCQ's involvement in general hospitals is mainly limited to investigating complaints relating to quality of care issues from the general public, and complaints referred to it by the Maryland Insurance Administration.

Maryland Medical Assistance Program.

As explained above, under the Maryland Medicaid program, child and adolescent inpatient psychiatric hospital services and RTC services for eligible Medicaid recipients are reimbursed through the "carve-out" of Medicaid funds administered by the Mental Hygiene Administration and its contracted administrative services organization, Maryland Health Partners.

Department of Public Safety and Department of Juvenile Justice. The criminal and juvenile justice programs spend a significant amount of funding on drug and alcohol programs serving the criminal justice population. Treatment programs serving this population operate inside institutions or incarceration and within communities. These programs are not

reviewed by CON, but provide a substantial proportion of overall treatment capacity. It should be noted that older adolescents are sometimes adjudicated by the adult criminal justice system when their crimes are of such severity that their cases are transferred to the adult criminal justice system.

The Maryland Department of Juvenile Justice ("DJJ") provides individualized care and treatment to youth who have violated the law, or who are a danger to themselves or others. Through a variety of programs, DJJ works closely with other state agencies, including the Departments of Education, Human Resources, Health and Mental Hygiene, and local agencies to efficiently and effectively work with young people and their families reach their full potential as productive and positive members of society. According to the State Health Plan, at COMAR 10.24.07, DJJ controls admissions to adjudicated juvenile sex offender RTC beds and programs, subject to medical necessity criteria. Additionally, DJJ is responsible for providing mental health services to adjudicated youth within DJJ facilities and detention centers. DJJ is a member of the Subcabinet and a member of the MART.

Maryland State Department of Education.

The Maryland State Department of Education ("MSDE") is charged with ensuring the right to a free and appropriate public education by implementing part B of the Individuals with Disabilities Education Act ("IDEA") for all educationally handicapped children from birth through the age of 20 years. It implements this charge within its Special Education Division, where services begin as soon as a child can benefit from them, regardless of age. COMAR 13A.09.10,

Educational Programs in Nonpublic Schools and Child Care and Treatment Facilities, is used to approve educational programs in facilities by state agencies and in facilities operating special education programs such as RTCs. The MSDE is responsible also for developing an Individualized Education Plan (“IEP”), a written description of goals and the means that the educational facility plans to use to help each student achieve these goals in the least restrictive environment. Representatives from local school systems participate on the local coordinating council and local management boards to plan for education services for the special education population. In an RTC, for Special Education students, the student to certified special education teacher ratio is 4 to 1; when the class size reaches 7 special education students, an educational aide is required. MSDE, too, is a member of the Subcabinet and a member of the MART.

Maryland Department of Human Resources. The Department of Human Resources (“DHR”), through its Social Services Administration, has the responsibility to determine eligibility for Medical Assistance, and to provide welfare services to children whose parents will not or cannot care for them. It also makes available a range of other services to children and families with special needs. These services include protective services to children, foster care, adoption, in-home aide services, day care, single parent services, respite care, intensive family services, services to families with children and family support centers. These services are provided primarily through the local departments of social services located in each of Maryland’s 24 subdivisions. DHR is also a member of the Subcabinet, and of the Multi-Agency Review Team.

The Subcabinet/Office of Children, Youth, and Families. The Subcabinet for Children, Youth, and Families was created to promote interagency collaboration and increased partnership opportunities across the State in issues focused on children and their families. The Subcabinet provides leadership and policy direction and is comprised of the Secretaries of the Departments of Budget and Management, Health and Mental Hygiene, Human Resources, Juvenile Justice; the State Superintendent of Schools; the Special Secretary for Children, Youth, and Families; the Director of the Office for Individuals with Disabilities; and representatives from other State agencies as designated by the Governor. The Subcabinet Partnership Team addresses day-to-day operations and makes policy recommendations to the Subcabinet. The Cabinet-level Governor’s Office of Children, Youth, and Families (“OCYF”) strives to provide support and assistance to help families nurture and care for their children. Established in May 1989 by Executive Order 01.01.1989.12, the Office for Children, Youth and Families believes that parents and local communities can best determine the strategies that will meet their children’s needs. OCYF is a partner, facilitator, and collaborator with other State and local agencies, local management boards, and other community organizations. OCYF promotes child-centered, family-focused, and culturally-competent support to families.³⁵

³⁵ www.ocyf.state.md.us

Initiatives under the leadership of the Special Secretary of OCYF include:

- Community Partnerships for Children and Families
- Governor’s Council on Adolescent Pregnancy
- Governor’s Commission on Infant Mortality Prevention
- Healthy Families Maryland
- Maryland School-Based Health Center Initiative
- State Coordinating Council for Residential Placement of Children with Disabilities
- Maryland Health Start Collaboration Office
- The Children’s Trust Fund
- State Council on Child Abuse and Neglect

One of these initiatives, the Maryland State Coordinating Council (“SCC”), has specific relevance to child and adolescent inpatient psychiatric services and RTC services. To further monitor the State’s long-standing concern for children who are placed in residential treatment, the SCC and the Local Coordinating Councils (“LCCs”) were established during the 1980’s as a strategy for bringing each agency’s resources together for the benefit of Maryland’s children needing residential placement. The SCC is the ongoing interagency collaboration responsible for ensuring that youth with disabilities are served in the most appropriate, least restrictive placement possible. Statutory language further detailing the SCC’s authority and responsibility took effect in July 1987. In 1990, the SCC administratively moved to the Governor’s Office for Children, Youth, and Families, and its enabling statute was

incorporated in Article 49D. The guiding principles of the SCC/LCC are:

- to ensure that services are provided in a manner which most safeguards the rights of both parent and child;
- to utilize a structure that builds upon the strengths of existing procedures at the local level; and
- to provide an opportunity and incentive for resolution of interagency disputes at the lowest level possible.

The two primary goals for the SCC/LCC are³⁶:

- to develop interagency plans for children to assure placement in the least restrictive environment appropriate; and
- to recommend to agencies the development of new and enhanced community-based programs to serve children with disabilities who might otherwise remain in restrictive placements that are distant (out-of-state or out-of-county) from their families and communities.

The members of the SCC include representatives from Maryland child-serving agencies: Department of Human Resources; Department of Health and Mental Hygiene; Department of Education; Department of Juvenile Justice; and the Office for Children, Youth, and Families and one nonvoting, *ex officio* representative of the Governor’s Office for Individuals with Disabilities. By

³⁶ Ibid.

statute, members of the Local Coordinating Council, located in each county and Baltimore City, must include a representative from the Mental Hygiene Administration, the Developmental Disabilities Administration, and the local health department, the Department of Juvenile Justice the local Department of Social Services, the Division of Rehabilitation Services, the Core Service Agency, and the Local Management Board.³⁷ In addition, each LCC must have a parent advocate as a nonvoting member to support the parents of any child referred to services.

The SCC/LCC process has been in operation for almost 20 years (since 1982) in some jurisdictions, and has been fully operational since 1987 in all 24. Many individuals in local communities, therefore, are aware that this interagency resource is available. In addition, a representative of the Local Management Board is now a member of the LCC and through their participation they bring broad community concerns and commitment to ensuring this process is effective.

Office of the Attorney General, Health Education and Advocacy Unit (HEAU)

The 1998 General Assembly passed the Appeals and Grievance Law to provide patients with an enhanced ability to resolve disputes with their health insurance carriers regarding denial of coverage by

carriers.³⁸ The process outlined in the Appeals and Grievance Law begins with an adverse decision issued to the patient by the carrier. An adverse decision is a written decision by a health insurance carrier that a proposed or delivered health care services are not medically necessary, appropriate, or efficient. After receiving an adverse decision, a patient may file a grievance through the carrier's internal grievance process. The Health Education and Advocacy Unit of the Office of the Attorney General is available to attempt to mediate the dispute, or if necessary, to help patients file grievances with carriers.³⁹

Maryland Insurance Administration. The Maryland Insurance Administration ("MIA") provides for the licensure of insurers and agents; establishes financial and capital standards for insurers of all types, and sets requirements for rate making and disclosure, and for fair practices. The MIA handles consumer complaints regarding coverage decisions and appeals of medical necessity decisions made by HMOs or insurers. The Administration's Division of Life and Health is responsible for regulating life, health (including mental health care), HMO, annuity, and dental plan insurance lines.

In an effort to provide customer information in the area of health insurance, including services provided for child and adolescent inpatient psychiatric hospitalizations and RTC care, the Maryland Insurance Administration publishes a series of

³⁷ Local Management Boards ("LMBs") were established throughout the State of Maryland as the conduit for collaboration and coordination of child and family services, and work with local stakeholders to address the needs of and to set priorities for their communities.

³⁸ Annotated Code of Maryland, Insurance §15-10A-01 through §15-10A-09

³⁹ Office of the Attorney General, *Annual Report on the Health Insurance Carrier Appeals and Grievances Process, Health Education and Advocacy Unit*, Consumer Protection Division, November 2000

publications including the *Consumer's Guide to Health Insurance in Maryland*, a comprehensive guide to health care coverage.

Health Services Cost Review Commission. The Health Services Cost Review Commission ("HSCRC") is empowered by Health-General Article §19-216 to review and approve the rates and costs of hospitals in Maryland. Its jurisdiction includes non-federal acute general hospitals, non-governmental chronic hospitals, and private psychiatric hospitals. In addition to establishing a uniform accounting and reporting system, the HSCRC develops rate-setting policies and methodologies to carry out its functions. The HSCRC establishes room rates and other charges for hospitals that have licensed acute psychiatric beds. Historically, the HSCRC has not established separate and distinct room rates for child and adolescent inpatient psychiatric services in the acute general hospitals, as it does for the private psychiatric hospitals.

Maryland is the only state in the nation with a rate-setting system that functions as an alternative to the federal Medicare prospective payment system, as provided in Section 1814(b) of the Social Security Act. The federal government reimburses waived facilities in Maryland for hospital services provided to Medicare patients on the basis of rates set by HSCRC, rather than by its own prospective payment system. The federal government also accepts the hospital rates set by HSCRC with regard to federal financial participation in the Maryland Medical Assistance Program (Maryland Medicaid) for hospital services. In this "all-payer" system, hospitals may not grant discounts to any other payers unless HSCRC has approved them; HSCRC has

allowed only limited discounts for some insurers. Maryland's waiver test is based on a comparison of average rates of increase in Medicare Part A payments per admission between Maryland and the rest of the country as a whole. Good performance on the test will reflect improvements in controlling Medicare payments under the federal perspective payment system.

Maryland Health Care Commission. Through the health planning statute, the Maryland Health Care Commission ("MHCC") is responsible for the administration of the State Health Plan, which guides decision making under the Certificate of Need program and the formulation of key health care policies, and the administration of the Certificate of Need program, under which actions by certain health care facilities and services are subject to Commission review and approval.⁴⁰ Through the Certificate of Need program, the Commission regulates market entry and exit by the health care facilities and individual medical services covered by CON review requirements, as well as other actions the regulated providers may propose, such as increases in bed or service

⁴⁰ The MHCC also establishes a comprehensive standard health benefit plan for small employers, and evaluates proposed mandated benefits for inclusion in the standard health benefit plan. In its annual evaluation of the small group market, the Commission considers the impact of any proposed new benefits on the mandated affordability cap of the small group market's benefit package, which is 12 percent of Maryland's average wage, and the impact of any premium increases on the small employers. Briefly, with regard to mental health and substance abuse, this is covered when delivered through a carriers' managed care system for 60 inpatient days with partial hospitalization traded on a 2 to 1 basis and unlimited outpatient visits subject to the following cost sharing: in-network carrier pays 70%; out-of-network carrier pays 50%. Prescription drugs are covered with a \$150 separate deductible for each covered person, and an open formulary with a three-tiered co-payment.

capacity, capital expenditures, or expansion into new service areas. The Commission has developed State Health Plan chapters in response to requests from the Subcabinet and other child serving agencies.

Entry into the market for proposed new inpatient child and adolescent facilities or bed capacity has been explicitly regulated through Certificate of Need since the 1988 enactment of a list of “medical services” subject to CON, if established by an otherwise-regulated health care facility⁴¹. As with all Certificate of Need review in Maryland, the analysis of applications for CON approval for new facilities or expanded bed capacity⁴² evaluates how proposed projects meet the applicable standards and policies in the State Health Plan, and how they address the six general review criteria found in the Certificate of Need procedural regulations at COMAR 10.24.01.08G.⁴³ The State Health Plan currently in effect requires that a facility obtain a separate Certificate of Need for each division of inpatient psychiatry

recognized by the SHP, i.e. a designated child, adolescent, or adult psychiatric service.

As noted in previous discussions in Phase I of this report concerning the effect of HB994 and its changes to Certificate of Need law applicable to “the closure of a hospital or part of a hospital,” two of these 1999 statutory provisions significantly altered the Commission’s oversight authority with regard to potential closures of hospitals or their inpatient psychiatry services, and with regard to the bed capacity of individual medical services.

The Certificate of Need procedural rules applicable to hospitals in jurisdictions with three or more hospitals at §19-120(l) explicitly include State hospitals, which also may close without action by the Commission, provided that the Commission has received written notification 45 days before the planned closure, and the hospital (or in this case, the Department of Health and Mental Hygiene, specifically, the Mental Hygiene Administration) has held a public informational hearing in the area affected by the closure. State statutes and regulation require that an RTC receive a Certificate of Need to close a facility. However, if a facility has been required to close as a result of an impending bankruptcy or violations of licensing or certification standards, which have resulted in a closure by the Office of Health Care Quality, the Commission has not required a CON review.

As noted in Chapter 5 of this report with respect to adult psychiatric beds and services, it is far less clear whether this comparatively quick and easy closure process also applies to the private

⁴¹ Health-General §19-120(a).

⁴² Bed increases in either service may be authorized by the commission without CON review through the statutory “waiver bed” rule that permits increases of 10 beds or 10% of total beds, whichever is less, two years after the last change in licensed bed capacity.

⁴³ In brief, these criteria require an application to: (1) address the State Health Plan standards applicable to the proposed project; (2) demonstrate need for the proposed new facility or service; (3) demonstrate that the project represents the most cost-effective alternative for meeting the identified need; (4) demonstrate the viability of the project by documenting both financial and non-financial resources sufficient to initiate and sustain the service; (5) demonstrate the applicant’s compliance with the terms and conditions of any previous CONs; and (6) “provide information and analysis on the “impact of the proposed project on existing health care providers in the service area.”

psychiatric hospitals, which are not classified as general hospitals under the licensure statute.⁴⁴ Interpretations of the provisions of HB994 related to acute general hospitals are based on their interconnectedness: the bill ended the creation of waiver, or “creep” beds in general hospitals (this was clarified in the Commission’s implementing regulations), in favor of the annual recalculation of licensed bed capacity “for a hospital classified as a general hospital,⁴⁵” according to a factor of 140% of its previous year’s average daily census. HB994 has not been interpreted as precluding the authorization of waiver beds for private psychiatric hospitals, and it has not been interpreted as permitting any but acute general hospitals (i.e., those subject to the annual application of 140% of last year’s average daily census) to increase or decrease beds between members of merged asset systems.

Maryland’s Certificate Of Need Regulation Of Inpatient Child And Adolescent Psychiatric And RTC Services Compared To Other States

Thirty-six states and the District of Columbia, as shown in the latest national directory published by the American Health Planning Association (“AHPA”), have Certificate of Need review for some number of health care facilities and proposed expansion of service capacity. Maryland is noted as one of twenty-six of those states that regulates psychiatric services.

In an effort to learn what other states are doing with regard to the regulation, by means of a Certificate of Need review

program of either child or adolescent inpatient psychiatric services or residential treatment center services, Commission Staff contacted other states by means of electronic mail communication through an Internet forum established by the American Health Planning Association. Through this forum, staff received a total of eight (8) responses from Staff from other states’ health planning units.

A representative from the State of Ohio responded that the state does not review either of these services through the CON program.⁴⁶

Staff from the Central Virginia Health Planning Agency responded that Virginia is in the process of reviewing all services included in the State Medical Facilities Plan, including psychiatric services. Currently, in Virginia, all psychiatric service is grouped together for regulatory purpose, a situation that is problematic. There is no separate licensure or need methodology for child or adult services, or acute inpatient or residential treatment center services. Moreover, there are no adjustments for acuity, and others needing single, locked rooms, where the facility only has semi-private rooms. This creates lower occupancies and less efficient utilization of facilities.⁴⁷

Staff from the State of Arkansas responded that Arkansas currently requires a CON for all psychiatric residential treatment facilities

⁴⁴ Health-General Article §19-307(a).

⁴⁵ Health-General Article §19-307.2(a)

⁴⁶ Electronic mail communication from Christine Kenney, Ohio Department of Health, September 21, 2001.

⁴⁷ Electronic mail communication from Karen L. Cameron, CHE, Executive Director/CEO, Central Virginia Health Planning Agency, Richmond, Virginia, September 21, 2001.

for children and youth. The formula that Arkansas uses is .385 beds per 1,000 persons age 6-17 and .300 beds per 1000 persons aged 18-21. Facilities requesting additional beds must have averaged a 90% occupancy rate for the previous calendar year. In order for a new facility to be approved for a given county, existing facilities in that county must have averaged an 80% occupancy rate for the previous calendar year.⁴⁸

In Florida, the CON review process regulates licensed hospitals for children's mental health services, according to staff from the Florida Hospital Administration; however, not other types of residential treatment settings—although one type of licensed hospital bed for psychiatric services is called “intensive residential treatment facility”. CONs are required in Florida in order to open specialty hospitals providing psychiatric services for children or adults through units in general hospitals. Florida also requires CONs for the expansion of bed capacity in either freestanding/specialty hospitals or units in general hospitals. Florida's regulations project need for children's mental health beds in two categories—psychiatric and substance abuse. The regulations use current use rates in each of 11 health planning districts applied to future population to predict gross bed need and then to adjust the need numbers based on occupancy at existing hospitals. In the most recent bed need projections, staff from the Florida Association reports, only one district was found to have a need for children's psychiatric beds (53 beds), and no districts

were found to have any need for substance abuse beds (even though licensed beds exist in only 1 district).

According to Florida's most recent CON Annual Report, published by the Florida state health planning agency, CON activity for these types of beds has been very limited in the last ten years—with only 17 applications being filed during this period for child psychiatric services, and no applications being filed for children's substance abuse beds. When new beds have been approved, they have mostly been by means of conversion or transfer. Only 4 psychiatric beds, in the last five (5) years have been added through new construction; the Florida Hospital Administration staff did not know whether these were child or adult beds.

Possibly one explanation for this limited activity for these types of services in Florida is that when Florida first recognized children's psychiatric beds and substance abuse beds as distinct licensure categories in 1991, the state inventory listed 1,841 licensed beds as child psychiatric along with 259 as child substance abuse beds. Since 1992, this inventory has declined markedly, to 606 licensed beds for children's psychiatric services, with 15 licensed beds for children's substance abuse services.⁴⁹

CON staff from the state of Missouri responded that the state does little to regulate inpatient child and adolescent psychiatric services by means of a Certificate of Need since it has have found

⁴⁸ Electronic mail communication from Mary Brizzi at the Arkansas Department of Health, September 21, 2001

⁴⁹ Electronic mail communication from Carol J. Gormley, Director of Governmental Relations, Florida Hospital Association, Tallahassee, Florida, September 21, 2001.

that the proposed service rarely goes over Missouri's \$1,000,000 expenditure minimum for CON review.

The state of Michigan regulates child and adolescent inpatient psychiatric services with a need methodology, the base year of which, according to its regulations, Michigan's CON Commission may modify. It is also interesting to note that a requirement for approval of a CON for child and adolescent inpatient psychiatric beds is that the average occupancy rate for all licensed beds at the psychiatric hospital or unit shall be at 75% for the second 12 months of operation, and annually thereafter. The State of Michigan's definition of a "specialized psychiatric program" is very much like Maryland's residential treatment center. Projects involving either an increase in the number of beds (whether new, additional, replacement or converted) for a specialized psychiatric program for children or adolescents are subject to a comparative review.

As of October 1, 2002, Michigan will be eliminating CON regulation of partial hospitalization psychiatric programs. These programs are defined as follows:

"a non-residential mental health treatment program in which clients are regularly scheduled to be treated for a minimum of six consecutive hours during any 24-hour period for a minimum of five (5) days per week; including psychiatric, psychological, social, occupational, therapeutic recreational elements, all of which are under psychiatric supervision; and provides services to clients who are diagnosed mentally or

emotionally ill, and who are at risk of psychiatric inpatient hospitalization, or who might otherwise remain hospitalized on an inpatient basis in the absence of such a program.^{50,}

Staff involved in CON review responded that South Carolina does not have separate bed need calculations or standards for inpatient child psychiatric beds. Any beds proposed must come from the general bed need, which the staff noted was currently negligible [with only two out of 14 service areas showing a need for psychiatric beds]. In South Carolina, adolescents can remain in an RTC up to age 21, whereas in Maryland it is up to the age of 18. South Carolina has CON standards and a bed need methodology projected by regional service area for RTCs. The standards note what minimum services should be available at a minimum. RTC beds for children and adolescents are distributed statewide, and are located within seventy-five (75) minutes travel time for the majority of residents of the state. South Carolina gives equal weight to the benefits of improved accessibility with the adverse affects of duplication in evaluating Certificate of Need applications for this service.⁵¹

Staff from the State of Kentucky responded that its State Health Plan provides that "no new psychiatric beds for children or adolescents shall be approved except for beds converted from existing acute care beds. No psychiatric beds for children or

⁵⁰ Electronic mail communication from Catherine Stevens, Michigan CON Commission, Michigan Department of Public Health, September 21, 2001.

⁵¹ Electronic mail communication from Les Shelton, South Carolina Department of Health and Environmental Control, September 24, 2001.

adolescents focus on short-term (under 30 days) crisis stabilization.” Kentucky also regulates psychiatric residential treatment facilities that are community-based, home-like eight bed facilities for ages six to 21⁵².

⁵² Electronic mail communication from Jayne M. Arnold, Kentucky Health Service, October 2, 2001.

Alternative Regulatory Strategies: An Examination Of Certificate Of Need Policy Options for Child And Adolescent Inpatient Psychiatric Services And RTC Services

The options discussed in this section represent alternative strategies governing oversight of inpatient child and adolescent psychiatric services and RTC services in Maryland. Each of these services is considered separately, with its potential alternative regulatory frameworks. All categories of inpatient psychiatric beds are regulated by the State Health Plan, whereas only the specialty RTC populations (“Lisa L” and adjudicated juvenile sex offenders) are addressed by individual sections of the State Health Plan at COMAR 10.24.07.07. The options below will apply differently to child and adolescent psychiatric hospitals as compared to RTCs.

Option 1: Maintain Existing Certificate of Need Review Program Regulation for Child and Adolescent Inpatient Psychiatric Beds and RTC Beds, With Commission-Mandated Data Collection for RTC Beds

This option would maintain the CON review requirement for new or expanded child and adolescent inpatient psychiatric and RTC services in current law and regulation, but with the addition of Commission-mandated data collection for RTC beds. Under current law, establishing a new inpatient child and adolescent psychiatric hospital requires a CON based on a state-projected need. The Commission’s decision on a given application is based on its review of a proposed project’s consistency with the State Health Plan’s review standards and consensus with other stakeholders about

need projection, along with the general CON review criteria. To exit from this market, the procedure varies according to the number of hospitals in the jurisdiction. In a jurisdiction with three or more hospitals, or for a State hospital, the facility must provide the Commission with written notification of the intended closure of the child and adolescent inpatient psychiatric hospital, and must hold an informational public hearing in the affected area. In jurisdictions with one or two hospitals, a public hearing must still be held, but action by the Commission through CON exemption is also required.

With regard to RTCs, only the “Lisa L” and violent juvenile sex offender populations are addressed in the SHP. Those wishing to develop an RTC serving other specialized populations or a generic RTC could have to petition the Commission to develop a State Health Plan section with applicable standards, or could apply for CON approval and be reviewed according to the general CON review criteria at COMAR 10.24.01.08G. The regulations establish the principle that the “burden of proof” of need for the new facility or bed capacity rests with the applicant.

This option also proposes to address the Commission’s long standing need for specific data that measures utilization of RTCs in relation to the capacity of the system, that monitors the system to project short and long term system trends, none of which can be accomplished through existing data systems. Active involvement in RTC data collection, which could be initiated under the Commission’s existing data collection authority, would require additional staff resources, and represent an extension of the Commission’s current involvement in this health care sector.

Option 2: Expand Certificate of Need Program Regulation

As noted above, the closure of an inpatient psychiatric service requires either a 45-day notice or an exemption from CON review, depending upon the number of hospitals in the jurisdiction. The closure of a State hospital or part of a State hospital requires only the 45-day notification, regardless of the jurisdiction. Restoring the statutory requirement for some level of action by the Commission in all proposed closures of inpatient psychiatric services in acute general hospitals is a second alternative regulatory strategy. A finding by the Commission that exempts a proposed hospital service closure from CON review is currently needed in jurisdictions with one or two hospitals; only notice to the Commission and a public hearing is necessary for service closure in a multiple hospital jurisdiction. Option 2 would strengthen current oversight of inpatient psychiatric service closures by requiring hospitals in multiple hospital jurisdictions to obtain an exemption to exit the market.

This option supports placing greater public policy emphasis on insuring geographic access to inpatient psychiatric services (including child and adolescent psychiatric services). This option does not apply to RTCs.

The recent hospital closures at Gundry-Glass Hospital and Chestnut Lodge may well have affected future access to care for mentally ill children and adolescents. Current statute allows hospitals in multiple hospital jurisdictions, including Baltimore City and Montgomery County, where these two hospitals were located, to close without

Commission oversight or action, after notification and a public hearing. Requiring the same level of review for multiple hospital jurisdictions as now exists in one- or two-hospital jurisdictions would allow public review and community input into the potential impacts and solutions of the closure of a child and adolescent psychiatry service in all areas of the State.

Expansion of regulation regarding RTCs would first require the expansion of the existing State Health Plan chapter to include standards and need projections for all RTCs. This expansion could also include respite care, since -- as it is presently constituted -- has become a placement characterized by much longer stays and services that mirror those in an extended-stay hospital setting. This expanded regulatory scope would require the development of new databases to make informed planning decisions.

Option 3: Partially Deregulate Child and Adolescent Inpatient Psychiatric Services and RTC Services

A partial deregulation of these services from Certificate of Need review could involve one or the other of the two services. The Commission could decide to retain CON review for inpatient services to children and adolescents, and defer in matters affecting RTC bed capacity to the Subcabinet for Children, Youth, and Families, since the Subcabinet agencies are so intensively engaged in providing services directly, and in bearing the cost of those services. The Commission already actively engages the Subcabinet and its individual agencies in CON reviews for RTCs and child/adolescent hospital facilities. Any decisions about health care services to the children and

adolescents for which the component agencies bear responsibility and cost have a direct impact on planning, budgeting, and legislation relating to all children and adolescents in the State, responsibilities which rest with the Subcabinet. This option could lead to better coordination of services because the same entity would be responsible for the planning for RTCs and community-based services for this population. Retaining Certificate of Need review for inpatient beds and services may still make sense, even under this scenario, because to remove some acute and special hospital beds from the dual authority of MHCC and HSCRC would fragment a unified and successful regulatory framework, and potentially destabilize an already challenged health care sector.

Taking the opposite perspective, the Commission could consider incorporating the approach proposed by Chapter 5's option, of removing the requirement for separate CON approval for a facility with an existing adult inpatient psychiatric program to add either a child or adolescent service. With the requisite changes to the State Health Plan, to help ensure the appropriate clinical and programmatic capabilities, this expansion of existing services could be accomplished through a less intensive level of review, such as CON exemption. It would have the advantage of enabling experienced providers of inpatient psychiatric care for adults to expand access to child and adolescent services, after an expedited review.

This option would, however, maintain regulation of RTC services by the Commission. The Commission has the knowledge, experience, and expertise to plan for the entire system of child and

adolescent inpatient care. No other governmental entity in the State has the statutory mandate to plan for both the public, private, and non-profit sectors of the health care system. The Commission is, and continues to be, situated where it can act as an arbiter among the child-serving agencies, providers, advocates and other stakeholders because its constituency comprises the entire State.

Option 4: Deregulation of Inpatient Child and Adolescent Psychiatric Facilities from CON Review With Responsibility for Monitoring Transferred to the Mental Hygiene Administration, the Subcabinet, or the Office for Children, Youth, and Families

As noted above, MHA is responsible for administering the Public Mental Health System as well as General Assembly-appropriated funds that support inpatient and outpatient programs. Given these planning and financial responsibilities, it would be logical to assign responsibility for the monitoring of need to the agency statutorily accountable to the legislature for the majority of the funding of child and adolescent psychiatric facilities. MHA plans for services, collects data, and assures that quality mental health care is available for the citizens of Maryland, including children and adolescents.

A similar rationale for the deregulation of child and adolescent psychiatric facilities and deferring to MHA would apply to either the Subcabinet or the Office for Children, Youth, and Families. Since the Subcabinet is comprised of representatives of all of the child-serving agencies plus representatives of the Department of Budget and the Office

of the Attorney General, this agency would also have the expertise and experience to monitor planning for these services. Likewise, the Office for Children, Youth, and Families would have similar capabilities.

Option 5: Deregulate Child and Adolescent Psychiatric Services from Certificate of Need Review; Create Data Reporting Model to Encourage Quality of Care

Another option for the regulation of psychiatric services for children and adolescents – similar that proposed for many of the other Certificate of Need-regulated services examined in this two-year study -- involves replacing the CON program's requirements governing market entry and exit with a program of mandatory data collection and reporting, to encourage continuous quality improvement through the gathering and periodic publication of comparative information about existing programs. Performance reports, or "report cards" are intended to incorporate information about quality decisions made by both employers and employees in their choice of health plans, and by consumers whose health plans permit a measure of choice in providers. Performance reports can also serve as benchmarks against which providers can measure themselves, and seek to improve quality in any areas found deficient. As such, report cards may both inform consumer choice and improve the performance of health services, and could either take the form of public report cards, designed for consumers, or performance reports designed to provide outcomes information and best-practices models for providers.

Option 6: Deregulation of Child and Adolescent Inpatient Psychiatric Services and Residential Treatment Centers from Certificate of Need Review

Under this option, all CON review related to both market entry and exit would be eliminated for child and adolescent inpatient psychiatric services and residential treatment centers in Maryland. Repeal of CON has been associated with increases in supply of services in several states, but the effect of removing any constraint on market entry (or exit) would be different for each service, depending on the role played by the present framework's constraints on reimbursement and length of stay constraints in the sector's stability and cost-effectiveness. It is unlikely, for example, that complete deregulation from CON review would result in a significant increase in the supply of child and adolescent hospital beds, because of the continued restrictions on inpatient admission and length of stay by managed care. However, the same level of constraint may not be operating with respect to RTC utilization, and without the pre-requisite of demonstrating need, the supply of RTC beds may increase. Another factor in any consideration of removing the CON requirement for an expansion of child and adolescent psychiatric hospital services or residential treatment centers is the increased pressure of any expansion on the critical shortage of nurses and other professional staff.

In the absence of CON regulation by the Commission, governmental oversight would

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come from existing agencies such as the Office of Health Care Quality, the Mental

Hygiene Administration, and the Medicaid program.

**Table 6-6
Summary of Regulatory Options:
Child and Adolescent Psychiatric Services**

Options	Level of Government Oversight	Description	Administrative Tool
Option 1: Maintain Existing CON Regulation	No Change in Government Oversight	<ul style="list-style-type: none"> Market Entry Regulated by CON/Exemption (for merged systems) Market Exit Through Notice or Exemption 	Commission Decision (Certificate of Need/Exemption/Notice)
Option 2: Expand CON Regulation	Increase Government Oversight	<ul style="list-style-type: none"> Market Entry Regulated by CON Market Exit Through Exemption 	Commission Decision (Certificate of Need/Exemption)
Option 3: Partially Deregulate Child & Adolescent Inpatient Psychiatric Services and RTCs	Partial Change in Government Oversight	<ul style="list-style-type: none"> Market Entry and Exit Changed for One or the Other of the Services 	Commission Decision (Certificate of Need/Exemption/Notice)
Option 4: Deregulate C/A Psychiatric Facilities from CON; Monitoring by MHA, the Subcabinet, or Office of Children, Youth, and Families	Change Government Oversight	<ul style="list-style-type: none"> No barrier to Market Entry; Decision by Funding Agency to Approve and Reimburse New Bed Capacity or Facilities 	Indicated Agency Reviews and Approves proposed new Capacity
Option 5: Deregulate C/A Inpatient Psychiatric Services, Create Data Reporting Model	Change Government Oversight	<ul style="list-style-type: none"> No Barrier to Market Entry or Exit 	Performance Reports/ Report Cards
Option 6: Deregulate C/A Inpatient Psychiatric Services and RTCs from CON Review	Change Government Oversight	<ul style="list-style-type: none"> No Barrier to Market Entry or Exit 	Remaining Agencies Exercise Oversight Authority (OHCQ, MHA, Medicaid)

Commission Recommendations

Recommendation 6.0

The Commission should continue its regulatory over-sight of child and adolescent inpatient psychiatric and resi-dential treatment center (“RTC”) services through the Certificate of Need review process.

Recommendation 6.1

The Commission should modify the State Health Plan’s current requirement for a separate Certificate of Need for each additional category of inpatient psychiatric service, to require an exemption from CON, based on clinical and program standards for the proposed new service to be established in the State Health Plan for each category of inpatient psychiatric service. This change is particularly important to expanding access to inpatient psychiatric beds dedicated to the care and children and adolescents, many of which have been closed by private psychiatric facilities over the past decade.

Recommendation 6.2

The Commission should support efforts to establish an on-going comprehensive data system and bed registry for RTCs. The Commission, in partnership with the Governor’s Office of Children, Youth, and Families and the Mental Hygiene Administration, should make recommendations to conduct a study on the scope, content, and ongoing administration of this database.

The Commission recommends that Maryland continue to regulate the establishment of inpatient psychiatric beds and facilities for children and adolescents, and residential treatment centers for this population, by means of the Certificate of Need process, and, proposes to develop certain changes and clarifications to its current regulatory authority, in the State Health Plan, to implement Recommendations 6.1, as discussed under a similar recommendation in Chapter 5.

This change to the existing State Health Plan for inpatient psychiatric services would remove the requirement that a hospital with an existing inpatient service obtain an additional separate CON approval for each category of psychiatric care. Staff will develop specific State Health Plan standards to guide the review and approval of proposed additional service, possibly through a CON exemption review. These standards will be included in an update and revision of the Plan, and thereby receive extensive additional public comments as part of the regulatory review process. They would include consideration of requirements for Board Eligible/Board Certified specialists in the service to be added, specialized staffing, and separate clinical space and programs.

In order to inform and support effective planning and sound CON decisions for RTC services, it is critical that a comprehensive data bank and bed registry be developed and maintained. To realize the development of such a data system will require the commitment of sufficient resources and agreements among key stakeholders on the appropriate roles of each agency. The Commission will work closely with the other responsible State agencies toward the

development of the data needed to make the best use of available funding.

APPENDIX 6-1

Inpatient Psychiatric Discharges, Acute General and Private Psychiatric Hospitals by Age Category Calendar Years 1996 to 2000

**Appendix 6-1
Inpatient Psychiatric Discharges, Acute General and
Private Psychiatric Hospitals by Age Category
Calendar Years 1996 to 2000**

COUNTY	HOSPITAL PROVIDER	AGE	DISCHARGES				
			1996	1997	1998	1999	2000
ALLEGANY	MEMORIAL CUMBERLAND	0-12 Years	2	1	0	1	3
		13-17 Years	3	1	2	0	2
		18 above	31	27	13	20	12
	SACRED HEART	0-12 Years	0	0	0	0	1
		13-17 Years	23	27	26	22	41
		18 above	536	487	598	672	657
FREDERICK	FREDERICK MEMORIAL	0-12 Years	0	1	2	1	0
		13-17 Years	3	1	4	1	1
		18 above	530	556	567	589	553
GARRETT	GARRETT COUNTY	0-12 Years	0	0	1	0	0
		13-17 Years	0	1	0	0	1
		18 above	22	14	11	22	14
WASHINGTON	WASHINGTON COUNTY	0-12 Years	1	1	0	1	2
		13-17 Years	16	19	22	9	20
		18 above	645	636	606	568	648
WESTERN MARYLAND TOTAL			1,812	1,772	1,852	1,906	1,955
MONTGOMERY	HOLY CROSS	0-12 Years	0	0	0	1	0
		13-17 Years	6	1	5	2	1
		18 above	209	174	179	81	31
	MONTGOMERY GENERAL	0-12 Years	0	0	0	0	0
		13-17 Years	86	80	57	64	91
		18 above	873	852	912	916	991
	SHADY GROVE ADVENTIST	0-12 Years	1	0	2	2	4
		13-17 Years	2	0	2	2	2
		18 above	13	19	31	19	28
	SUBURBAN	0-12 Years	0	1	0	0	1
		13-17 Years	48	53	47	61	76
		18 above	671	567	588	706	789
	WASHINGTON ADVENTIST	0-12 Years	0	2	2	0	0
		13-17 Years	102	100	99	95	113
		18 above	1,338	1,389	1,414	1,480	1,453
MONTGOMERY COUNTY TOTAL			3,349	3,238	3,338	3,429	3,580

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COUNTY	HOSPITAL PROVIDER	AGE	DISCHARGES				
			1996	1997	1998	1999	2000
CALVERT	CALVERT MEMORIAL	0-12 Years	0	0	1	0	1
		13-17 Years	146	152	138	121	110
		18 above	340	263	324	318	355
CHARLES	CIVISTA MEDICAL	0-12 Years	0	1	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	6	5	11	12	6
PRINCE GEORGE'S	DOCTORS HOSPITAL	0-12 Years	0	1	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	11	9	5	12	13
	FORT WASHINGTON	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	0	5	0	2	5
	LAUREL REGIONAL	0-12 Years	0	0	0	0	0
		13-17 Years	8	12	8	12	8
		18 above	601	509	553	510	641
	PRINCE GEORGE'S HOSPITAL	0-12 Years	1	0	1	0	0
		13-17 Years	79	54	45	21	34
		18 above	929	754	1,000	1,040	1,240
	SOUTHERN MARYLAND	0-12 Years	0	0	0	0	2
		13-17 Years	65	73	119	104	103
		18 above	701	769	785	704	811
ST. MARY'S	ST. MARY'S	0-12 Years	1	0	0	0	0
		13-17 Years	2	4	3	5	3
		18 above	396	374	337	345	328
SOUTHERN MARYLAND TOTAL			3,286	2,985	3,330	3,206	3,664
ANNE ARUNDEL	ANNE ARUNDEL MEDICAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	1	0	2	0
		18 above	28	15	24	13	30
	NORTH ARUNDEL	0-12 Years	1	1	0	1	0
		13-17 Years	1	0	1	0	0
		18 above	634	626	571	604	689
BALTIMORE COUNTY	FRANKLIN SQUARE	0-12 Years	17	136	182	173	211
		13-17 Years	13	26	28	4	4
		18 above	750	820	904	728	954
	GBMC	0-12 Years	0	0	0	1	1
		13-17 Years	1	1	1	0	4
		18 above	35	41	39	56	82

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NORTHWEST HOSPITAL	0-12 Years	0	0	0	0	0
	13-17 Years	0	1	0	0	1
	18 above	32	31	22	25	22
ST. JOSEPH	0-12 Years	2	9	5	6	9
	13-17 Years	8	55	69	88	86
	18 above	376	465	464	517	483

COUNTY	HOSPITAL PROVIDER	AGE	DISCHARGES				
			1996	1997	1998	1999	2000
BALTIMORE CITY	BON SECOURS	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	1
		18 above	16	20	9	447	1,768
CHILDREN'S HOSPITAL	CHILDREN'S HOSPITAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	0	0	1	0	0
CHURCH HOSPITAL	CHURCH HOSPITAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	14	13	11	8	0
GOOD SAMARITAN	GOOD SAMARITAN	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	35	35	26	20	25
HARBOR HOSPITAL	HARBOR HOSPITAL	0-12 Years	0	3	0	1	0
		13-17 Years	0	0	0	0	0
		18 above	16	12	13	18	18
JAMES L. KERNAN	JAMES L. KERNAN	0-12 Years	5	2	3	1	4
		13-17 Years	68	59	60	53	95
		18 above	0	1	0	0	0
JOHNS HOPKINS	JOHNS HOPKINS	0-12 Years	315	231	269	237	262
		13-17 Years	250	212	193	208	233
		18 above	1,447	1,563	1,539	1,918	1,890
JOHNS HOPKINS BAYVIEW	JOHNS HOPKINS BAYVIEW	0-12 Years	0	0	1	0	0
		13-17 Years	25	24	24	12	20
		18 above	744	684	697	724	820
JOHNS HOPKINS ONCOLOGY	JOHNS HOPKINS ONCOLOGY	0-12 Years	0	0	0	0	0
		13-17 Years	1	0	0	0	0
		18 above	3	0	0	2	2
LIBERTY MEDICAL	LIBERTY MEDICAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	1	0	0
		18 above	2,270	1,995	2,143	1,039	0
MARYLAND GENERAL	MARYLAND GENERAL	0-12 Years	0	0	0	0	0
		13-17 Years	13	0	0	1	1
		18 above	929	770	725	825	1,030
MERCY	MERCY	0-12 Years	2	2	0	0	0
		13-17 Years	39	14	9	0	0
		18 above	125	81	37	18	23

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SINAI	0-12 Years	0	0	3	1	2
	13-17 Years	4	14	27	22	17
	18 above	800	1,036	1,132	1,231	1,274
ST. AGNES	0-12 Years	2	1	2	0	1
	13-17 Years	2	0	3	1	0
	18 above	40	24	34	35	34
UNION MEMORIAL	0-12 Years	1	0	1	0	1
	13-17 Years	1	1	2	3	1
	18 above	903	824	879	952	1,094

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COUNTY	HOSPITAL PROVIDER	AGE	DISCHARGES				
			1996	1997	1998	1999	2000
CARROLL	UNIVERSITY OF MARYLAND	0-12 Years	179	260	293	340	300
		13-17 Years	12	24	20	12	14
		18 above	1,540	1,471	1,413	1,384	1,340
	CARROLL COUNTY GENERAL	0-12 Years	0	2	18	7	6
		13-17 Years	59	73	110	101	127
		18 above	703	619	687	688	666
HARFORD	FALLSTON GENERAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	1
		18 above	18	19	17	35	44
HOWARD	HARFORD MEMORIAL	0-12 Years	0	0	0	1	0
		13-17 Years	24	25	35	28	24
		18 above	541	417	501	524	443
	HOWARD COUNTY	0-12 Years	5	2	3	1	4
		13-17 Years	68	59	60	53	95
		18 above	542	457	413	459	466
CENTRAL MARLAND TOTAL			17,651	17,271	17,720	17,626	18,722
CECIL	UNION HOSPITAL	0-12 Years	0	0	0	0	0
		13-17 Years	1	0	1	0	1
		18 above	535	475	402	392	381
DORCHESTER	DORCHESTER GENERAL	0-12 Years	11	2	1	0	0
		13-17 Years	146	76	44	87	104
		18 above	310	387	327	446	526
KENT	KENT AND QUEEN ANNE'S	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	1	0	0
		18 above	18	8	2	12	14
SOMERSET	EDWARD W. MC CREADY	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	0	14	4	5	7
TALBOT	MEMORIAL AT EASTON	0-12 Years	2	1	0	3	2
		13-17 Years	2	0	3	2	0
		18 above	171	24	15	22	28
WICOMICO	PRMC	0-12 Years	1	0	1	1	0
		13-17 Years	3	3	1	5	1
		18 above	429	408	402	476	518
WORCESTER	ATLANTIC GENERAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	1
		18 above	4	3	5	6	5

	EASTERN SHORE TOTAL		1,633	1,401	1,209	1,457	1,588
		0-12 Years	544	657	788	778	813
		13-17 Years	1,262	1,187	1,210	1,148	1,342
		18 above	21,860	20,767	21,392	21,645	23,255
	MARYLAND TOTAL		23,666	22,611	23,390	23,571	25,410

EXHIBIT 2

Data Resource Guide Fiscal Year 2014

Maryland Department of Juvenile Services

State of Maryland

Lawrence J. Hogan, Jr., Governor

Sam Abed, Secretary

January 2015

This guide fulfills the Statutory Reporting Requirements set forth in Md. Human Services Code Ann. §9-204 regarding the Agency's comprehensive juvenile services plan as well as reporting juvenile recidivism rates.

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The DJS Executive Staff and Project Leaders would like to thank everyone who contributed to this document. Our appreciation goes to the members of the agency who contributed a wealth of information with special thanks to Scott Beal, Gilbert Becker, Richard Burton, Toni Christian, Michael DiBattista, Esther Diggs, Cory Fink, Patricia Flanigan, Reginald Garnett, Lisa Garry, Donna Hamilton, Michael Ito, Wallis Norman, Nic Ryan, Betsy Tolentino, and John Wisniewski. We would also like to thank Jill Farrell at the University of Maryland, School of Social Work, The Institute for Innovation and Implementation, Jane Trainer at the Office of State Planning, Ida J. Williams at the Maryland State Police, Katharine Oliver and Beth Hart at the Maryland State Department of Education, and Boyce Williams at the Department of Public Safety and Correctional Services. We are especially grateful to the field staff who gather the data necessary to complete the *Data Resource Guide*.

Table of Contents

INTRODUCTION

Letter from the Governor	iv
A Word from the Secretary	v
Terms and Concepts	vi

SECTION I: AN OVERVIEW OF THE MARYLAND DEPARTMENT OF JUVENILE SERVICES

Introduction to the Maryland Department of Juvenile Services (DJS)	3
Organizational Chart and Agency Organization	4
Agency Vision, Goals, and Values	5
DJS Operating Expenditures, FY 2014	6
DJS Historical Evolution and Timeline	7
Maryland Juvenile Justice Services Process Flowchart	10
Professional Training and Education Unit	12
Flow of FY 2014 Case Referrals	13

SECTION II: INTAKE AND COMMUNITY SUPERVISION

Introduction to Intake and Community Supervision	17
Statewide, Regional, and County Activity	20
Trends	84

SECTION III: DETENTION

Introduction to Detention	93
Statewide and Specific Detention Facility Information	96
Alternatives to Detention (ATD)	118

SECTION IV: COMMITTED PROGRAMS

Introduction to Committed Programs	123
Statewide and Committed Programs by Type	128
State-Operated Facilities	146
Silver Oak (Private Provider)	162
Community-Based Family Therapy Programs for Committed & Probation Youth	164

SECTION V: RECIDIVISM RATES

Measuring Recidivism Rates	169
Recidivism Rates for Committed Program Releases	171
Recidivism Rates for Youth with New Probation Dispositions	183

APPENDICES

Appendix A: Community Services Staffing Distribution as of June 30, 2014	189
Appendix B: Detention Center Staffing (Filled Positions) as of June 30, 2014	190
Appendix C: Committed Program Staffing (Filled Positions) as of June 30, 2014	190
Appendix D: State Operated Facility Expenditures, FY 2014	191
Appendix E: State Operated Facility Per Diems & Average Annual Costs, FY 2014	191
Appendix F: Detention Risk Assessment Instrument (DRAI)	192
Appendix G: DJS Housing Classification Assessment/Reassessment for Youth in Detention	196
Appendix H: DJS Housing Classification Assessment/Reassessment for Committed Youth	198
Appendix I: Maryland Comprehensive Assessment & Service Planning (MCASP) Intake Risk Screen	200
Appendix J: Questions from the DJS MCASP Needs Assessment	203
Appendix K: Crimes of Violence	205
Appendix L: Maryland Citations Pertaining to DJS	205
Appendix M: Alternatives to Detention and Shelter Care by Region and County	207
Appendix N: Disproportionate Minority Contact (DMC) Strategies and Contact Information	209
Appendix O: Relative Rate Index (RRI)	210
Appendix P: Census Information by Race, 2013	213
Appendix Q: Number and Ratio of Youth, Cases, and Placements by County, FY 2014	214
Appendix R: Classification of Offenses	215
Appendix S: Commonly Used Acronyms	219

DJS STATISTICAL SUMMARY INFORMATION SHEET (PULLOUT)	221
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Introduction to Committed Programs

The DJS Division of Operations is responsible for selecting the most appropriate out-of-home placement for youth who have been committed to the custody of DJS by the juvenile court. Program placements vary based on the treatment services provided as well as by security level. The full range of DJS placement options include: (a) Foster Care Homes (traditional and treatment foster care); (b) Group Homes (general service, and therapeutic); (c) Independent Living Programs/Alternative Living Units (often used as a step-down from a more restrictive program placement); (d) Residential Treatment Centers (RTCs) and non-Medicaid residential treatment facilities (out-of-state); (e) Intermediate Care Centers for Addictions (ICFAs); (f) Behavioral Programs e.g. DJS-operated Youth Centers (including the Green Ridge Mountain Quest program) and out-of-state programs in a staff secure setting; and (g) Treatment Programs in a hardware secure setting (both DJS-operated and privately contracted out-of-state).

DJS has established three levels of residential program placements based largely on the level of program restrictiveness (see Figure below). Level I includes all programs where youth reside in a community setting and attend community schools. Level II includes programs where educational programming is provided on-grounds and youth movement and freedom is restricted primarily by staff monitoring and supervision. Level III programs provide the highest level of security by augmenting staff supervision with physical attributes of the facility, i.e., locks, bars and fences.

PLACEMENT PROCESS

The DJS placement process is designed to select the most appropriate program and treatment services for committed youth. The process begins with a comprehensive assessment of each youth. A staffing



CAPACITY, ADP, AND SECURITY TYPE FOR STATE-OPERATED COMMITTED FACILITIES, FY 2014

Facility	Rated Capacity	ADP	Security Type
Backbone Mountain YC	48	35.3	Staff
Green Ridge Mountain Quest	10	9.3	Staff
Green Ridge YC	30	25.5	Staff
J. DeWeese Carter Center	14	10.9	Hardware
Meadow Mountain YC	40	37.8	Staff
Savage Mountain YC	36	31.7	Staff
Victor Cullen Center	48	45.3	Hardware
Wm. Donald Schaefer House	19	14.1	Staff
Total	245	209.9*	N/A

*Averages may not add to totals due to rounding.

The utilization rate for State-Operated facilities was 85.7% in FY 2014.

meeting is then held to bring together key staff members responsible for resource and treatment service planning. Principal participants include the youth's case manager, case manager supervisor, and resource coordinator as well as parents and/or guardians who are invited to participate.

At the staffing meeting, all pertinent information collected as part of the assessment is reviewed, including the current offense, delinquency history, social history, MCASP recommended supervision level, MCASP assessment of need, educational records, clinical assessments, and the involvement of any other state agency. The staffing meeting culminates with recommendations for program participation and/or treatment services tailored to the circumstances of each youth. DJS then refers the youth's case to the recommended programs for consideration. Programs may either accept or reject an applicant based on program eligibility criteria and capacity. Upon acceptance, program services are authorized by DJS prior to placement in the program.

DJS contracts with private in-state as well as out-of-state vendors to provide services to committed youth. A Certificate of Placement (COP) database is used to manage the referral and placement of youth with private providers. The database facilitates the placement process, for example, by automatically pulling staffing information from the DJS information system (ASSIST), creating program referral letters, and tracking acceptances and rejections from potential programs.

Multidisciplinary Assessment Staffing Team (MAST): DJS has augmented the placement process for cases at risk of being committed to out-of-home placement by creating a specialized diagnostic team responsible for assessing youth, who are detained and at risk of placement, prior to court disposition. The process has been in place statewide since December 2013. The diagnostic

ASSIST is a live database; therefore, updates made subsequent to this data being run will not be included. Percentages may not add to 100% due to rounding. Data may not be comparable to previous Data Resource Guides due to methodology changes. VOPs are categorized by the original offense.

Residential Treatment Centers (Includes Psychiatric Hospitals & Diagnostic Units/CEUs)

Residential Treatment Centers (RTCs) provide more intensive psychiatric and psychological treatment services. They are required to have psychiatrists, psychologists, and psychiatric nurses on staff to lead treatment. Maryland RTCs are approved for operation through the State Certificate of Need (CON) process and are licensed through the Mental Health Administration. Some RTCs concentrate on specific populations of youth. For example, locked RTCs focus on youth with behavioral problems and/or who are considered to be potentially harmful to self or others. The RTCs are intended to stabilize the youth's emotional condition; to provide services that increase the youth's ability to manage his/her mental illness as a potentially life-long challenge; to help the youth develop social skills for coping with both daily and difficult situations and interpersonal relationships; and to transition the youth to a less restrictive environment or home.

ADMISSIONS AND ADP BY PROGRAM, FY 2014

Residential Treatment Ctr.	County	Adm.	ADP
Behav. Health - Eastern Shore*	Dorchester	15	12.7
Good Shepherd Ctr Female Prg	Balt. Co.	9	7.9
Good Shepherd Ctr Male Prg	Balt. Co.	3	3.7
Jefferson School	Frederick	11	11.0
New Dir. Ches Tr. Ctr-Hickey	Balt. Co.	22	23.2
Potomac Ridge	Mont.	19	13.3
RICA Baltimore RTC	Balt. City	9	8.1
RICA Rockville RTC	Mont.	0	2.0*
Sheppard Pratt Towson MANN	Balt. Co.	19	8.4
Villa Maria	Balt. Co.	4	3.8
Woodbourne	Balt. City	35	30.6
Psychiatric Hospitals¹			
Behav. Health Hosp. Rockville	Mont.	3	0.1
Brook Lane Hospital	Washington	2	0.1
Eastern Shore Acute Unit*	Dorchester	2	0.1
Shep. Pratt Hosp. Ell. City & Towson	Balt. Co.	2	0.1
Spring Grove Hospital Center	Balt. Co.	60	5.6
Springfield Adult Hospital Ctr.	Carroll	4	1.5
Thomas Finan Center	Allegany	1	0.1
Diagnostic Unit/Clinical Evaluation Unit (CEU)¹			
Arrow Child & Fam Ministries	Balt. Co.	34	8.3
Children's Home Diag Shelter	Balt. Co.	4	0.9
RICA Rockville	Mont.	9	1.5
Woodbourne	Balt. City	39	9.3
Total Admissions	All	306	152.3

*Potomac Ridge

¹ Psychiatric Hospitals and Diagnostic Unit/CEUs are included on the RTC table because similar services are provided at these facilities.

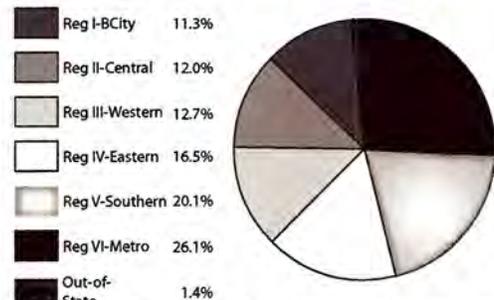
*Although there were no admissions to this program in FY 2014, ADP reflects a balance from prior FYs.



RICA Baltimore

- **Trends for Program Placements:**
 - Between FY 2012 and FY 2014, overall placements to residential treatment centers increased 2.9%.
- **Program Admissions:**
 - In FY 2014, Spring Grove Hospital Center had the highest number of admissions.
- **Region of Residence (FY 2014):**
 - 26.1% were from the Metro Region, 20.1% were from the Southern Region, and 16.5% were from the Eastern Shore Region.
 - Of those from Out-of-State, 2 were from Delaware, 1 was from West Virginia, and 1 was from Pennsylvania.
- **Offense Type (FY 2014):**
 - The most common offense type for juveniles placed in FY 2014 was Second Degree Assault (36.3%).
- **Offense Category (FY 2014):**
 - The two most common offense categories were Misdemeanor Person-to-Person offenses (42.6%) and Misdemeanor Property offenses (28.2%).
 - See the *Terms and Concepts* section for an explanation of felony and misdemeanor as the definitions are helpful when examining offense severity.
- **Average Length of Stay:**
 - The average LOS decreased 6.4% between FY 2012 and FY 2014, and decreased 3.2% between FY 2013 and FY 2014.
- **Average Daily Population:**
 - ADP decreased 8.0% between FY 2012 and FY 2014, and decreased 5.0% between FY 2013 and FY 2014.
- **Completion Status:**
 - 52.8% of releases in FY 2014 were considered successful.
 - 14.6% of FY 2014 releases were considered unsuccessful.
 - 32.6% of releases in FY 2014 were transferred to another program.

PLACEMENTS BY REGION OF RESIDENCE, FY 2014



ASSIST is a live database; therefore, updates made subsequent to this data being run will not be included. Percentages may not add to 100% due to rounding. Data may not be comparable to previous Data Resource Guides due to methodology changes. VOPs are categorized by the original offense.

EXHIBIT 3

Exhibit 9

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Youth Rehabilitation Services



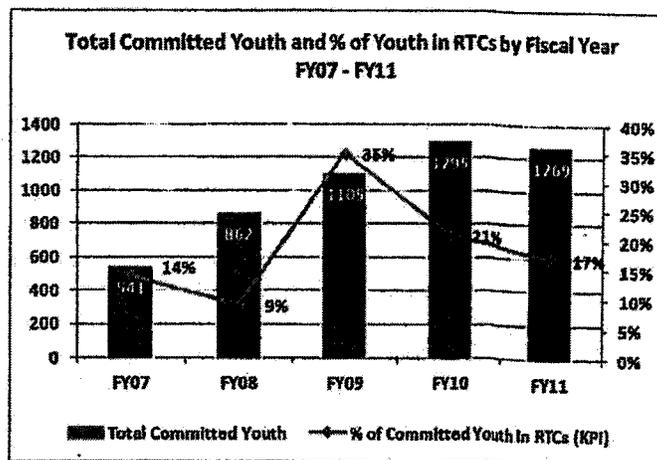
TRENDS IN DYRS RESIDENTIAL TREATMENT CENTER USAGE
In Response to the District of Columbia's Behavioral Health Association's
Sensible Budget Choices: Aligning DYRS Dollars to Youth Treatment Needs

Residential treatment centers (RTCs) and psychiatric residential treatment facilities (PRTFs) play an important role in the continuum of services at the Department of Youth Rehabilitation Services (DYRS). Serving DYRS committed youth with specific mental health, behavioral, or substance abuse needs, RTCs and PRTFs provide specialized treatment programs in a secure, structured environment.

RTC/PRTF POPULATION STATISTICS AND TRENDS

During FY2011, there were a total of 378 DYRS youth placed in RTCs/ PRTFs. Although this number has risen since FY2007, this upward trend primarily reflects the significant growth that has occurred in the overall DYRS committed population during that time. In FY2007, the overall DYRS committed population was 541 youth; by FY2011, this number had increased to 1,269.¹ This overall growth of the committed population helps explain the increase in the number of youth placed in RTCs and PRTFs.

On an average day in FY2011, 17% of DYRS committed youth were residing in an out-of-state RTC/PRTF.² This rate has decreased noticeably and consistently since FY2009, when 35% of the average daily population of committed youth were in an out-of-state RTC/PRTF. Due to this steady decline, the FY2011 levels are basically aligned with the 14% rate from FY2007.



¹ Population figures were obtained using DYRS' case management database and are available in the DYRS FY2011 Annual Performance Report, located at <http://dyrs.dc.gov>. On February 14, 2012, the District of Columbia Behavioral Health Association (DCBHA) released a report entitled *Sensible Choices: Aligning DYRS Dollars to Youth Treatment Needs* (DCBHA Report). In determining the DYRS population levels and the number of youth in RTCs/PRTFs between FY2007-FY2011, the DCBHA Report makes estimates based on prior DYRS Key Performance Indicator (KPI) data which reflects the number of youth newly committed to DYRS, but not the overall number of youth under the agency's supervision. These estimates inadequately reflect the significant growth that occurred in the overall committed population between FY2007 and FY2011.

² The percentage of youth in RTCs/PRTFs is reported in DYRS' KPI data, which is available to the public at <http://capstat.oca.dc.gov/PerformanceIndicators.aspx>. This figure includes only out-of-state placements because the large majority of RTCs/PRTFs are located outside the Washington, DC metropolitan area, and those that are located within the District are different from typical RTCs/PRTFs in that they largely serve youth who are awaiting placement in another secure facility or who are returning home from facilities with higher levels of supervision.

Population by placement type

On any given day during FY2012, nearly half of all committed youth lived in the community, either at home or in a community-based residential facility, a foster home, or an independent living program.

Placement Types by Average Daily Population, Average Length of Stay, and Gender FY2012

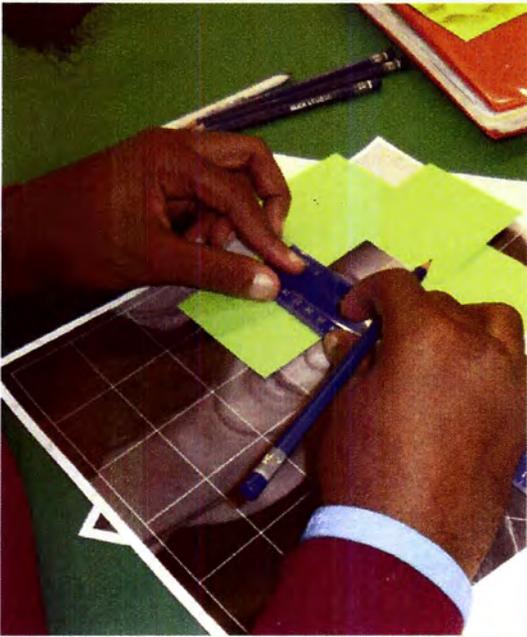
		Average Daily Population	Average Length of Stay (days)	Male	Female
Community-based Placements	Home	256	172	91%	9%
	Community-based residential facility	105	60	95%	5%
	Foster homes	27	179	66%	34%
	Independent living programs	21	144	52%	48%
	Total	409			
Non-Community Placements	Detention center or jail	122	119	97%	3%
	RTC	139	189	81%	19%
	Model Unit at New Beginnings	51	218	100%	0%
	YSC/Awaiting Placement	41	24	179%	21%
	Sub-acute care	4	32	63%	38%
	PRTF	20	141	87%	13%
	Total	377			

In addition to reductions in the overall residential treatment center population, DYRS youth are being placed in facilities closer to home. Between January 2012 and December 2012, there was an overall 51% reduction in the agency's out-of-state residential treatment center population, with the greatest reductions being in the West (67% decline) and Midwest (67% decline).

DYRS Out-of-State RTC Population January 2012-December 2012

Region	January 2012 Population	December 2012 Population	Percent Decline
West	27	9	-67%
Midwest	60	20	-67%
Mid-Atlantic	80	45	-44%
South	20	18	-10%
Nationwide	187	92	-51%

EXHIBIT 4

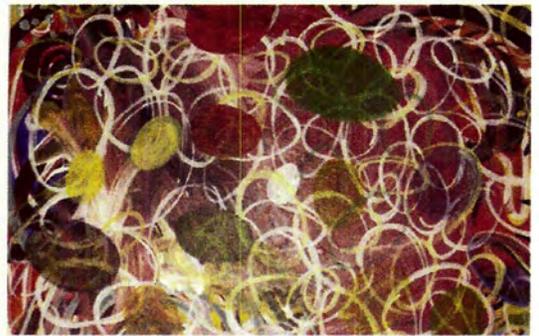
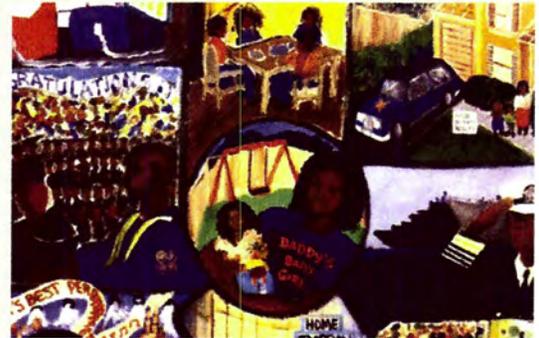


★ DC ★
YOUTH

REHABILITATION
SERVICES

AGENCY
PROGRESS
REPORT

2014



AGENCY PROGRESS REPORT 2014

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DC YOUTH REHABILITATION SERVICES**

Vincent C. Gray, Mayor

BB Otero, Deputy Mayor for Health and Human Services

Paul A. Quander Jr., Deputy Mayor for Public Safety and Justice

Neil A. Stanley, Director

December 2014

Prepared by:
DC Youth Rehabilitation Services
dyrs.dc.gov

*The artwork included in this report are original pieces by DYRS youth.
Credit: D'angelo Martino (cover artwork, upper left and lower left)*

TABLE OF CONTENTS

Letter from the Director	1
Executive Summary	2
Public Safety Gains	2
Navigating Youth Toward Success	2
Fine-Tuning Our Management Strategies.....	3
Our Work Continues.....	3
Section One – Inside DYRS	4
An Overview	4
Positive Youth Justice	6
Programs and Services.....	6
Section Two – Data-Driven Approach	9
Expanded Community Supervision	9
Improved Tracking and Redirecting of Youth	10
Increased Rate of Law-Abiding Youth	10
Navigating Youth Toward Success	11
Our Youth Succeeding in the District of Columbia 2011–2014.....	12
Section Three – Youth Succeeding in Homelike, Community Settings	13
Community Placements	13
Assessment Tools	14
Achievement Center	14
DC YouthLink	15
Partnering with Families.....	16
Community-Based Residential Facilities.....	16
Section Four – Youth Succeeding in Secure Settings	18
Secure Placements	18
New Beginnings	19
Youth Services Center	20
Section Five – Moving Toward Continued Success	21
Improved Use of Data for Placement Decisions	21
Promising Practices.....	22
Team Decision Making.....	22
Responsible Stewardship of Taxpayer Dollars	23
Cultivating an Elite Workforce	23
Our Work Continues.....	24
Glossary	25
Appendix – Positive Youth Justice Outcomes and Measures	27

December 2014

Dear District Resident,

I am pleased to present the DC Youth Rehabilitation Services Progress Report for 2014. I hope you'll find that the agency is committed to promoting public safety through an effective community-based approach to rehabilitation.

DYRS became a cabinet-level agency in 2004. Since then, many changes have occurred. In 2009, we opened the New Beginnings Youth Development Center, a facility based on a positive approach to rehabilitation. This change not only affected our secure facilities, but it also created a cultural shift throughout the agency, promoting Positive Youth Justice.

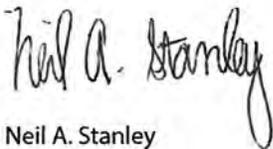
This year we opened the Achievement Center, a centrally located headquarters where youth empower themselves and our communities through programs providing career development, life skills, and healthy living. In addition to receiving these services, our youth meet with their social workers while at the center. This unified approach enables youth and their families to develop into healthy, independent, and capable people who can thrive and enjoy a high quality of life. This is a stark contrast to years past, when our youth needed to travel around the District of Columbia to receive these services, an approach we knew could be improved.

We could not launch these initiatives without tremendous guidance and steadfast support from numerous partners, including, but not limited to, Deputy Mayor for Health and Human Services BB Otero, Deputy Mayor for Public Safety and Justice Paul Quander, and, of course, Mayor Vincent Gray.

I would also like to thank our staff. Their tireless efforts are often unrecognized, but I see their commitment every day and am continually inspired by their dedication to our mission. Without their unparalleled service to our youth and community, none of this would be possible.

We are extremely proud of the work done here. However, we know more can, and will, be achieved. Our foundation is strong and we look forward to building upon it.

Sincerely,



Neil A. Stanley
Director

EXECUTIVE SUMMARY

Helping court-involved youth develop the skills and relationships they need is DYRS's most important long-term strategy for public safety and rehabilitation. We use the Positive Youth Justice (PYJ) framework, an evidence-based model, to help young people transition to a successful adulthood.

The pages that follow describe our core belief that public safety improvements and the expansion of community-based services are directly correlated with one another. Through the innovative DC YouthLink initiative, we prepare youth to succeed in their home communities by building on their strengths and supporting them with targeted, community-based services.

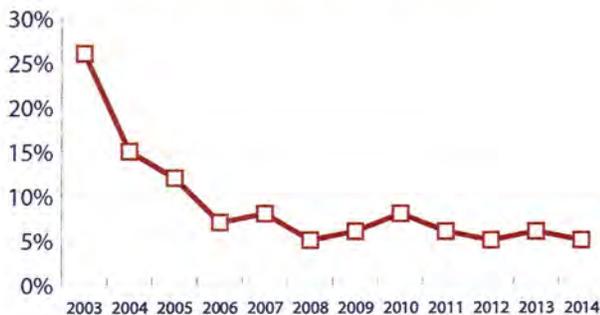
PUBLIC SAFETY GAINS

To reduce the likelihood that youth will re-offend, we combine comprehensive rehabilitative services with careful monitoring. In 2010, only 1% of our youth were monitored in the community electronically; now, almost 60% of DYRS youth in the community maintain GPS electronic monitoring systems on their person.

Improved Tracking and Redirecting of Youth

In 2003, over 25% of our youth required redirecting to authorized DYRS placements. Today, through aggressive strategies using real-time data and the assistance of external stakeholders like the Metropolitan Police Department, this number is at 5%.

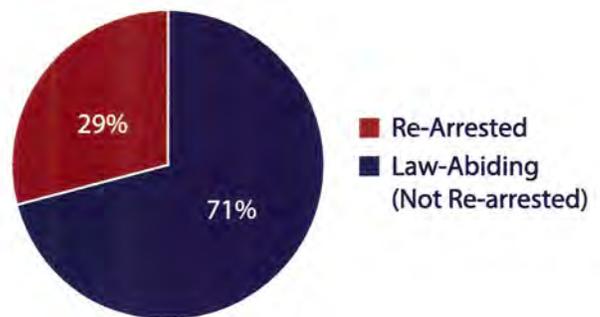
Percentage of DYRS Youth Requiring Redirection: 2003-2014



Increased Rate of Law-Abiding Youth

DYRS is considered the "deep end" of the juvenile justice system. In order to prevent re-arrest, we aggressively leverage technology and utilize key stakeholders to produce impressive results. Less than one-third of youth in our custody are re-arrested under new charges.

Rate of Law-Abiding DYRS Youth: 2011-2014



NAVIGATING YOUTH TOWARD SUCCESS

In 2009, we launched DC YouthLink, a national award-winning initiative that focuses on connecting youth with community support and services where they live. Since DC YouthLink's inception, we have simultaneously improved public safety metrics and positive youth outcomes. More than ever before, DYRS youth are achieving success in education and workforce development. Equally important, we are leveraging the power of the District's nonprofit community to achieve these results.

Outcomes for Youth Committed to DYRS

Number of Youth Achieving Education Milestones					
Milestone	FY 11	FY 12	FY 13	FY 14	Grand Total
Advancement to next school grade*			34	71	105
GED/HS Diploma*	28	48	18	32	126
College Enrollment	6	8	24	22	60
TOTAL	34	56	76	125	291

Number of Workforce Development Milestones Achieved					
Milestone	FY 11	FY 12	FY 13	FY 14	Grand Total
Certificates Earned**	23	117	106	92	338
25 Hours of Community Service Completed			7	31	38
Paid Work	5	51	38	35	129
TOTAL	28	168	151	158	505

*These data are incomplete and primarily reflect outcomes reported by education service providers with DC YouthLink.

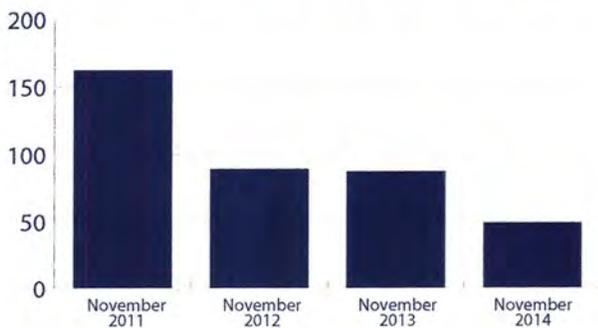
**Examples include food handler's license, A+ technology certification, and Microsoft Office proficiency.

FINE-TUNING OUR MANAGEMENT STRATEGIES

Community Investment

We reallocated savings from expensive out-of-state placements to community intervention programs and services while simultaneously improving all public safety metrics and youth success rates.

Total Youth in Out-of-State Placements



Improved Compliance with DC Superior Court

DYRS has been subject to accountability standards pursuant to a consent decree established in 1986 by the DC Superior Court as part of the Jerry M. case regarding the District's juvenile detention facilities. We have diligently and successfully pursued performance objectives, and the Court has found DYRS in compliance with 15 of these requirements. The District recently filed a motion to vacate the consent decree, and it is foreseeable that DYRS will exit the legislation within the next 18 months.

Enhancing our Staff

DYRS recruits the best and the brightest — all new case managers must be licensed social workers or licensed clinical social workers, and all new Youth Development Representatives in our secure facilities must have a minimum of 60 hours of college credits in a relevant field.

OUR WORK CONTINUES

In the pages that follow, we provide a more detailed look at the agency's operations, programs, and outcomes. We are ready to build on the progress attained to better serve our youth and our community.



SECTION ONE – INSIDE DYRS

AN OVERVIEW

At DC Youth Rehabilitation Services (DYRS), we work every day to improve public safety and give court-involved youth the opportunity to become more productive citizens by building on the strengths of youth and their families in the least restrictive, most homelike environment consistent with public safety.

We believe a comprehensive program based on youth and family needs offers the best chance for youth to learn, grow, and change. Our therapeutic rehabilitation process includes individual and group work, family involvement, individual treatment planning, and experiential learning activities. In addition, youth participate in structured daily and weekly schedules that include educational, career development, recreational, and treatment oriented activities, as well as regular group meetings with a focus on building positive, healthy peer-to-peer relationships and youth-to-adult interactions. Through these activities, we encourage our youth to develop useful coping and decision-making skills, as well as self-awareness insights and behavioral change.

Safe Facilities and Communities

Public safety is a core goal of DYRS. Our initiatives focus on improving the long-term safety of the District of Columbia by enhancing outcomes for youth.

Safety is not just an end for DYRS; it is also the means to achieving our mission. Promoting and maintaining safe environments for all youth is fundamental to our theory of change. As we state in our guiding principles, “a safe environment is the foundation for a flourishing community.”

Employee Spotlight: Carl Matthews, Acting Lead Worker

“I believe that I was put here for a reason greater than just the job. I believe I was put here to make a difference in young people’s lives. It’s more than just a job to me. I’m one of the few people who gets to love coming to their job for 17 years every day.”

DYRS Strategic Plan

Goal 1: Youth Prepared to Succeed

Vision	Youth engage in Positive Youth Development	Our culture demonstrates that youth can change	Communities invest in our youth
Strategic Focus	<ol style="list-style-type: none"> 1. Develop youths' sense of well-being and belonging 2. Offer youth opportunities to achieve a skill 3. Connect youth to people and community 	<ol style="list-style-type: none"> 1. Involve youth in planning and realizing change 2. Empower youth through our activities 	<ol style="list-style-type: none"> 1. Work to ensure that our city has everything needed to serve youth locally 2. Meaningfully partner with families

Goal 2: Safe Facilities, Safe Communities

Vision	The public feels safe	Youth feel safe	Staff are equipped to work safely
Strategic Focus	<ol style="list-style-type: none"> 1. Keep youth on track with their treatment plans 2. Ensure youth are where they are supposed to be 3. Communicate our public safety record clearly 	<ol style="list-style-type: none"> 1. Ensure youth have strong positive relationships 2. Establish and maintain best-in-class facilities 	<ol style="list-style-type: none"> 1. Provide appropriate professional training 2. Deploy our staff appropriately

Goal 3: Efficient and Effective Management

Vision	Our efforts maximize youth outcomes	We are the employer of choice	Our approach is clear and effectively implemented	We establish strategic partnerships
Strategic Focus	<ol style="list-style-type: none"> 1. Align our business processes with best practices 2. Identify creative funding streams 3. Empower staff to manage their budget 	<ol style="list-style-type: none"> 1. Attract and retain the highest quality employees to best serve our youth 2. Define the culture to reflect the mission and vision 3. Strengthen our local image 	<ol style="list-style-type: none"> 1. Enhance training and professional development 2. Effectively leverage technology and communication 3. Apply our policies consistently and fairly 	<ol style="list-style-type: none"> 1. Enhance sister agency and system stakeholder partnerships 2. Enhance partnerships with unions

The DYRS Strategic Plan, developed in FY2013, provides an overview of our overall approach to meeting the agency's mission by listing our overarching goals, vision, and strategic focus areas. The plan provides a window into where we think the agency has the greatest opportunities to leverage our resources to maximize our impact.

POSITIVE YOUTH JUSTICE

We have adopted the Positive Youth Justice (PYJ) framework developed by Dr. Jeffrey A. Butts from the John Jay College of Criminal Justice as the evidence-based model for helping youth successfully transition to adulthood. PYJ is derived from the broader body of research behind Positive Youth Development (PYD). The PYD principles are grounded in the philosophy that youth are assets and resources to the community. With the right programs, opportunities, supports, and services, youth can develop to their full potential.

While PYD is broadly focused on the developmental needs of youth generally, PYJ focuses on the specific needs of youth involved in the juvenile justice system. The PYJ model adapts the traditional 40 developmental assets identified through PYD, honing them into six core developmental domains:

- **Work.** Work experience, apprenticeships, employment readiness, income, and independence.
- **Education.** Literacy, credentials, learning skills, and career planning.
- **Health.** Physical activity, diet and nutrition, behavioral health, lifestyle, and sexuality.
- **Relationships.** Communication skills, conflict resolution, family systems, intimacy, and support.
- **Community.** Civic engagement, community leadership, services, and responsibility.
- **Creativity.** Personal expression, visual arts, performing arts, and language arts.



As part of the agency's performance planning process, we have developed and started implementation of a PYJ Monitoring and Evaluation Plan. The plan links performance measures and outcomes to key activities conducted within the PYJ domains by DYRS staff and community-based service providers. Over time, this plan will allow us to capture relevant and compelling data points that showcase the success of our youth. **Outcomes and measures from the plan are included in the appendix.**

PROGRAMS AND SERVICES

Committed Case Management

Each youth committed to DYRS is assigned to a social worker who works with the youth, their families, teachers, and other individuals involved in the youth's life to develop and implement a Success Plan based on the youth's strengths, risks, and needs. The Success Plan outlines the ongoing supervision, services, supports, and opportunities required to foster the youth's successful transition to adulthood and to reduce the likelihood of re-offending. The social worker gets to know each youth personally and monitors how the youth is doing with his or her plan, guiding the youth to make adjustments as necessary.

Case Planning

Once a judge commits a youth to DYRS, we are responsible for all decisions regarding the youth's placement and rehabilitation plans. This determination involves the following process:

- **Review of Court Recommendations.** When making placement decisions, we give great weight to the court's recommended plans for treatment and supervision.
- **Review of Reports and Assessments.** DYRS staff reviews disposition reports, social studies prepared by Court Social Services, psychological and psychiatric evaluations, psycho-educational evaluations, and discharge summaries from other programs and placements.
- **Mental Health and Substance Abuse Needs Assessments.** Licensed clinicians and behavioral health specialists conduct mental health and substance abuse needs assessments for youth placed at New Beginnings. Youth housed at the Youth Services Center (YSC) awaiting their disposition hearing also have access to our clinicians.
- **Risk Assessments.** We conduct risk assessments using the Structured Decision Making (SDM) tool. The

SDM tool uses factors such as committing offense severity, prior offenses, and peer relationships to assess a youth's risk level, and the results are taken into account when determining the level of supervision that the youth requires.

Programs for Community-Based Youth

Based on their supervision and treatment needs, youth who have been adjudicated and committed to DYRS custody may be placed within a continuum of community-based programs or in a secure facility.

Our primary goal and our legal mandate are to place youth in the least restrictive, most homelike environment consistent with public safety. Community-based placements include the following options:

- **Community-Based Residential Facilities (CBRFs).** We contract with providers to house youth in a structured, homelike residential setting. These “group home” programs are staffed 24 hours a day and typically house 6-8 youth. Although youth reside full-time in the program, they attend local schools, hold outside jobs, participate in family visits, and receive support services within the community. CBRFs provide supervision, counseling services, structured recreational activities, and programs designed to promote positive youth development.
- **Community-Based Shelter Homes.** When appropriate, DC Superior Court judges place detained youth in alternatives to secure detention. Detention alternatives in the District include shelter homes, which are under contract with DYRS to provide supervision and services. Alternatives like shelter homes help ensure that youth arrive on time to their scheduled court appointment and remain crime-free while their court case is being processed.
- **Independent Living Programs.** Youth assigned to independent living programs reside within a structured living program and receive monitoring by a DYRS contract provider. The program provides basic living expenses and youth are required to attend school or maintain full-time employment.
- **Therapeutic Foster Care/Extended Family Homes.** Youth can also reside with a foster family in a private

home where their activity is monitored. When placed in foster care or an extended family home, youth receive individual, group, and family counseling, and attend school or maintain employment within the community.

- **Home Placement.** Youth may be placed at home with a parent or guardian, or with a third-party guardian, such as a foster parent. A DYRS social worker monitors the youth's activities and connects the youth with community-based support services. Youth are required to attend school or have full-time employment.

Programs for Youth Placed in Secure Facilities

Secure placements include the following options:

- **New Beginnings Youth Development Center.** New Beginnings is a 60-bed secure detention facility that provides youth with 24-hour supervision, care, and custody. Services include diagnostic screening, onsite medical and dental care, behavioral health care and counseling, structured recreational activities, workforce and life skills training, family visits, and transition services. The Maya Angelou Academy, a nationally recognized alternative school operated by the See Forever Foundation, operates on-site educational services for youth at New Beginnings.
- **Youth Services Center (YSC).** YSC is an 88-bed secure detention facility that provides youth with 24-hour supervision, care, and custody. Services include diagnostic screenings, onsite medical care, individual and group counseling, education provided by District of Columbia Public Schools (DCPS), structured recreational activities, and family visits.
- **Residential Treatment Centers (RTCs).** RTCs are secure treatment facilities for youth with specific mental health, behavioral, or substance abuse needs. RTCs provide specialized educational and behavioral modification programs in a structured, supervised environment. Typically, RTC placements last from 6 to 12 months. Most RTCs are located outside the Washington metropolitan area.
- **Residential Drug Treatment.** Youth requiring substance abuse detoxification and stabilization receive short-term treatment at the Psychiatric Institute of Washington. Extended residential substance abuse treatment is available through selected DYRS contract providers.

Community-Based Support Services

DYRS youth placed in the community receive comprehensive support services designed to promote positive development and successful integration into the community, including:

- **DC YouthLink.** DYRS and the DC Children and Youth Investment Trust Corporation (CYITC) oversee the award-winning DC YouthLink initiative, operated by two community-based organizations known as the Lead Entities. The Lead Entities work with youth, their families, other service providers, and our staff to connect youth to services and opportunities tailored to each youth's needs. Through a network of providers, youth can receive an array of services, including mentoring, tutoring, medical and mental health care, workforce training and job placement, recreational and cultural activities, leadership development training, and community service opportunities.
- **Workforce Training and Job Placement.** Community partners provide DYRS youth with workforce readiness training, job coaching, and placement assistance. DYRS youth use these services to pursue internships, subsidized and unsubsidized long-term employment, occupational training and certification, and post-secondary education. We also organize career fairs and provide best practice support to our community partners.
- **Educational Support.** Community organizations provide youth with accredited education classes and tutoring, after-school mentoring, educational assessment and placement, GED and SAT prep courses, and other educational support services. DYRS also works with DCPS to provide transition services and academic placement assistance and partners with area colleges and universities to strengthen access to post-secondary opportunities.
- **Mental and Behavioral Health Care.** Based on their needs, youth are linked with clinicians and behavioral health specialists to receive individual counseling, family therapy, and substance abuse counseling.
- **Health and Wellness.** DYRS sees to the physical, social, and behavioral needs of youth committed to the agency. We believe that physical activity, diet and nutrition, mental and behavioral health, and a healthy lifestyle are critical for a successful transition to adulthood. We have medical personnel who are experts in their fields and we link youth to outside services when needed.
- **Family Empowerment.** A young person's long-term chances for success are greatly improved when his or her family is supportive and involved in the treatment process. We treat the family as a partner in the youth's treatment, rehabilitation, and success in the community. Our enrichment activities for families include orientation sessions, participation in Team Decision Making meetings, parent and caregiver retreats, visits and calls, and other valuable opportunities for families to engage with each other and in the treatment process.
- **Electronic Monitoring.** Youth residing in the community may be required to wear an electronic Global Positioning System (GPS) device as part of the agency's electronic monitoring program. Electronic monitoring technology allows the agency to track the location of an individual to monitor compliance with any pre-determined movement or curfews.

Employee Spotlight: Donneatrice Brown, Youth Development Representative

"When I was in high school, I wanted to be a policeman. I became a Special Police Officer and worked in the community. I started working at the DC jail with the adults. I was like, there's got to be something different. I saw an opening for this position and I've been here for 10 years. I thought, maybe I could help them so they won't go into [the] adult system."



SECTION TWO – DATA-DRIVEN SUCCESS

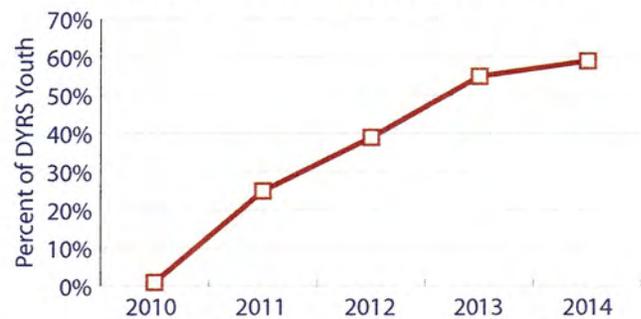
We have made substantial progress over the past four years in improving community safety while enhancing the lives of youth.

EXPANDED COMMUNITY SUPERVISION

We use GPS technology as a key part of monitoring youth placed in the community. This allowed DYRS to fulfill two primary goals: to place the youth in a local, homelike setting and to prioritize public safety.

In 2010, only 1% of youth were monitored in the community electronically; now, almost 60% of DYRS youth in the community maintain GPS electronic monitoring systems on their person.

DYRS GPS Usage: 2010-2014

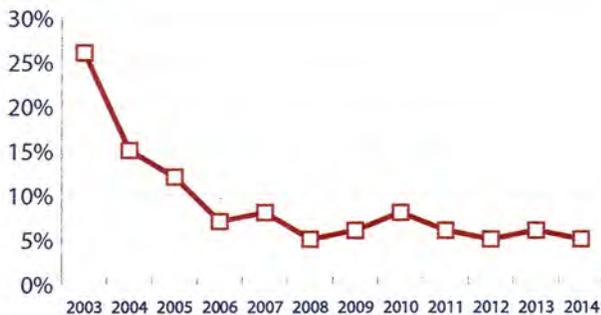


IMPROVED TRACKING AND REDIRECTING OF YOUTH

Correlated to our increased use of GPS technology is a dramatic reduction in the number of youth in need of redirection — that is when a youth veers out of pre-determined acceptable geographic boundaries and we redirect them to where they are supposed to be.

Currently, less than 5% of all committed youth are in need of redirection, a far cry from the rates in 2003, when on an average day 25% of all youth were unable to be located. Our youth engagement specialists work proactively with the DC Metropolitan Police Department and the Court Services and Offender Supervision Agency to ensure that youth remain connected to their services and in their placements. Over the next four years, we are committed to eliminating the need to redirect youth who have deviated from their growth path.

Percentage of DYRS Youth Requiring Redirection: 2003-2014

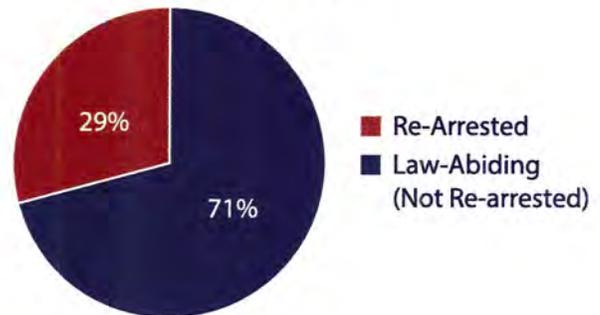


INCREASED RATE OF LAW-ABIDING YOUTH

DYRS is considered the “deep end” of the juvenile justice system, which means we have to move swiftly and aggressively to prevent future criminal offenses. Our methodology is producing impressive results in encouraging youth to remain law abiding. Less than one-third of youth in our custody are re-arrested under new charges.

Not only are youth being re-arrested at relatively low rates, but the seriousness of youth offenses has also declined dramatically.

Rate of Law-Abiding DYRS Youth: 2011-2014

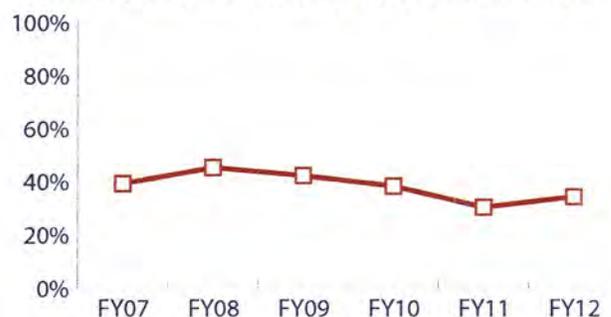


Declines in Offenses: 2011 to 2013



In addition to declines in re-arrest rates, the DYRS recidivism measure (defined as re-conviction within one year of community release) has also decreased, with FY2012 being the third consecutive year of less than 40% recidivism for the agency.

Overall Recidivism Rates Stay Down for DYRS Youth
One-Year Re-conviction Rates for DYRS Youth



NAVIGATING YOUTH TOWARD SUCCESS

Helping a young person transform his or her life requires a team-oriented approach.

In 2009, we made a radical shift by launching DC YouthLink, a national, award-winning initiative that connects youth with community support and services where they live, while ensuring effective supervision. Since the launch of DC YouthLink our public safety metrics have improved, and youth are demonstrating a positive transition into adulthood.

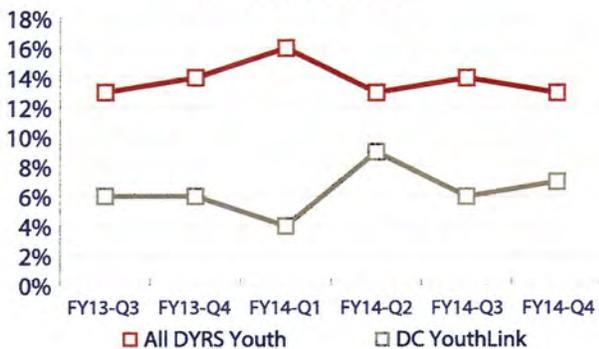
Improvements in Public Safety

Youth enrolled in DC YouthLink are arrested about half as frequently as the overall committed population.

Youth Demonstrate Positive Transitions While Committed to DYRS

With the continued growth of DC YouthLink, DYRS youth are achieving impressive milestones in educational and workforce development — acquiring the necessary skills to transition into adulthood as positive members of society.

Re-Arrest Comparison
All DYRS Youth vs. DC YouthLink Youth



Outcomes for Youth Committed to DYRS

Number of Youth Achieving Education Milestones

Milestone	FY 11	FY 12	FY 13	FY 14	Grand Total
Advancement to next school grade*			34	71	105
GED/HS Diploma*	28	48	18	32	126
College Enrollment	6	8	24	22	60
TOTAL	34	56	76	125	291

Number of Workforce Development Milestones Achieved

Milestone	FY 11	FY 12	FY 13	FY 14	Grand Total
Certificates Earned**	23	117	106	92	338
25 Hours of Community Service Completed			7	31	38
Paid Work	5	51	38	35	129
TOTAL	28	168	151	158	505

*These data are incomplete and primarily reflect outcomes reported by education service providers with DC YouthLink.

**Examples include food handler's license, A+ technology certification, and Microsoft Office proficiency.

Our Youth Succeeding in the District of Columbia: FY2011-FY2014

Youth Succeeding at Work

1125

DYRS youth linked to job programs

473

DYRS youth with job experiences

141

DYRS youth with paid work experiences

Youth Succeeding at Education

739

DYRS youth linked to education programs

116

DYRS youth who earned HS diplomas/ GEDs

34

DYRS youth enrolled in colleges/ universities

Youth Succeeding in Health

656

DYRS youth linked to community-based health services

296

DYRS youth linked to substance abuse treatment services

92%

Youth receiving a complete medical screening upon entry to DYRS secure facilities

Youth Succeeding in Relationships

988

DYRS youth linked to relationship programs

277

DYRS youth working to improve family engagement

875

DYRS youth working directly with a mentor

Youth Succeeding in Creativity

228

DYRS youth linked to community-based creativity programs

59

DYRS youth participating in artistic services at the Achievement Center

12

DYRS vendors providing artistic services at the Achievement Center

Youth Succeeding in Community Engagement

277

DYRS youth linked to community service programs

4300

Hours of community service DYRS youth have participated in

Examples:

- Volunteering
- Serving the homeless
- Voter registration



SECTION THREE – YOUTH SUCCEEDING IN HOMELIKE, COMMUNITY SETTINGS

A core DYRS goal is to place youth in the least restrictive, most homelike environment possible, so long as public safety is not compromised. Most of our committed youth are able to receive treatments/services and demonstrate success in community settings.

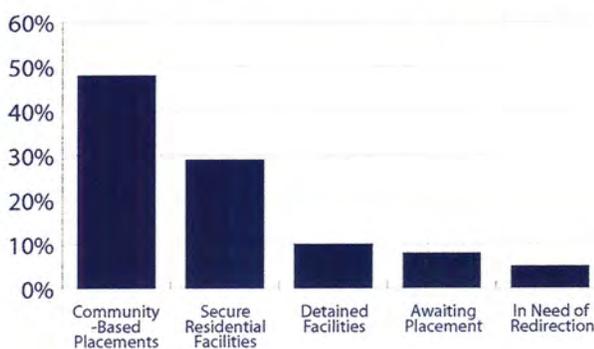
COMMUNITY PLACEMENTS

Community-based placements include residential homes, foster homes, or in some cases a youth's own family home. On an average day in FY2014, roughly one-half of all committed youth resided in community-based placements.

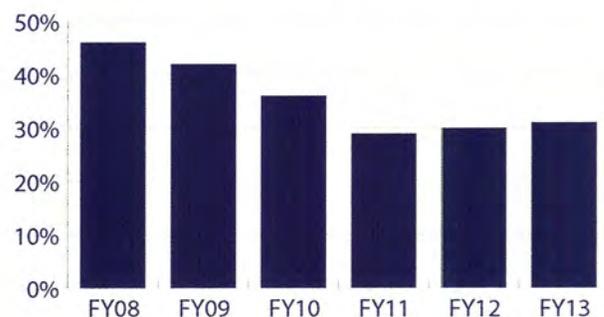
We are able to continue the trend of connecting youth to their home communities and local services because of consistently improving public safety outcomes.

For those youth deemed capable of immediate re-entry into a community setting at the point of commitment, recidivism rates have consistently improved over the past six years. The figure below shows a 33% drop in one-year recidivism rates from 2008 to 2013.

Average Placement Distribution: FY2014



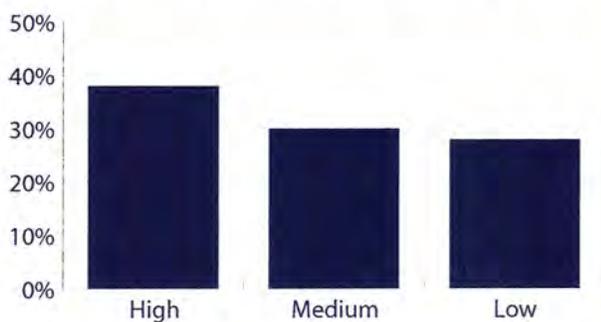
One-Year Recidivism Rates for Youth with an Initial Community Placement



ASSESSMENT TOOLS

We began using the Structured Decision Making tool with all committed youth in 2009. By performing accurate assessments throughout the youth's commitment with DYRS, we are able to make informed placement decisions that benefit both the individual youth and the community at large, such as providing high-risk youth with more intense supervision.

Recidivism Rates by Structured Decision Making Risk Classification: 2011-2013



In general, youth placed in community-based homes are unlikely to be discharged from their placement due to a new arrest. Less than 10% of youth released from a foster care placement, group home, or independent living facility were re-arrested in FY2014.

ACHIEVEMENT CENTER

DYRS opened the Achievement Center in August 2014 committed to the concept of holistic development and the belief that court-involved youth will not return into the system when provided with resources that prime them for success. Since its opening, the Center has worked with 125 youth and 39 specific service providers. We plan to open another Center in Southeast DC in 2015.

The mission of the Center is to inspire court-involved youth to empower themselves and their communities through Positive Youth Justice (PYJ) programs that foster career development, life skills, and healthy living. This unified approach enables families and their youth to develop into healthy, independent, and capable people who can thrive and enjoy a high quality of life.

Recent Successes and Activities at the Achievement Center

- Developed a partnership with DDOE in Rain Water Gardens. Youth will gain employment skills and a chance to give back to the community.
- Hosted a networking breakfast to form partnerships with local businesses for youth employment opportunities.
- Launched a workforce development orientation and job search program.
- Hosted the first "African American Male Summit: Why am I unemployed?" This powerful event brought in 24 young men who came to learn more about reaching their employment goals and how to connect with companies within their community.
- Connected youth in the customer service and interview technique class with an opportunity to work for a day on Capitol Hill, where they met with senators and representatives to talk about careers in federal government.

Activities at the Achievement Center

The Center offers DYRS youth a robust selection of classes six days a week. Youth may receive certifications in areas such as culinary arts, food safety and handling, bicycle repair, dog training, and photography, as well as academic assistance that includes GED classes and other skills-based programming.

The Center also offers programming 25 hours per week during the school year and over 60 hours per week during vacation breaks. Saturday scheduling allows opportunities for all members of the family to engage in Achievement Center services.

The Center is located in a LEED-certified building that also features:

- A state-of-the-art culinary center that teaches youth proper food handling and cooking skills.
- A fully equipped music room that allows youth to create and produce their own music.
- A flexible and newly renovated space for youth to engage with staff and one another, take workforce development classes, and learn about small business development, among other activities.

- Accommodating hours that offer youth a productive and safe environment during times when youth are most vulnerable to inappropriate activity.

DC YOUTHLINK

DC YouthLink is an active partnership between DYRS, the National Center for Children and Families, and the Progressive Life Center. Our partners, known as Lead Entities, enroll our youth in programming with a network of local service providers. The East of the River Clergy-Police Community Partnership (ERCPCP) previously served as a Lead Entity. ERCPCP continues to provide valuable community-based services through a partnership with the Achievement Center.

Our service providers are selected through a formal process and their work is incentivized based on the achievement of youth milestones, including high school graduation or earning employment. We work with the Lead Entities to:

- Advance the rehabilitation of DYRS youth by helping them succeed in a community setting.
- Enhance public safety by promoting structured activities and enhanced supervision.
- Invest in and build upon the strengths of community-based organizations to create safe, strong environments for our youth.

We emphasize active, ongoing engagement with locally based providers who are able to help our youth achieve milestones across the youth development domains. Initial data shows certain providers combining comprehensive services in the areas of health, workforce development, and other domains with low re-arrest rates.

Success

Since its inception, DC YouthLink has grown to serve approximately half of the DYRS population. DYRS youth enrolled in DC YouthLink are less likely to be re-arrested, less likely to abscond, more likely to contribute to the public safety and overall strength of the District, and more likely to be engaged in structured, positive activities.

As of the end of FY2014, DC YouthLink successes include:

- More than 530 youth participated in subsidized employment programs.

- Less than 10% of youth who were enrolled with a Lead Entity were re-arrested.
- More youth than ever before have transitioned from our care to independence, allowing the agency to reallocate resources to ensure optimal outcomes for youth, families, and communities.

“DC YouthLink operates a concerted effort among local youth agencies to improve the likelihood of successful reintegration and enhance opportunities for at-risk and formerly incarcerated youths. Drawing from effective juvenile justice reform models, including Wayne County in Michigan and RECLAIM Ohio, DCYL helps to connect youth and their families with a range of educational, vocational, and rehabilitative supports that they can access in their own communities. These programs and services increase the likelihood of youth reform and also enhance community safety, while costing far less than secure and residential facilities.”

Douglas Evans, John Jay College of Criminal Justice

Author of [Pioneers of Juvenile Justice Reform: Achieving System Change Using Resolution, Reinvestment, and Realignment Strategies](#)

Measuring Performance

In order to measure the success of DC YouthLink, DYRS and the DC Children and Youth Investment Trust Corporation (CYITC) developed a system of oversight that includes regular reporting on youth engagement, site visits and case file monitoring, and financial reviews. This system allows DYRS and CYITC to track the public safety outcomes of DC YouthLink and the success of DYRS youth overall.

Expanding DC YouthLink

We have recruited an expanded group of providers for 2015, with an emphasis on community and secure facility-based engagement. Additionally, we are expanding the DYRS continuum of care by introducing community-based service providers to youth in secure facilities. This effort will help grow dynamic programming, as well as provide more

opportunities to build relationships between DYRS youth and service providers, which increases the likelihood for active programmatic engagement as youth transition back to the community.

PARTNERING WITH FAMILIES

Parents, caregivers, and other family members are critical to supporting a youth's positive development. They are also valuable resources for each other. We invest in various forms of peer support and leadership development for families of DYRS youth. The DYRS approach uses family-centered best practices from juvenile justice systems across the country.

For example, we recently partnered with the DC Department of Behavioral Health, family advocates, and other agencies to strengthen peer support for families. In FY2014, DYRS families participated as faculty members and trainees in the District's first cohort of Certified Family Peer Specialists.

Other family-centered practices include:

- Comprehensive **staff training** in family engagement.
- A dedicated staff member who serves as **family engagement coordinator**.
- Family **support groups**.
- A **Family Bill of Rights** that represents our commitment to partnering with families.
- Active **involvement of families in key decisions** regarding their youth.
- Classes, activities, and other **programming** open to families through the Achievement Center and DC YouthLink.
- A **shuttle service** for families to visit youth at New Beginnings and active encouragement of youth to call their families regularly.
- **Leadership development** for families, including opportunities to serve on panels in support of community-based juvenile justice practices.
- A **Youth, Family, and Staff Circle** that involves families in identifying and pursuing agency improvements.

COMMUNITY-BASED RESIDENTIAL FACILITIES

Recently, we implemented a plan to efficiently and effectively assess our Community-Based Residential Facilities (CBRFs), including all aspects of their human care agreements, which guide their partnerships with us. As part of this work, we launched our first CBRF performance report. This report provides a framework of specific performance targets focused on maximizing positive youth outcomes.

We work closely with our CBRF providers to identify appropriate training opportunities to include effective management, unusual incident reporting, positive youth development, reducing recidivism, and effective programming. Additionally, we work with our providers to help them attain accreditation from the Council on Accreditation.

Parent Profile: Jennifer F.

Jennifer is a standout among family members of DYRS youth. A mother of two youth who have been committed to DYRS, Jennifer exemplifies the strength and resilience that our families possess.

Jennifer wants her children to do better. When her sons were committed, she decided to make some changes in her own life to help her entire family. She embraced wellness and recovery and sought out a workforce development provider that helped her find a rewarding job. She also joined our family panel, which helps train DYRS staff in family engagement.

Jennifer found encouragement and a bond with other families as she participated in our support group. As she shared her experiences, she realized the value of peer support. Jennifer applied and was accepted into our inaugural class of Family Peer Support Specialist trainees. After completing the training process, Jennifer was hired to use her skills at the Department of Behavioral Health and at a DC YouthLink service agency. In her new role, she assists families of DYRS youth every day and encourages other parents and caregivers to become Family Peer Specialists.

TOOLS FOR POSITIVE YOUTH JUSTICE

At DYRS, we focus on providing our youth with a strong continuum of care that emphasizes achievement and leadership development. Our work revolves around community-based solutions grounded in the domains of Positive Youth Justice (PYJ).

Workforce Development

DYRS supports and emphasizes programming that assists our youth in the development of job readiness skills. For example, DC YouthLink provider Life Deeds Inc. has demonstrated a growing ability to successfully link transitioned youth to long-term and secured employment opportunities after completion of a residential treatment program.

Education

We recognize that many youth placed in our care experience numerous and often complex challenges that impact their ability to attend and remain in school. Our youth are enrolled in educational services soon after entering our facilities and attend educational programming 5 days per week. Our staff also works to enroll youth who have been suspended or expelled in alternative schools or GED programs.

Health

The DYRS health and wellness program promotes physical, social, behavioral, and mental health for youth and employees by placing emphasis on nutrition, healthy eating, physical fitness, recreation, and stress management. We operate from the belief that healthy habits and attitudes enable our youth to do better in school and in training programs, leading to positive outcomes and lower recidivism rates.

Relationships

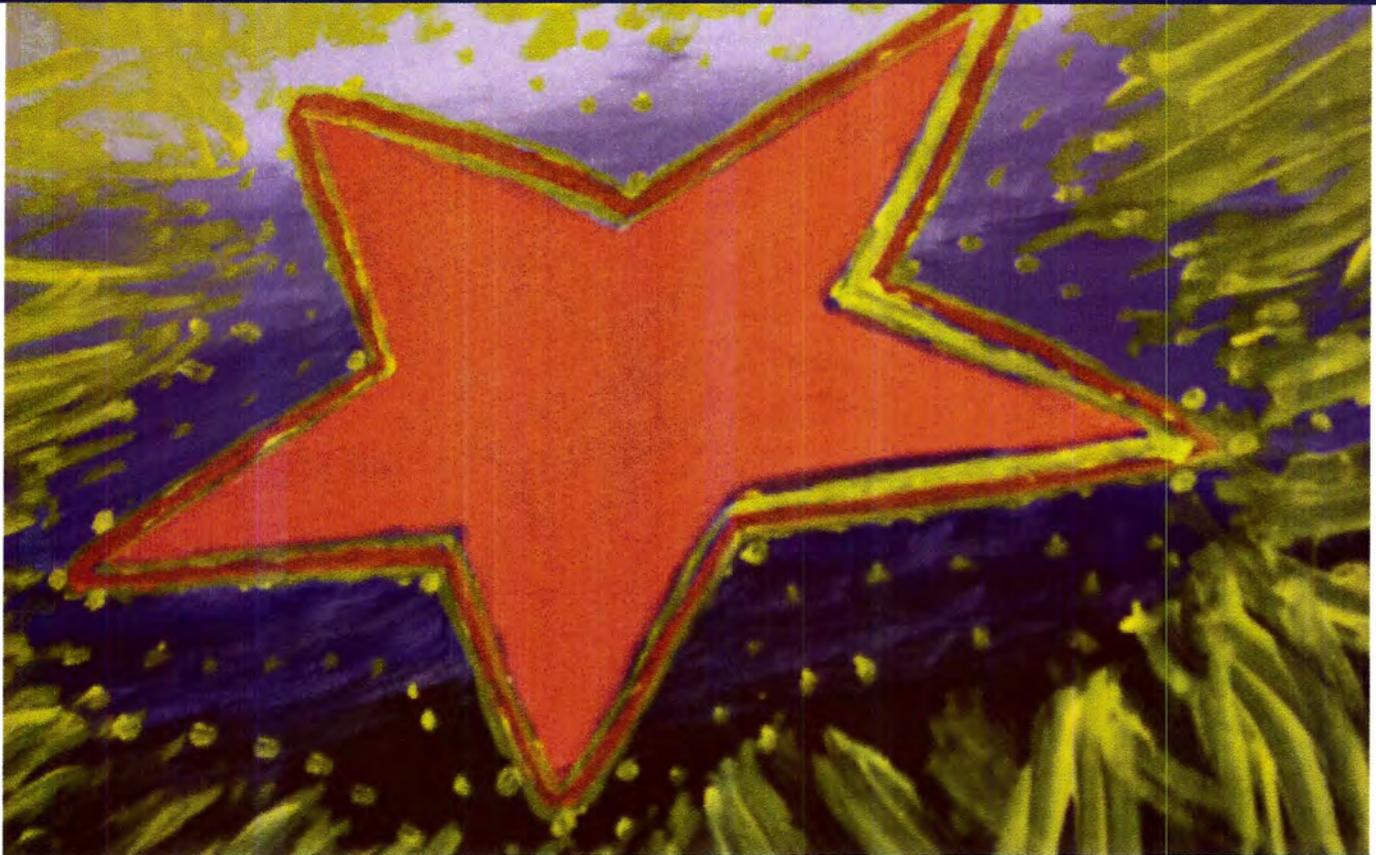
Positive relationships give youth opportunities to learn and experience new things, develop positive relationships and a sense of belonging, and ultimately aid in the development and rehabilitation process. We make it a priority to provide youth access to a caring and consistent adult role model in their lives through mentoring services and by encouraging active involvement with family and friends who positively influence their lives.

Community Engagement

Our community engagement programming emphasizes the development of core leadership skills among our youth. Our providers work to not only engage youth but also challenge their actions to help generate positive social change. Our programs provide structured activities that contribute, teach, and allow learning from each other to drive home the importance of positive community engagement.

Creativity

Positive culture and creative outlets play an essential role in promoting sustainable social and economic development for our youth. Our community programs and secure placements offer dynamic, creative programming in the arts, music, and creative writing, among other areas. With the opening of the Achievement Center in August 2014, we are providing positive creative and cultural interactions for our youth every day.



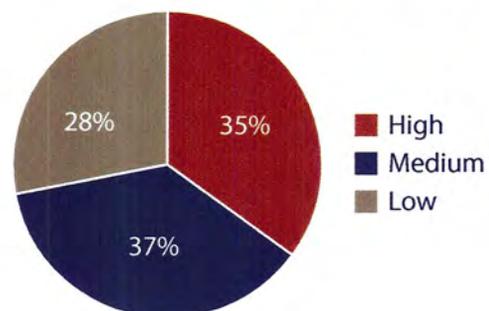
SECTION FOUR – YOUTH SUCCEEDING IN SECURE SETTINGS

Some DYRS youth require more intensive treatments in secure environments before they can transition to a less restrictive community setting. However, even in secure settings, we are committed to preserving human dignity and creating facilities that encourage vibrancy, learning, and development. We operate two secure environments: New Beginnings and the Youth Services Center.

SECURE PLACEMENTS

We use the Structured Decision Making (SDM) tool to assess DYRS youths' public safety risk. On average, the SDM classifies approximately two-thirds of DYRS youth as low or medium risk to the community; the remaining one-third are identified as high risk.

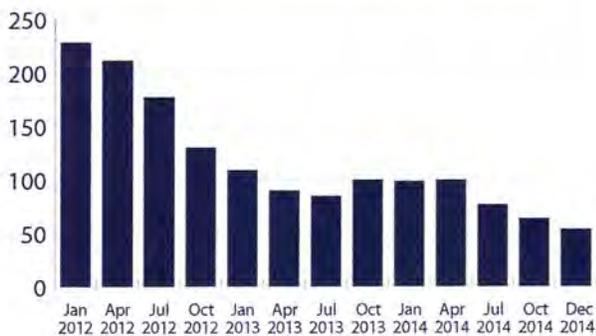
Structured Decision Making Risk Classifications: 2011-2014



Our primary goal is to improve public safety, so youth determined “high risk” start their treatment at an intensive, secure placement, which can provide them with the necessary supports to address underlying issues and improve overall behavior. The agency emphasizes using the initial secure placement as a stepping-stone to community re-engagement and placements in less-restrictive environments.

We emphasize placements closer to home. This comes after a period in our agency’s history during which we had no alternative but to place high-risk youth in secure treatment facilities out-of-state through contractual relationships with vendors. In early December 2014, fewer than 60 committed youth were placed at out-of-state treatment facilities, enabling more youth to re-engage with their local communities and take advantage of growth in local service options.

DYRS Youth in Out-of-State Residential Treatment Facilities: 2012-Present

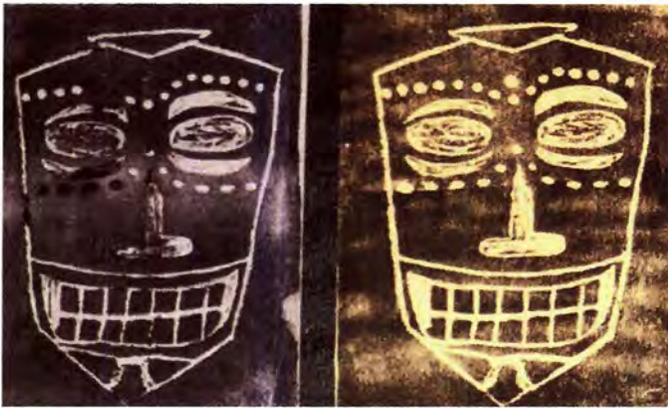


NEW BEGINNINGS

Youth at the 60-bed New Beginnings Youth Development Center spend the better part of a year receiving behavior modification treatment and positive youth development services before they are transitioned to less restrictive, community settings. New Beginnings provides highly structured schedules that focus on developing positive relationships, successful coping and decision-making skills, self-awareness, and behavioral change.

New Beginnings offers DYRS youth needed benefits across the PYJ domains:

- **Work.** Youth participate in vocational education programs and work readiness classes. Our vendors help prepare and connect youth to career/employment opportunities in their communities when released. In FY2014, 24 youth participated in a work readiness training session and four youth received work certificates while enrolled at New Beginnings.
- **Health.** Our youth receive a full range of behavioral, medical, and mental health services when placed at our RTCs. In total, over 20,000 hours of therapy and counseling were provided to New Beginnings residents in FY2014. Additionally, New Beginnings residents received over 10,000 hours of physical education and activity in FY2014.
- **Relationships.** Families are more involved in the treatment process. Rather than asking parents to travel to far-away facilities to visit their children, they are more easily able to visit their children regularly, observe the care received, and even participate in some services to help our youth get the treatment they need before returning home.
- **Education.** At the Maya Angelou Academy, youth receive DCPS-eligible credits for attending school daily while receiving treatment at New Beginnings.
- **Creativity.** New Beginnings has several programs aimed at encouraging youth to share their ideas and experiences in a safe environment and directing youth creativity toward positive, productive outlets. Examples include The Beat Within program (a national program encouraging literacy, self-expression, critical thinking, and healthy, supportive relationships with adults), the Theatre Lab Group, and the Annual Speech Competition.



Maya Angelou Academy

In FY2014, five youth received GEDs while attending the Maya Angelou Academy at New Beginnings. Additionally, three youth earned their high school diplomas, and one enrolled in a four-year university.

The picture displays two drawings from a young man at New Beginnings.

YOUTH SERVICES CENTER

We also operate the Youth Services Center (YSC), an 88-bed, 24-hour secured juvenile detention center. YSC serves youth, both female and male, who have been remanded to the custody of Court Social Services and are awaiting dispositions regarding their court hearings and/or future placements.

Programs and Services

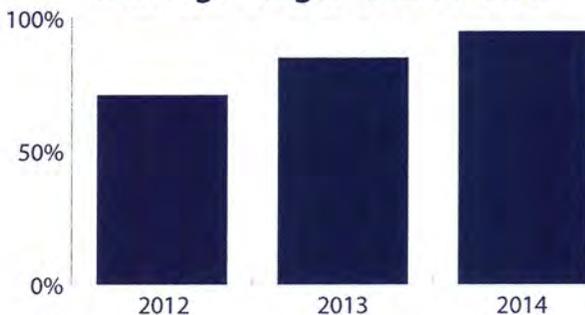
YSC staff provides various enrichment programs and services to meet basic and wellness needs of each youth. Programs and services include behavioral health assessment and placement services, onsite medical care, trauma-based care, individual and group counseling, workforce and vocational training, educational services, structured recreational activities, and family visits and engagement programs.

Each youth typically participates in daily educational programming provided by DC Public Schools. YSC residents participated in 50,000 hours of educational development in FY2014. Arts, music, and creative writing are staples of the YSC curriculum, giving YSC residents a constant variety of creative outlets. YSC residents participated in 8,000 hours of creative activities in FY2014.

YSC residents also participate in community engagement activities by working with volunteers who provide valuable services at the YSC facility. In FY2014, YSC provided almost 2,000 hours of programming with local volunteers, with 230 youth benefitting from these programs.

All YSC residents receive a complete physical upon admission. In FY2014, youth participated in over 15,000 hours of physical activity, while also receiving consistently healthy meals from the facility cafeteria. Additionally, in FY2014, 83% of residents received an initial mental/behavioral health screening within four hours of admission. With a variety of counseling programs in place, residents participated in over 12,000 hours of mental and behavioral health services, including counseling, team building, and group therapy exercises.

Percent of Youth with Positive Connections Upon Release from New Beginnings: 2012-Present



Nurturing Relationships at New Beginnings

95% of all youth who completed programming at New Beginnings were connected with school, work, and a positive adult within six months of their release into the community. This is the third consecutive year DYRS has improved in this metric.



SECTION FIVE – MOVING TOWARD CONTINUED SUCCESS

We embrace a vision of excellence and continued improvement. By implementing promising practices, ensuring the responsible stewardship of taxpayer dollars, cultivating an elite workforce, and taking a data-driven approach to decision making, we guide our youth through a continuum of care that emphasizes the positive contributions they can make to their communities.

IMPROVED USE OF DATA FOR PLACEMENT DECISIONS

In 2011, DYRS joined with the National Council for Crime and Delinquency and other national experts to recalibrate a key placement decision instrument called Structured Decision Making (SDM). This objective tool helps us decide which youth can safely remain at home and which need the intensive supervision provided by group homes and residential treatment centers like New Beginnings.

[DYRS] has developed and implemented a structured decision making (SDM) system that assists staff in identifying the appropriate level of restrictiveness for committed youth. In the SDM system, an evidence-based instrument classifies each committed juvenile into one of three risk levels based on the relative likelihood that he or she will commit a new offense. The risk assessment currently used by DYRS successfully classifies committed youth into three groups according to their likelihood of recidivating, thus showing the current risk assessment to be a valid tool for predicting recidivism.

The National Council on Crime and Delinquency, 2014

We have also joined with other DC government agencies, including the Department of Behavioral Health (DBH) and the Child and Family Services Agency (CFSA) to use the Child and Adolescent Functional Assessment Scale (CAFAS) with all committed youth during their period of DYRS engagement. The CAFAS assesses how a youth functions day-to-day in critical life subscales while tracking changes over time.

The SDM and CAFAS help us understand the public safety and developmental needs of our youth and identify the necessary supports to rehabilitate youth.

PROMISING PRACTICES

Our Reinvestment Strategy

By avoiding costly out-of-state placements when possible, DYRS is reinvesting in community-based programs and practices proven to reduce recidivism. We aim to invest resources in strategies that can improve public safety outcomes and maximize return on investment. In alignment with this strategy, we have reduced our use of RTCs. The savings have enabled DYRS to sustain successful initiatives such as workforce development programs that were previously funded by federal grants.

Collaboration with District Government Partners

Our partnerships with public agencies and non-profit organizations are key to our success. We work closely with the Metropolitan Police Department, Court Social Services, the Court Services and Offender Supervision Agency, and the Pretrial Services Agency to ensure access to community-wide intelligence we rely on to keep youth on course. Partners alert us of hot spots and neighborhood disputes, as well as identify youth who drift out of bounds, among other information sharing activities.

Helping a young person transform his or her life requires a team-oriented approach. Our collaboration with DBH, CFSA, DCPS, and the Office of the State Superintendent of Education are equally important. We also work closely with the Raise DC cradle-to-career initiative to pursue common goals with measurable outcomes in areas such as education advancement, work readiness, and employment.

Community Reinvestment with DC YouthLink

With the inception of DC YouthLink, we have grown the number and types of services available to our youth. Increasingly, youth are remaining involved in those services and staying out of trouble. Recidivism is dropping as we work to keep more youth closer to home and enrolled in quality, comprehensive community-based services. This is not only a public safety gain, but also a cost-efficiency, allowing us to reinvest public dollars locally.

TEAM DECISION MAKING

In a Team Decision Making (TDM) meeting, a youth's parents, extended family and other supportive people in the youth's life, foster parents (if the child is in placement), service providers, other community representatives, and the caseworker come together to create a Success Plan. Every youth committed to DYRS embarks on a Success Plan, which is updated every 90 days through the TDM process.

The TDM meeting is collaborative. Participants share all information relating to the youth, including but not limited to issues related to safety, functioning of the family, strengths, challenges, placement, goals, and mental health treatment. Strengths, challenges, and needs are identified based on the youth's most recent CAFAS, which allows the team to make clinical and evidence-based decisions.

Clinical Case Management

Over the past several years, DYRS transformed its case management team by shifting from non-licensed case managers to licensed social workers. This shift has allowed the agency to empower our case management teams with a high level of responsibility, as well as leverage the specific knowledge base of well-trained social workers. Our social workers have enhanced the variety and complexity of services provided to court-involved youth in essential areas like prevention, treatment, and after-care services.

RESPONSIBLE STEWARDSHIP OF TAXPAYER DOLLARS

Agency Performance Planning

Every fiscal year, the agency creates a performance plan to identify goals and measure outcomes related to those goals. This process is integral toward helping the agency achieve objectives in the DYRS Strategic Plan.

Goals are developed with an eye toward accomplishing something new, better, or different for the next fiscal year. We update the agency's performance plan every quarter and review our goals and performance at the end of the fiscal year. Information gathered at the end of the year helps us prepare a performance accountability report, which informs performance planning for the next year.

National Recognition

In 2013, DC YouthLink won recognition from the National Criminal Justice Association as an Outstanding Criminal Justice Program.

DYRS was recognized as one of the Top 50 Programs for *Harvard's Innovations in American Government* award.

Intensive Program Monitoring

DYRS has an aggressive plan focused on program compliance. We review case management practices to ensure all relevant information concerning our youth is captured, including timely assessments, goal setting meetings each quarter, and progress related to youth Success Plans. Our compliance specialists review case files, confer with social workers, and alert managers when they identify opportunities for improvement.

Our compliance specialists also oversee the licensing of Community-Based Residential Facilities (or group homes) for safety, security, and other requirements. This process helps ensure that youth receive adequate services to meet the goals in their Success Plans.

CULTIVATING AN ELITE WORKFORCE

Our staff promotes the mission of the agency on a daily basis by focusing on enhancing public safety and increasing positive outcomes through the effective rehabilitation of our youth. Together, we focus on positive and measurable results consistent with the efficient management of agency resources.

Managing for Success

As part of our vision for continuous learning, we have implemented "Managing for Success" meetings, which draw on agency data and performance standards as the underpinning for regular conversations focused on improving our service delivery.



The program emphasizes five core values:

- Data-driven decision-making.
- Competitive problem solving.
- Thoughtful experimentation.
- Continuous improvement.
- Relentless follow-up.

Professional Development

Our professional development team provides various services to refine staff talent, support innovative training, and assist in the professional development of the agency's staff, including:

- Pre-service certification for new DYRS employees.
- Continuing education for existing employees.
- Curriculum development.
- Procurement of vendor-supplied training.
- Consultative services for departments and divisions within DYRS.

In 2011, we partnered with the George Washington University's Center for Excellence in Public Leadership to develop a leadership academy for our managerial and supervisory staff. The program spanned six months and offered various learning activities to aid employees in developing their leadership competencies. We are replicating the program for 2015 and expanding its scope to include a live application project, peer learning circles, project team coaching, and individual leadership coaching.

OUR WORK CONTINUES

When DYRS was launched in 2004, city officials charged the agency with leading the reform of the District's juvenile justice system and serving as a nationwide model for excellence. DYRS takes this directive seriously. We apply research to practice, studying the latest proven developments and incorporating them into our work.

Over the past four years, we have made great strides in our efforts to becoming a nationwide leader. We see the potential of the District's youth and more importantly, they see it for themselves. DYRS continues to improve and grow every year. We are committed to studying what works, improving our practices, and helping youth and families build successful futures for themselves and our communities.

GLOSSARY

CAFAS: Child and Adolescent Functional Assessment Scale. An assessment that tracks how youth are doing in all areas of life. These include school/work, home, community, behavior toward others, moods/emotions, self-harmful behavior, substance use, and thinking problems. Each youth has a CAFAS every 90 days to help with planning at their Team Decision Making (TDM) meeting.

CFAA: Child and Family Services Agency.

CBRF: Community-Based Residential Facility, often called a "group home."

CPA: Community Placement Agreement. The rules that youth must obey while in the community. These may include curfews, school attendance, drug screening, etc.

CSOSA: Court Services and Offender Supervision Agency.

CSS: Court Social Services. Part of the DC Superior Court Family Court, Court Social Services is the District's juvenile probation agency.

CYITC: DC Children and Youth Investment Trust Corporation. A local non-profit organization that works with DYRS to lead the DC YouthLink initiative.

DBH: Department of Behavioral Health (formerly known as Department of Mental Health).

DCPS: District of Columbia Public Schools.

DC YouthLink: A group of community-based organizations that provide services and supports to DYRS youth. It is headed by two Lead Entities: Progressive Life Center and the National Center for Children and Families.

DOC: Department of Corrections.

DYRS: DC Youth Rehabilitation Services.

ERCPCP: East of the River Clergy-Police Community Partnership. Community-based organization that provides services at the Achievement Center.

GED: General Educational Development. A test that certifies that someone has academic skills equal to a high school graduate.

GPS: Global Positioning System device. A device that tracks the wearer's location. Also known as an ankle bracelet.

JJIC: Juvenile Justice Institutional Counselor. A type of case manager who works at New Beginnings.

MAA: Maya Angelou Academy at New Beginnings.

MRT: Moral Reconciliation Therapy. A program to address substance abuse and other issues. It is offered at New Beginnings.

NCCF: National Center for Children and Families. A DC YouthLink Lead Entity that provides services primarily for DYRS youth in wards 7 and 8.

NBYDC: New Beginnings Youth Development Center. A 60-bed secure residential treatment facility in Laurel, MD for young men involved with the most serious and chronic offenses.

OE: Office of Education. Department in DYRS that helps youth achieve their educational goals (e.g., GED, High School diploma, trade school, college).

OSSE: Office of the State Superintendent of Education.

OWD: Office of Workforce Development. Department in DYRS that helps youth get employment and job skill certifications.

PINS: Person in Need of Supervision. A youth who is in need of care or rehabilitation and regularly missing school without reason, has committed an offense committable only by children, or regularly disobeys their parent, guardian, or other custodian and is out of control.

PDS: Public Defender Service. A federally funded, independent legal organization that provides attorneys for clients who cannot afford a private attorney.

PLC: Progressive Life Center. DC YouthLink lead organization that provides services for DYRS youth in Wards 1-6 and the Maryland suburbs.

PRTF: Psychiatric Residential Treatment Facility. Any non-hospital facility that provides in-patient psychiatric services to eligible youth under the age of 21.

PYD: Positive Youth Development. A concept and set of principles underpinned by the belief that all youth can develop positively when they have the right mix of opportunities, supports, positive role models, and relationships.

PYJ: Positive Youth Justice. A complementary framework to PYD, focused specifically on the needs of court-involved youth.

RTC: Residential Treatment Center. Secure treatment facility for youth with specific mental health, behavioral, or substance abuse needs. RTCs provide specialized programs in an out-of-community placement.

Success Plan: A plan for DYRS youth's treatment goals, level of supervision, and the services and supports that they will receive. Success Plans are based on each youth's strengths and needs and are created through teamwork between the youth, their family and support system, and DYRS.

SDM: Structured Decision Making. A tool to assess a youth's risk of re-offending. The score (high, medium, or low) is used to make decisions about the youth's level of custody.

SYDR: Supervisory Youth Development Representative. Supervisors over the YDRs at New Beginnings or the Youth Services Center.

TDM: Team Decision Making. A DYRS case-planning meeting for making service plans personalized for each youth's strengths and needs. A TDM should include the youth, the youth's family members, case manager, and other people who are part of the youth's support network. TDMs are held every 90 days while youth are committed to DYRS.

YDR: Youth Development Representative. Staff member at one of DYRS's secure facilities: Youth Services Center or New Beginnings. YDRs work with youth in the facilities 24 hours a day, 7 days a week.

YFTM: Youth Family Team Meeting. A meeting for making placement and service plans for each youth. Team Decision Making (TDM) meetings now replace YFTMs.

YSC: Youth Services Center. An 88-bed secure residential facility on Mount Olivet Road in Northeast DC. YSC provides youth (male and female) with 24-hour supervision, custody, and care.

APPENDIX – POSITIVE YOUTH JUSTICE OUTCOMES AND MEASURES

We developed the following outcomes and measures to track youth successes in the Positive Youth Justice (PYJ) domains. The outcomes listed are part of a larger PYJ Monitoring and Evaluation Plan and are considered ongoing objectives in the agency's performance planning process.

EDUCATION

Outcome: Improved youth attendance in school

- # of youth with fewer unexcused absences from previous year or quarter

Outcome: Improved youth attendance in GED classes

- # of youth attending GED classes

Outcome: Youth educational gains

- % of youth with improved core competencies (e.g. reading, sentence construction, writing, math)
- # of youth completing a school grade
- # of youth acquiring HS diploma
- # of youth acquiring GED
- # of youth with college acceptance

Outcome: College retention

- # of semesters of college completed

WORKFORCE DEVELOPMENT

Outcome: Improved knowledge in specific employment sector

- # of youth acquiring vocational certifications

Outcome: Demonstration of soft skills

- % of youth reporting prepared for work, ready for interviews, etc.

Outcome: Improved job placement

- # of youth in apprenticeships
- # of youth job offers
- # of youth with unsubsidized employment (0-45 days)
- # of youth with unsubsidized employment (45-90 days)
- # of youth in job after 6 months

Outcome: Financial stability and independence

- Youth salary/wages
- # of youth receiving health and other benefits

Outcome: Youth implementing workforce development learnings and excelling

- # of youth promoted or otherwise demonstrating career advancement

Outcome: Improved employment opportunities for youth

- # of youth matched to specific jobs offered by employer partners
- # of youth enrolled in the military
- # of youth invited to job interviews

HEALTH

Outcome: Healthy body composition/BMI

- % of youth getting regular exercise

Outcome: Stress management

- % of youth engaging in fewer fights
- Decline in incidents

Outcome: Improved access to high quality and appropriate physical activity

- % of youth participating in recreational activities or athletic programming
- % of youth reporting access to high quality and appropriate physical activity

Outcome: Improved knowledge of STI prevention, pregnancy prevention and healthy lifestyle choices, and substance abuse

- % of youth reporting they know how to prevent STI
- % of youth reporting they have knowledge of birth control methods
- % of youth reporting engaging in safer sex

Outcome: Positive behavioral changes

- % of youth complying with individual treatment plans
- % of youth complying with medication treatment plan

Outcome: Improved coping mechanisms/Reductions in risk behaviors

- % of youth reporting they have improved communication/conflict resolution skills
- Decline in incidents

Outcome: Improved knowledge of individual mental health

- % of youth reporting knowledge of mental health needs

Outcome: Improved family communication

- % of youth reporting improved family communication

Outcome: Reductions in risk behaviors

- % of youth showing decline in illegal drug use
- % of youth with clean drug screens over time

Outcome: Improved knowledge of substance abuse risks and effects

- % of youth reporting increased knowledge of the effects and risks associated with substance abuse

RELATIONSHIPS

Outcome: Youth on track with treatment plan

- % of youth receiving services identified in their Singular Plan of Care
- % of youth completing enrolled activities/attendance reports
- % of youth displaying increased prosocial behavior
- # of youth whose CAFAS score risk levels decrease
- # of youth successfully completing the model unit/Level system

Outcome: Reduction in risk behaviors

- % of youth absconding, being rearrested, or reconvicted
- % of youth engaging in fewer fights
- % of youth reporting declines in gang activity
- % of youth reporting they are not carrying a gun

Outcome: Families and caregivers are engaged in TDM

- % of family participation in TDM meetings

Outcome: Improved outlook on life

- % of youth reporting they have a positive future
- % of youth who report they have an adult they can trust

Outcome: Improved socio-emotional well being

- % of youth who report they have an adults they can call in a crisis
- % of youth reporting increased self-esteem

Outcome: Improved attitude toward school/education

- % of youth reporting that education is important
- # of youth with fewer unexcused absences from previous year or quarter
- # of youth attending GED classes

Outcome: Increased exposure to new activities and exploring options for their future

- # of youth going on college tours
- # of youth who can identify safe and fun activities

Outcome: Reaching advanced psychological and developmental milestones

- % of youth reporting they can see things from another person's perspective (empathy)

Outcome: Improved relationships with caregiver or adult

- % of youth who report they have an adult they can trust
- % of youth who report they have an adults they can call in a crisis

Outcome: Family reunification

- % of youth placed at home
- % of youth receiving home visit passes

CREATIVITY

Outcome: Improved core competencies

- % of youth with improved core competencies (e.g. reading, sentence construction, writing, math)

Outcome: Creative skill development

- % of youth with improved knowledge or skills in creative outlets (music, playing an instrument, sports, culinary arts)

Outcome: Improved awareness of other cultures, religions, and sexual orientations

- % of youth reporting that they learned something new about a different cultural/religious group or sexual orientation

Outcome: Improved personal, interpersonal and social development

- % of youth reporting improved self-efficacy
- % of youth reporting increased self-esteem

Outcome: Improved civic engagement

- % of youth reporting that helping others is important
- # of hours of community service completed
- % of youth reporting they value community
- % of youth reporting they demonstrate leadership in their community
- % of youth reporting they contribute to improving their community

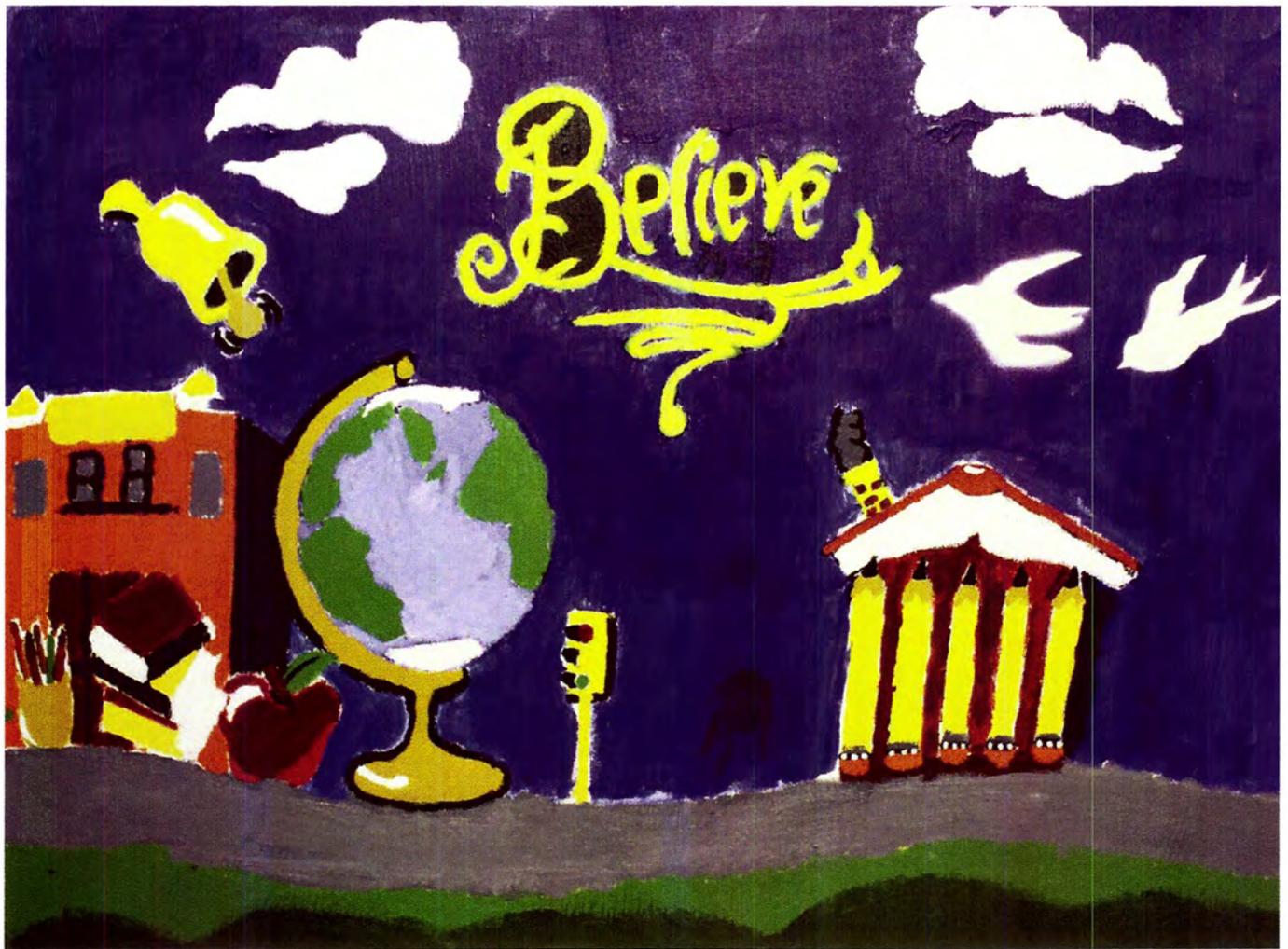
PUBLIC SAFETY

Outcome: Improved public safety record

- Decline in % of youth absconding
- Decline in % of youth being rearrested
- Decline in % of youth reconvicted

Outcome: Improved youth safety record

- % of youth who report they feel safe
- Decline in % of youth who become victims of crime





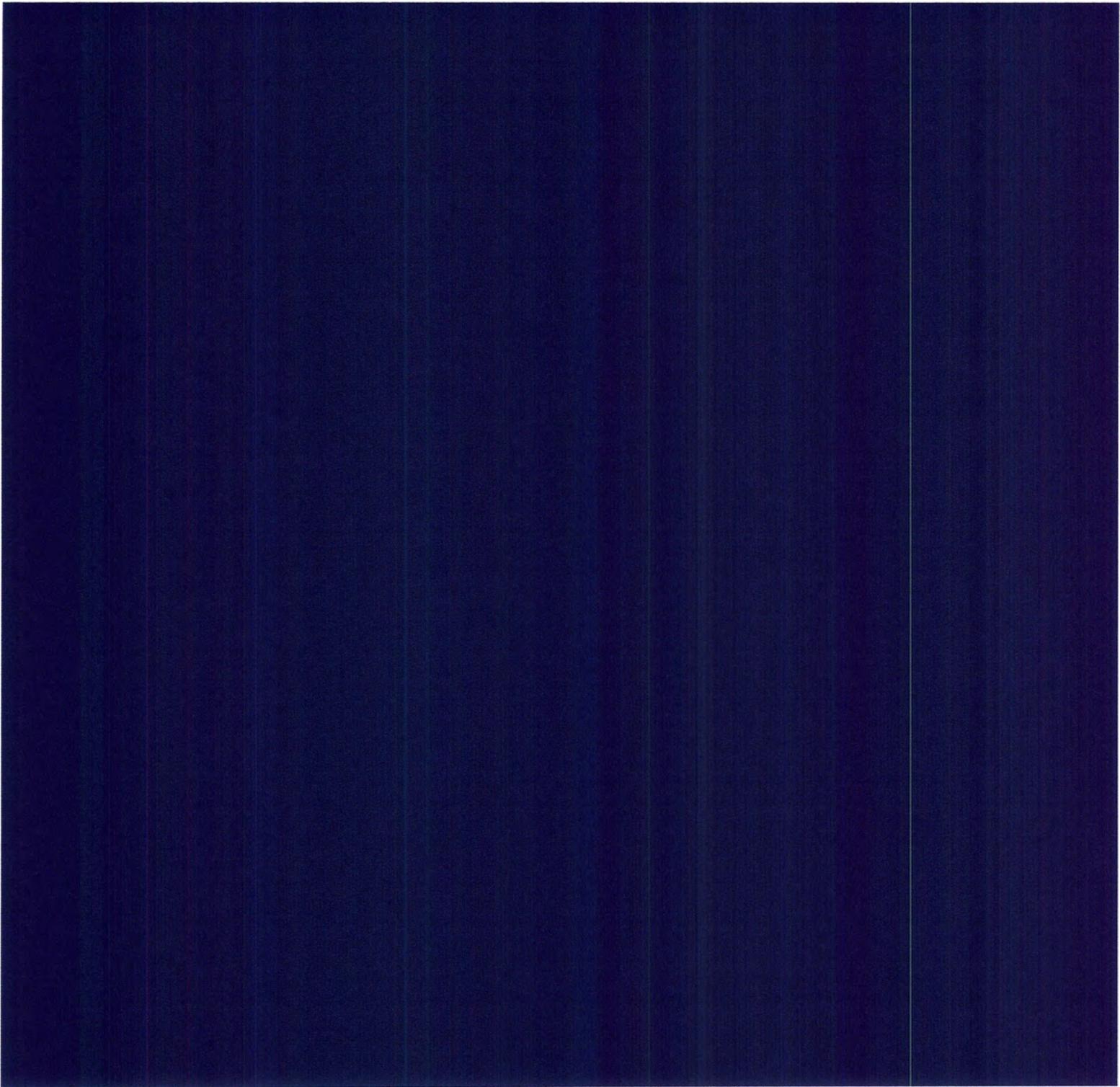


EXHIBIT 5

Footnote Index

- * From Table 5: Manpower Information from Seasons CON
- ** From the answers to Question 13 regarding table 2 in the Seasons CON
- *** From Table 4: Revenue and Expenses - Proposed Project

2018 Staffing Grid Assumptions in Seasons CON Breakdown by Service Line									
	Capacity	Estimated Census **	Direct Care FTE	RN FTE	LPN FTE	Total Pt Care FTE/Shift	Patient: Pt Care FTE Ratio		
D&A Unit	AM	5.9	1.00	0.33	0.83	2.16	2.8		
	PM	5.9	1.00	0.33	0.83	2.16	2.8		
	Midnight	5.9	1.00	0.33	0.83	2.16	2.8		
PRTF	AM	14.3	4.00	0.66	0.00	4.66	3.1		
	PM	14.3	4.50	0.66	0.00	5.16	2.8		
	Midnight	14.3	4.00	0.66	0.00	4.66	3.1		
Adult Male	AM	4.4	1.00	0.33	0.00	1.33	3.3		
	PM	4.4	1.00	0.33	0.00	1.33	3.3		
	Midnight	4.4	1.00	0.33	0.00	1.33	3.3		
Total	AM	24.7	6.00	1.30	0.83	8.13	3.0		
	PM	24.7	6.50	1.30	0.83	8.63	2.9		
	Midnight	24.7	6.00	1.30	0.83	8.13	3.0		
a)	Total Productive FTEs per day (Sum of all units & all shifts) *		18.50	4.00	2.49				
b)	365 days a year/24 hours a day/7 days a week coverage (a x 1.4)		25.90	5.60	3.49				
c)	Estimated 10% PTO Coverage (b x 0.1)		28.49	6.16	3.83				
d)	Total Paid FTE (= c)		28.49	6.16	3.83				
e)	1.0 FTE Salary Cost Per Job Code *		\$ 45,000	\$ 78,250	\$ 55,200				
f)	Total Salary Cost (d x e)		\$ 1,282,050	\$ 482,020	\$ 211,670	\$ 1,975,740			
g)	Total Fringe Benefit Cost		\$ 265,675	\$ 83,148	\$ 19,474	\$ 368,297			
h)	Total Salary & Fringe Benefit Cost (f + g)		\$ 1,547,725	\$ 565,168	\$ 231,144	\$ 2,344,037			
i)	Seasons CON Proforma Salary Cost *		\$ 833,219	\$ 313,000	\$ 138,000	\$ 1,284,219			
j)	Seasons CON Proforma Fringe Benefit Cost *		\$ 165,765	\$ 53,993	\$ 12,696	\$ 232,454			
k)	Total Seasons Salary & Fringe Benefit Cost (i + j) *		\$ 998,984	\$ 366,993	\$ 150,696	\$ 1,516,673			
l)	Salary/Fringe Benefit Var for in 2018 (k - h)		\$ (548,741)	\$ (198,176)	\$ (80,448)	\$ (827,364)			

2019 Staffing Grid Assumptions in Seasons CON Breakdown by Service Line

		Capacity	Estimated Census **	Direct Care FTE	RN FTE	LPN FTE	Total Pt Care FTE/Shift	Patient: Pt Care FTE Ratio
D&A Unit	AM	20	12.2	2.05	0.68	1.70	4.44	2.8
	PM	20	12.2	2.05	0.68	1.70	4.44	2.8
	Midnight	20	12.2	2.05	0.68	1.70	4.44	2.8
PRTF	AM	36	28.1	7.86	1.30	0.00	9.16	3.1
	PM	36	28.1	8.84	1.30	0.00	10.14	2.8
	Midnight	36	28.1	7.86	1.30	0.00	9.16	3.1
Adult Male	AM	16	9.4	2.12	0.70	0.00	2.82	3.3
	PM	16	9.4	2.12	0.70	0.00	2.82	3.3
	Midnight	16	9.4	2.12	0.70	0.00	2.82	3.3
Total	AM	72	49.7	12.03	2.70	1.70	16.44	3.0
	PM	72	49.7	13.01	2.70	1.70	17.42	2.9
	Midnight	72	49.7	12.03	2.70	1.70	16.44	3.0
Total Productive FTEs per day (Sum of all units & all shifts) *			49.7	12.03	2.70	1.70	16.44	3.0
a)	365 days a year/24 hours a day/7 days a week coverage (a x 1.4)							
b)	Estimated 10% PTO Coverage (b x 0.1)							
c)	Total Paid FTE (= c)							
d)	1.0 FTE Salary Cost Per Job Code *							
e)	Total Salary Cost (d x e)							
f)	Total Fringe Benefit Cost							
g)	Total Salary & Fringe Benefit Cost (f + g)							
h)	Seasons CON Proforma Salary Cost							
i)	Seasons CON Proforma Fringe Benefit Cost							
j)	Total Seasons Salary & Fringe Benefit Cost (i + j)							
k)	Salary/Fringe Benefit Var for in 2019 (k - h)							
l)								

2020 Staffing Grid Assumptions in Seasons CON Breakdown by Service Line

		Capacity	Estimated Census **	Direct Care FTE	RN FTE	LPN FTE	Total Pt Care FTE/Shift	Patient: Pt Care FTE Ratio
D&A Unit	AM	20	16.1	2.71	0.89	2.25	5.85	2.8
	PM	20	16.1	2.71	0.89	2.25	5.85	2.8
	Midnight	20	16.1	2.71	0.89	2.25	5.85	2.8
PRTF	AM	36	34.5	9.65	1.59	0.00	11.24	3.1
	PM	36	34.5	10.86	1.59	0.00	12.45	2.8
	Midnight	36	34.5	9.65	1.59	0.00	11.24	3.1
Adult Male	AM	16	15.3	3.45	1.14	0.00	4.58	3.3
	PM	16	15.3	3.45	1.14	0.00	4.58	3.3
	Midnight	16	15.3	3.45	1.14	0.00	4.58	3.3
Total	AM	72	65.9	15.81	3.60	2.25	21.66	3.0
	PM	72	65.9	17.01	3.60	2.25	22.86	2.9
	Midnight	72	65.9	15.81	3.60	2.25	21.66	3.0
			Total Productive FTEs per day (Sum of all units & all shifts) *					
a)	365 days a year/24 hours a day/7 days a week coverage (a x 1.4)							
b)	Estimated 10% PTO Coverage (b x 0.1)							
c)	Total Paid FTE (= c)							
d)	1.0 FTE Salary Cost Per Job Code *							
e)	Total Salary Cost (d x e)							
f)	Total Fringe Benefit Cost							
g)	Total Salary & Fringe Benefit Cost (f + g)							
h)	Seasons CON Proforma Salary Cost							
i)	Seasons CON Proforma Fringe Benefit Cost							
j)	Total Seasons Salary & Fringe Benefit Cost (i + j)							
k)	Salary/Fringe Benefit Var for in 2020 (k - h)							
l)								

	43.63	14.00	67.5					
	68.08	15.40	9.45					
	74.88	16.94	10.39					
	74.88	16.94	10.39					
	\$ 45,000	\$ 78,250	\$ 55,200					
	\$ 3,369,816	\$ 1,325,555	\$ 573,718	\$ 5,269,089				
	\$ 698,316	\$ 228,658	\$ 52,782	\$ 979,757				
	\$ 4,068,132	\$ 1,554,213	\$ 626,500	\$ 6,248,846				
	\$ 2,190,082	\$ 860,750	\$ 374,040	\$ 3,424,872				
	\$ 435,707	\$ 148,479	\$ 34,412	\$ 618,599				
	\$ 2,625,790	\$ 1,009,229	\$ 408,452	\$ 4,043,471				
	\$ (1,442,343)	\$ (544,984)	\$ (218,048)	\$ (2,205,375)				

2021 Staffing Grid Assumptions in Seasons CON Breakdown by Service Line

		Capacity	Estimated Census **	Direct Care FTE	RN FTE	LPN FTE	Total Pt Care FTE/Shift	Patient: Pt Care FTE Ratio
D&A Unit	AM	20	19.2	3.23	1.07	2.68	6.98	2.8
	PM	20	19.2	3.23	1.07	2.68	6.98	2.8
	Midnight	20	19.2	3.23	1.07	2.68	6.98	2.8
PRTF	AM	36	35.5	9.93	1.64	0.00	11.57	3.1
	PM	36	35.5	11.17	1.64	0.00	12.81	2.8
	Midnight	36	35.5	9.93	1.64	0.00	11.57	3.1
Adult Male	AM	16	15.3	3.45	1.14	0.00	4.58	3.3
	PM	16	15.3	3.45	1.14	0.00	4.58	3.3
	Midnight	16	15.3	3.45	1.14	0.00	4.58	3.3
Total	AM	72	70.0	16.61	3.80	2.68	23.09	3.0
	PM	72	70.0	17.85	3.80	2.68	24.33	2.9
	Midnight	72	70.0	16.61	3.80	2.68	23.09	3.0
a) Total Productive FTEs per day (Sum of all units & all shifts) *			51.07	16.09	8.99			
b) 365 days a year/24 hours a day/7 days a week coverage (a x 1.4)			71.49	15.40	11.27			
c) Estimated 10% PTO Coverage (b x 0.1)			78.64	16.94	12.39			
d) Total Paid FTE (= c)			78.64	16.94	12.39			
e) 1.0 FTE Salary Cost Per Job Code *			\$ 45,000	\$ 78,250	\$ 55,200			
f) Total Salary Cost (d x e)			\$ 3,538,893	\$ 1,325,555	\$ 684,186	\$ 5,548,634		
g) Total Fringe Benefit Cost			\$ 733,354	\$ 228,658	\$ 62,945	\$ 1,024,957		
h) Total Salary & Fringe Benefit Cost (f + g)			\$ 4,272,247	\$ 1,554,213	\$ 747,131	\$ 6,573,591		
i) Seasons CON Proforma Salary Cost			\$ 2,299,967	\$ 860,750	\$ 446,061	\$ 3,606,778		
j) Seasons CON Proforma Fringe Benefit Cost			\$ 457,569	\$ 148,479	\$ 41,038	\$ 647,086		
k) Total Seasons Salary & Fringe Benefit Cost (i + j)			\$ 2,757,536	\$ 1,009,229	\$ 487,098	\$ 4,253,863		
l) Salary/Fringe Benefit Var for in 2021 (k - h)			\$ (1,514,711)	\$ (544,984)	\$ (260,032)	\$ (2,319,727)		

EXHIBIT 6



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

TABLE OF CONTENTS

SECTION	PAGE NUMBER
Background	4
Policy	5
531.1.1 Provider Participation Requirements	5
531.1.1.1 Physical Environment/Equipment.....	6
531.1.1.2 Non-Discrimination	6
531.1.1.3 Staffing Requirements	7
531.1.1.4 Fingerprint-Based Background Check	8
531.1.1.5 Staff Training	10
531.1.1.6 Direct Care Staff, Case Manager, and All Clinical Staff	10
531.1.1.7 Confidentiality	11
531.1.1.8 HIPAA Regulation.....	12
531.1.1.9 Emergency/Disaster Preparedness Procedures	12
531.1.1.10 Infection Control	13
531.1.1.11 Parental Involvement.....	13
531.1.1.12 Incident/Accident Reporting and Policy	14
531.1.1.13 Quality Assurance/Utilization Review	15
531.1.1.14 Out-of-State Certification/Review Process	16
531.1.1.15 Corrective Action Plan	17
531.1.1.16 Waivers and Variances.....	18
531.1.1.17 Notice to BMS and Legal Guardian/Parent of Adverse Action	18
531.1.2 Medical Eligibility/Medical Necessity	19
531.1.3 Service Provision	19

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

531.1.3.1 Admission20

531.1.3.2 Admission Criteria21

531.1.3.3 Resident Rights and Responsibilities22

531.1.3.4 Interstate Compact on the Placement of Children (ICPC)23

531.1.3.5 Assessment23

531.1.3.6 Treatment Planning24

531.1.3.7 Treatment Team Composition24

531.1.3.8 Treatment Team Development25

531.1.3.9 Treatment Plan Review and Revision26

531.1.4 Active Treatment26

531.1.4.1 Mental Health Services26

531.1.4.2 Therapeutic Behavior Management28

531.1.4.3. Physical Health Services28

531.1.4.4 Pharmacy Services29

531.1.4.5 Consent for Medication30

531.1.4.6 Administration of Medication31

531.1.4.7 Medication Errors31

531.1.4.8 Dietary Services32

531.1.4.9 Visitation with Parents and Extended Family32

531.1.4.10 Life Skills33

531.1.4.11 Therapeutic Leave33

531.1.4.12 Billing and Reimbursement for Therapeutic Leave34

531.1.5 Continuing Stay Criteria34

531.1.6 Discharge35

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531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

531.1.6.1 Emergency Discharge36

531.1.6.2 Elopements/Run Away37

531.1.7 Documentation Requirements37

531.1.7.1 Administrative38

531.1.7.2 Documentation of Assessments38

531.1.7.3 Treatment Planning38

531.1.7.4 Therapeutic Interventions39

531.1.8 Records Maintenance40

531.1.9 Specialized Procedures/Seclusion/Restraint40

531.1.9.1 Staff Training40

531.1.9.2 Member/Parent Notification40

531.1.9.3 Types of Seclusion and Restraints40

531.1.9.4 Appropriate Use41

531.1.9.5 Prohibited Practices42

531.1.9.6 Procedural Requirements42

531.1.9.7 Documentation of Seclusion/Restraint44

531.1.10 Education44

531.1.11 Transportation and Vehicle Maintenance45

531.1.12 Clothing45

531.1.13 Reimbursement Methodologies46

531.1.13.1 PRTF Services Included in the Daily All Inclusive per Diem Rate47

531.1.13.2 Prerequisites for Payment47

Glossary48

Change Log51

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

POLICY METADATA

Policy ID = 531.1
Policy Author = Facility Based and Residential Care Services
Policy Status = Pending
Creation Date = 2/1/2013

Initial Approval Date = 2/1/2013
Initial Effective Date = 5/1/2013
Last Revised Date = 4/27/2015
Revision Approval Date = TBD
Next Review Date = TBD

BACKGROUND

This policy describes West Virginia Title XIX Medicaid's coverage for Psychiatric Residential Treatment Facilities (PRTF) and any service, procedure, or situation not discussed in this policy must be presumed not covered. Providers of PRTFs are required to provide services as they are outlined in this policy. Each agency is subject to monitoring and evaluation by all appropriate State entities and is bound to all requirements outlined in this policy. This policy does not address all the complexities of Medicaid policies and Procedures, and must be supplemented with all State and Federal laws and regulations.

A PRTF is defined as a separate, stand-alone entity or a distinct part of an acute care general psychiatric hospital which holds licensure in West Virginia as a behavioral health agency pursuant to West Virginia code §27-9-1 or §27-2A-1 and licensed as a child care agency pursuant to West Virginia Code §49-2B-3.

PRTF's located outside the State of West Virginia must meet all licensing requirements for PRTFs in the state where the facility is located and be certified to serve Title XIX recipients in that state as a PRTF. West Virginia is not in a position to interpret other state's descriptive designations to confirm that they do in fact comply with the PRTF designation. Therefore, if a state does not offer a PRTF designation on a license, facilities will be required to provide documentation from their state's licensing agency, signed and dated by the director of the state licensing agency, on official states' letterhead, that the facility meets all criteria for psychiatric residential treatment facility service provision as indicated in 42 CFR and is approved to serve Title XIX recipients in that state as a PRTF or evidence of certification as a PRTF provider from another jurisdiction. PRTFs must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or the Council on Accreditation of Services for Families and Children, or the Commission on Accreditation of Rehabilitation Facilities, or any other accrediting body with comparable standards that are recognized by the State licensing agency. When different accreditation, certification or licensing standards exist, between West Virginia and the state where the facility exists, the more stringent standard must be followed, for West Virginia Medicaid members (West Virginia CSR §78-3-22.2. Accreditation Requirements).

The purpose of a PRTF is to provide full-time psychiatric treatment for children under age twenty-one (21) with mental/emotional/behavioral problems who do not require emergency or acute psychiatric care but whose symptoms are severe enough to require supervision/intervention on a twenty-four (24) hour basis. Inpatient psychiatric services for beneficiaries under age twenty-one (21) must be provided before the beneficiary reaches age twenty-one (21) or, if the beneficiary was receiving the services immediately before he/she reached age twenty-one (21), before the earlier of the following: the date he/she no longer requires the services or the date he/she reaches age twenty-two (22). (42 CFR §441.151). The goal of PRTF treatment is to help the child reach a level of functioning where less restrictive treatment will be possible. (42 CFR §441.152(a)(3)).



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

PRTF care is the most restrictive type of care for children. A secure facility is used for treatment of children who have been clearly diagnosed as having a psychiatric, emotional, or behavioral disorder that is so severe the child is a danger to himself or others. All services must be delivered under the direction and orders of a physician and psychiatrist. Educational services for the child must be provided on the grounds of the facility. The ultimate goal of the PRTF services is to promote a successful return of the child or adolescent into the community.

PRTFs are limited in size to 30 beds within the state of West Virginia according to the West Virginia State Plan. PRTFs providing services to children out of state are limited to the number of beds prescribed by that state's plan or licensure.

POLICY

531.1.1 PROVIDER PARTICIPATION REQUIREMENTS

To be certified as a PRTF, the facility must attest to meeting the Conditions of Participation (CoP) found in 42 CFR Subpart A, Definitions §440.160, 42 CFR Subpart D-Inpatient Psychiatric Services for individuals under age 21 in Psychiatric Facilities or Programs, sections §441.150 - §441.182, Subpart G, Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21, 42 CFR Subpart G, §483.350 - §483.376.

Each PRTF that provides inpatient psychiatric services to individuals under age 21 must attest, in writing that the facility is in compliance with CMS' standards governing the use of restraint and seclusion. This attestation must be signed by the Facility Director. A facility with a current provider agreement with West Virginia Medicaid must provide that attestation to BMS at the time of enrollment and yearly by July 21, or upon a change in the Facility Director. (42 CFR §483.374).

Providers of PRTF services will receive a reminder to submit the attestation letter to BMS' fiscal agent 90 days prior to July 21 each year. Facilities failing to submit the attestation letter will be considered in non-compliance and will be subject to withholding payment until the facility is in compliance.

In order to participate in the West Virginia Medicaid program for reimbursement of covered services provided to West Virginia Medicaid members, PRTF services must be approved through BMS' fiscal agent contract enrollment process prior to billing for any services. Chapter 300, Provider Participation Requirements presents an overview of the minimum requirements that health care providers must meet to enroll in and be reimbursed by the West Virginia Medicaid Program.

All providers are required to meet eligibility requirements. In addition to the licensing and certification requirements, all PRTF's must maintain good standing with the West Virginia Bureau for Medical Services, the West Virginia Bureau for Children and Families (BCF), and the West Virginia Department of Education, (DOE) in order to continue to participate as a West Virginia Medicaid provider. The Bureau for Medical Services requires that all educational instruction for West Virginia Medicaid members meet West Virginia standards, unless the standards are higher in the state where the PRTF is located. West Virginia is the final arbitrator of whether the treatment services or educational standards are sufficient for West Virginia Medicaid members. Failure to remain in good standing with the BCF and/or DOE resulting in admission restrictions by BCF will result in admission restrictions by the Bureau for Medical Services. If



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

the state agency licensing the facility places admission restrictions on the PRTF facility as a result of a negative review of services, the West Virginia Bureau for Medical Services will place admission restrictions on the facility until the negative action is corrected and BCF/BMS is notified by the licensing agency that the admission restrictions have been lifted.

All providers are required to sign/date a West Virginia Medicaid Provider Agreement. Additionally an agreement specific to psychiatric residential treatment services must be signed/dated by the Administrator. This agreement may be renewed at BMS' discretion and is subject to the terms and conditions contained therein and all applicable state and federal law and regulations.

The goal for WVDHHR is for all children to be served within the state. Out-of-state facility applications for enrollment with West Virginia Medicaid will be considered **ONLY** if a child in DHHR custody requires this level of service and the service is not available to meet the child's needs in West Virginia.

531.1.1.1 Physical Environment/Equipment

The facility must be housed, equipped, and maintained in a manner that is suited to the program of services being provided and that reflects the facility's positive regard for its members. The physical environment must be consistent with contemporary, accepted concepts of service and care and is one that enhances individual dignity and feelings of self-worth for the members served.

Bedrooms must be adequately furnished and provide a minimum of 80 square feet of floor space per person for one person occupancy and a minimum of 60 square feet of floor space per person for two or more person occupancy. Each member of a facility shall be provided a permanent, separate bed with a clean, comfortable, covered mattress, clean bedding, clean towels, and other furnishings appropriate to the length of stay and needs of the member. Each bedroom window must have covering for privacy. Furnishings shall be homelike and personalized.

The facility must allocate sufficient space and safe and varied equipment for outdoor play to meet the member's recreational needs.

Offices or rooms must be available and accommodating to personnel to engage in interviewing or counseling families and children in a private and confidential manner.

The West Virginia DHHR through BCF, BMS, and the West Virginia DOE through the Office of Institutional Education Programs (OIEP) and the Office of Special Programs (OSP) have engaged in a collaborative effort to evaluate and monitor the quality of services provided by all PRTFs on an annual basis. This is to ensure children are in a safe environment and are provided behavioral health treatment and educational services commensurate with acceptable standards as set forth by West Virginia DHHR and the West Virginia DOE.

531.1.1.2 Non-Discrimination

The facility must assure that no person shall be excluded from participation, denied benefits, or otherwise subjected to discrimination in the performance of the services or in employment practices on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by federal, West Virginia State Constitutional, or statutory law.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

- Written facility policy must assure that the need for the facility's services are the primary criterion of eligibility and its services are offered without discrimination.
- The facility must have a written equal opportunity policy that clearly states its practices in recruitment, employment, transfer, and promotion of employees.
- The facility must actively recruit, employ, and promote qualified personnel broadly representative of the community it serves and administer its personnel practices without discrimination based upon age, sex, race, ethnicity, nationality, disability, or religion of the individual under consideration.
- The facility provides for internal and external dissemination of its equal opportunity policy and recruitment materials that specify the nondiscriminatory nature of the facility's employment practices.
- If the facility recruits and selects with regard to specific characteristics, it does so with the needs of the facility's defined clientele in mind and in accord with exemptions in the law(s) governing equal opportunity employment.
- The facility shall show proof of nondiscrimination and post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.
- The facility is free of those architectural barriers that restrict the employment of or use by personnel with disabilities. Likewise, the facility is free of architectural barriers that restrict use by the aged, families with young children, and persons with disabilities and/or makes provision for use of accessible facilities in order to provide services to persons with disabilities.

A copy of the Resident's Rights and Responsibilities is visibly displayed in the facility. At time of admission the West Virginia Medicaid member and the parent/guardian must be provided with a clearly written and readable statement of rights and responsibilities. The statement must be read to the resident or parent/guardian if either cannot read.

531.1.1.3 Staffing Requirements

PRTF's participating in the West Virginia Medicaid program are required to have the following staff:

1. **Facility Director:** The governing body of the PRTF must appoint a Facility Director to be responsible for the overall management of the facility. The Facility Director must have appropriate academic credentials and administrative experience in child/adolescent psychiatric treatment. The Facility Director is responsible for the fiscal and administrative support of the facility's clinical program.
2. **Medical Director:** The facility must appoint a medical director to be responsible for coordinating medical services and directing member treatment. The medical director must be a board eligible or board-certified psychiatrist (experienced in child/adolescent psychiatry) or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry.
3. **Clinical Director:** The facility must appoint a full-time director to be responsible for coordinating clinical services and implementing patient treatment. The clinical director must be a board eligible or board-certified psychiatrist (experienced in child/adolescent psychiatry), a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry, a licensed psychologist who is experienced in child/adolescent mental health treatment, a psychiatric mental health nurse practitioner (PMHNP)/advanced practice registered nurse (APRN) who is experienced in child/adolescent mental health treatment, or a Licensed Professional Counselor



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

(LPC), a Marriage and Family Therapist (MFT) or a licensed certified social worker who is experienced in child/adolescent mental health treatment. A board eligible or board-certified psychiatrist with experience in child/adolescent psychiatry (or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry) may serve as both medical director and clinical director provided that he/she is a full-time employee.

4. **Professional staff:** The facility must employ sufficient full-time professional staff to provide clinical assessments, therapeutic interventions, ongoing program evaluations, and adequate residential supervision 24 hours a day, seven days a week. Professional staff must be appropriately licensed, trained, and experienced in providing mental health and residential treatment.

The mental health treatment team must include at a minimum the following:

- A Board-eligible or Board-certified Psychiatrist (experienced in child/adolescent psychiatry);
- A Licensed Psychologist; (as indicated by needs of child);
- A Registered Nurse(s);
- A Psychiatric social worker(s), LPC;
- A Certified Teacher(s);
- A Recreation Specialist; and,
- An Occupational/Physical/Speech Therapist (as indicated by needs of child).

The PRTF must notify BMS of changes in the facility director, medical director or clinical director. The Director of Facility Based & Residential Care at BMS must receive notification via the signed/dated Attestation Letter from the facility, in writing within 72 hours of the effective change.

Attestation Letters must be mailed to BMS, Attention: Office Director, for Facility Based and Residential Care.

**West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301**

The staffing ratio for a PRTF shall be one staff to three members (1:3) during day and evening hours (one staff whose primary responsibility is providing direct care for every three children) and (1:6) during sleep hours with the capability to increase staff ratio in response to acuity, extending to the provision of one-on-one (1:1) care when necessary. (78 CSR §3.22.3 Employee Ratios) Staff assigned to work a defined unit and providing care to the children on that unit including nursing, teachers, and activity's therapists can be included in the staff to client ratio. Staff assigned to supervisory duties or whose duties cause them to be away from the unit (nursing supervisor) cannot be included in the count.

531.1.1.4 Fingerprint-Based Background Check

West Virginia Code, Chapter 49 (Child Welfare), Article 2B, Section 8 requires a criminal background check of personnel criminal records for licensed, certified and registered child welfare agencies. The Adoption and Safe Families Act requires criminal background checks on all individuals and agency staff providing care for foster children.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

A thorough Fingerprint-Based Background Check and review by a Federal Registry is required with results of an on-line preliminary check available for review **PRIOR** to employment of any individual (including volunteers) who will be working in a facility providing treatment or care for **all** West Virginia Medicaid members (custodial and non-custodial). The on-line preliminary results may be used for a period of three months (90 days) while awaiting the final results of fingerprinting. During that time period the individual may **not** work unsupervised. Results of the Fingerprint-Based Background check must be documented in the personnel file **within three months (90 days)** of hiring the employee. (Refer to requirements listed below regarding exclusions/sex offender registries lists which must be completed with a negative result prior to hiring or allowing to volunteer.) An applicant must complete a Statement of Criminal Record every two years after the initial submission to the respective agency or department. A subsequent Fingerprint-Based Background Check must be completed at least every five years, but may be submitted at any point if there is an indication that the Fingerprint-Based Background Check information may have changed.

The applicant shall not be approved, employed, utilized, nor considered for employment if ever convicted of:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, malicious wounding, unlawful wounding, felonious domestic assault or battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation of a child or an incapacitated adult;
- Misdemeanor domestic battery or domestic assault;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony Driving Under the Influence (DUI) within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Health care fraud; and
- Felony forgery.

The applicant shall not be approved or employed if on parole or probation for a felony conviction.

It is the responsibility of the employer to check the list of excluded individuals/entities (LEIE) monthly at:



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

- (LEIE) at: <http://exclusions.oig.hhs.gov/>;
- (Formerly EPLS) <https://www.sam.gov/>;

The following web addresses are provided to assist the governing body or designee to check applicants against the sex offender registries for West Virginia and the National sex offender registry, on a monthly basis. Results of this check must be present in the employee/volunteer personnel file and available for review upon request:

- West Virginia's state police offender registry is at <http://www.wvsp.gov>
- National sex offender registry is at <http://www.nsopw.gov/>

531.1.1.5 Staff Training

A PRTF that contracts with DHHR ensures that qualified personnel meet or exceed the requirements for pre-service and in-services trainings with respect to facility objectives, policies, services, community resources, DHHR policies, and best practice standards. See 78 CSR 3-11 for training and Supervision of Employees.

The facility is required to document evidence of the participation/completion of all employee training and retain in each personnel record the required new worker orientation and annual in-service training, as well as any in-service training provided by the facility during the year. Facilities will provide proof by individual employee records that training requirements are fulfilled. Review of those records will occur during monitoring both by the UMC retrospective reviews and the Certification Review Process as well as review by the Office of Program Integrity (OPI). Personnel records must reflect the date of training, number of training hours, and the signature of the participant.

In addition, the facility will keep a log/calendar of ongoing training that includes the title of the training, the type of training (video/lecture/lab), dates of training, location of training, sign-in sheets, subject matter, name, phone number, credentials of the instructor and any reviews by employees.

All training is to be provided by licensed or certified professional staff, or an agency qualified trainer. Video, audio, and on-line or web based trainings are restricted to no more than 50% annually for each employee. Training which includes live lecture must also contain demonstration and the active participation of employees. Training attendees are expected to attend training for the entire session. The log on training is to be kept by the facility for a period of five years.

531.1.1.6 Direct Care Staff, Case Manager, and All Clinical Staff

All direct care staff shall have a minimum of a high school diploma or GED and professional staff shall have appropriate education and certification consistent with professional licensing standards. (78 CSR §3-22.4.a, Employee Training and Credentials).

Personnel development is an ongoing, integral, and identifiable part of the facility's program of services, and the facility has specific guidelines as to the time commitment expected of personnel in various positions. Pre-Service Training including all of the following that demonstrates training sessions last at a minimum eight and one-half hours excluding first aid and CPR training which are prescriptive in nature with specific training criteria.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

The following pre-service training is required:

All personnel are required to have pre-service and annual in-service trainings in the following topics.

- All appropriate/applicable facility policies,
- Conflict resolution,
- Member rights,
- Managing behavior,
- Psychiatric emergencies,
- First aid (All staff having direct contact with West Virginia members must receive training in first aid.),
- CPR (facility staff member must be immediately available who has been trained in CPR.),
- Incident reporting/completion/follow up,
- Recognition of substance abuse,
- Elopement procedure/reporting
- Child abuse prevention/reporting,
- Suicide prevention,
- HIPAA/Confidentiality
- Emergency/Disaster Preparedness,
- Infection Control,
- Sexual harassment including prevention,
- Cultural awareness,
- De-escalation procedures.

All training sessions must include both lecture and active participation (return demonstration) activities for the staff.

All policy on de-escalation, restraint, seclusion, CPR certification, and requirements must be readily available to all staff 24 hours a day, seven days a week. The facility shall post in a centralized location the name of at least one person who is on-duty with proper CPR certification for the use of all staff at all times West Virginia Medicaid members are in the facility. Evidence of current certification in CPR must be maintained and available upon request.

All staff utilizing or monitoring restraints must do so as required under federal regulations. Such staff shall be CPR certified and fully trained and certified in nationally recognized physical restraint methods. Facility policy regarding Restrain/Seclusion must be readily available to all staff 24 hours a day, seven days a week.)

(See also Section 531.1.9 and its subparts on Specialized Procedures/Seclusion/Restraint).

531.1.1.7 Confidentiality

Strict standards of confidentiality of medical records and information must be maintained in accordance with applicable state and federal law. The facility must have written policies and procedures governing access to, use of, and release of all information about its members, and assures that such policies meet



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

any applicable legal requirements. Written policies must be approved by the governing board and must specify the responsibility of all personnel for maintaining confidentiality of information contained in member and personnel records.

A release of information form must be obtained and approved prior to sharing information in any situation other than those described here. Access to medical records is limited to the member, the parent or legal guardian (when the West Virginia member is a minor), authorized facility personnel, and others outside the facility whose request for information access is permitted by law and is covered by assurances of confidentiality and whose access is necessary for administration of the facility and/or services and reimbursement.

A West Virginia member may review their medical record in the presence of professional personnel of the facility and on the facility premises. Such review is carried out in a manner that protects the confidentiality of other family members and other individuals whose contacts may be contained in the record. Access to medical records is limited and should be available on a medical need to know basis and as permitted under federal and state law and any relevant court rulings.

Pictures of West Virginia Medicaid members are to be used for identification purposes only (contained in the member medical record and medication administration record). Usage for any other purposes, including public displays or for promotional materials, are prohibited.

All West Virginia Medicaid member information is kept locked in a secure place.

531.1.1.8 HIPAA Regulation

Providers must comply with all requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all corresponding federal regulations and rules. The enrolled provider will provide upon request of BMS, timely evidence and documentation that they are in compliance with HIPAA. The form of the evidence and documentation to be produced is at the sole discretion of BMS.

Additional information on HIPAA may be found in [Chapter 300, Provider Participation Requirements](#).

531.1.1.9 Emergency/Disaster Preparedness Procedures

The facility's governing body/designee must establish written procedures for personnel to follow in an emergency/disaster. Evacuation of a facility may become necessary in the event of an emergency/disaster (e.g., fire, smoke, bomb threat, explosion, prolonged power failure, structural damage, water loss or sewer loss, tornado, flood, earthquake, chemical leak, chemical spill, or elopement. This is not an all-inclusive list of emergency/disasters). The facility's emergency/disaster care procedures must include at a minimum:

- Care of the child;
- Notification of the attending physician/psychiatrist, EMS, law enforcement, parent/guardian and other persons responsible for the West Virginia Medicaid member;
- Arrangements for transportation;
- Arrangements for hospitalization;
- Arrangements for other appropriate services;



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

- Arrangements for emergency physician/psychiatrist services and;
- An elopement plan and;
- An evacuation plan.

The facility's governing body/designee must ensure staff rehearses, at a minimum annually, the facility's emergency/disaster plans. Fire drills must be conducted as required by the state where the facility is located.

531.1.1.10 Infection Control

The facility must have in place policy and procedures approved by the governing board that address:

- a. Infection control policies and practices (e.g. **hand washing**, glove use, isolation procedures, and outbreak precautions).
- b. The potential for the spread of infection in bathrooms, bedding, food preparation areas, prevention of the spread of preventative infection control practices including; infectious diseases including antibiotic resistant strains of bacteria, Cabapenem Resistant Klebsilla Pneumoniae (CRPK), Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin Resistant Enterococcl (VRE), Clostridium Difficile (C Diff), eye infections, skin rashes (especially if spreading, undiagnosed, and/or not responding to treatment), respiratory infections, gastroenteritis including diarrhea, nosocomial infection, etc.
- c. Locked storage of cleaning supplies and hazardous materials, including medication in a safe locked location, with all controlled medications under double locks.
- d. Maintenance of a hazard-free environment in facilities through a daily log of all refrigerator temperatures and water temperatures, covering electric outlets, securing floor covering or equipment, and reviewing the adequacy of lighting and ventilation.
- e. Policies and Procedures for the use of personal protective equipment (PPE).
- f. Policies and Procedures concerning the cleaning of blood spills, Biohazards.
- g. Policies and Procedures to cover safety measures when physical injuries occur.

531.1.1.11 Parental Involvement

Services are provided to children in order to meet their permanency needs. Each child served is prepared for a placement outside the home and:

- helped with conflicts about the placement and separation from family members;
- encouraged to maintain contact with the biological family and provided with support in making such arrangements, unless specifically contraindicated because of the child's safety;
- provided information about parents activities and progress toward the goal of returning home, unless the home is not a possibility;
- provided with assistance in maintaining the relationship with siblings through visits and shared activities; and
- prepared for the return home, adoption, or for placement in a stable, nurturing environment that is to be permanent, and when this is not possible;
- prepared for independent living and helped to identify a significant adult with whom a relationship can be maintained.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

Permanency is the primary goal for discharge. As permitted under the law and as appropriate for the child's safety and well-being, the facility shall make efforts to engage the parents in continuing contact with their child and implementing the plans for permanency for the child. Such contact shall include participation in developing case plans, updating the parents on progress and inviting the parents to all case conferences.

When in the best interests of the child, the facility designs and implements service in a manner that supports and strengthens family relationships and empowers and enables parents and family members to assume their roles. A written plan of family involvement, when appropriate, shall be developed at intake and updated no less than quarterly. The plan of family involvement will address but not be limited to the following issues:

- visitation guidelines and/or restrictions;
- facility responsibility for working with the family;
- the state agency's (BCF) responsibilities for working with the family;
- any other appropriate issues.

The facility must provide coordination of social services to children, adults, and families as needed. The goals of such services may include family reunification, to stabilize family ties, or to obtain a permanent family for a child receiving services in the PRTF.

Services must be provided to help the child's parents maintain and enhance parental functioning, parental care, maintenance of parent-child relationships, or when in the best interest of the child termination of parental rights.

531.1.1.12 Incident/Accident Reporting and Policy

PRTF's are required to maintain a written Incident/Accident Reporting Policy in a centralized location for easy access to all staff personnel. The written policy must be approved by the governing body of the facility.

The facility accepting/admitting West Virginia Medicaid members for care must ensure that they are cared for in an environment which meets high standards of safety and maintenance and that special precautions are taken that no harm or injury to the member occurs. The facility promptly reports to appropriate state and/or legal authorities any serious accident, emergency, or dangerous situation, including immediate verbal reporting of instances of child abuse, and reports to parents or legal guardians any of the above which affect their child or the child for which they are responsible. The PRTF must **verbally** report to the parent/legal guardian any accident or incident involving a child which results in injury within 24 hours of the facility's knowledge of the accident or incident. The PRTF must **verbally** report suspected abuse or neglect of a child to the parent/guardian and the appropriate authorities in the state where the facility is located within 24 hours of the facility's knowledge of its occurrence with a detailed written report within five days. The PRTF must **verbally** report the findings of abuse and neglect investigations conducted by the state where the facility is located within 24 hours of completion of the investigation, with a detailed written report within five days.

Incident/Accident reports will be forwarded the following business day to BMS, Attention: Office Director, for Facility Based and Residential Care. Reports must be mailed to:



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Office Director, Facility Based & Residential Care
350 Capitol Street, Room 251
Charleston, West Virginia 25301

Serious injury of a West Virginia Medicaid member is defined as any significant impairment of the physical condition of the member as determined by qualified medical personnel. This includes, but is not limited to:

- Burns, lacerations, substantial hematoma requiring medical intervention by a licensed physician.
- Bone fractures
- Injuries to internal organs, whether self-inflicted or inflicted by someone else
- Suicide attempt
- Elopement (See also *Section 531.1.6.2, Elopements/Run Away*)
- Any allegations of sexual contact (member/member, member/staff)
- Any allegation of abuse and/or neglect
- Any injury of a member while in seclusion or restraint (See also *Section 531.1.9 and its subparts on Specialized Procedures/Seclusion/Restraint*)
- Medication errors requiring medical intervention by a licensed physician.

A death of ANY member or a serious incident involving harm to ANY member, regardless of whether they are a West Virginia Medicaid member or not, must be reported as follows:

- Immediately upon death (within eight hours) a phone call must be made to BMS at (304) 558-1700. If the death is that of a West Virginia Medicaid member, staff must identify the name of the member and a narrative description of the incident. If the death is not a West Virginia Medicaid member, the caller must provide sufficient details that will permit review of the incident.
- Within 24 hours, facility staff must fax a written report to BMS at (304) 558-1542.
- Immediately notify local law enforcement of the incident.

Reports may be faxed to the Bureau for Medical Services at (304) 558-1542, Attention: Director, Office of Facility Based and Residential Care.

531.1.1.13 Quality Assurance/Utilization Review

The facility must have an ongoing quality assurance program in which each service of the facility and service to individual members is reviewed quarterly and monitored in order to promote the highest quality service, to resolve problems that are identified, and to assure that services meet the facility's expectations as to outcome.

The overall scope of the quality assurance program is described in a written plan that describes mechanisms, committees, or other methods used to coordinate the facility's approach to monitoring and evaluating the quality and appropriateness of service.

The facility must set goals and objectives for the benefits or outcomes to be achieved by members who use the facility services, and on a regular basis the facility conducts member satisfaction surveys or



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

utilizes other methods of determining the outcome of its services, including the reasons for termination of members who drop out of service, to the extent this can be ascertained.

The facility must monitor the quality of care and review the appropriateness of service at least quarterly.

The facility must have a utilization review or other quality assurance mechanisms that ensures that the cases of all members are formally reviewed on a quarterly basis.

The facility must participate in utilization reviews at least every 30 days. Utilization reviews are to include the Bureau's Utilization Management Contractor (UMC) representatives to evaluate the necessity, appropriateness, quality, and intensity of individual member services to facilitate permanency and less restrictive service delivery as soon as possible. The utilization review focuses on appropriateness and effectiveness of member services, and reduction of length of stay in out-of-home care. Documented, measurable criteria are utilized in the review process, extended treatment or service, changes in status or level of need presented by the member, and/or other criteria developed by the facility. Retrospective review of prior authorization requests and relevant clinical information will be conducted on and off site by the UMC. Requested information will be provided for reviews.

The facility cooperates with authorized external review systems (including the Bureau's Utilization Management Contractor (UMC), the Bureau for Children and Families (BCF), and the West Virginia Department of Education (DOE)), and, where applicable and where possible, organizes its internal review schedules to complement those conducted by external review systems.

531.1.1.14 Out-of-State Certification/Review Process

West Virginia Code 49-7-34 establishes the Commission to Study Residential Placement of Children. The Commission has been actively involved in carrying out their responsibilities since 2005. The Commission was to study and provide recommendations regarding:

- Current practices of placing children out-of-home and into residential placements, with special emphasis on out-of-state placements and,
- ways to certify out-of-state providers to ensure that children receive high quality services consistent with this state's (West Virginia) standards of licensure and rules of operation.

As a result of their work, recommendations currently being implemented include:

- Requirements that out-of-state placements be made **only** to providers meeting West Virginia standards of licensure, certifications, and expected rules of operation.
- Requirements that ensure education standards are in place and students are fully receiving the appropriate education services in all out-of-state facilities where West Virginia children are placed.

The West Virginia DHHR through BCF, BMS, and the West Virginia DOE through the Office of Institutional Education Programs (OIEP) and the Office of Special Programs (OSP) have engaged in a collaborative effort to evaluate and monitor the quality of services provided by out-of-state facilities. This is to ensure children are in a safe environment and are provided behavioral health treatment and



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

educational services commensurate with acceptable standards as set forth by West Virginia DHHR and the West Virginia DOE.

The Team representing West Virginia DHHR and West Virginia DOE will conduct on-site reviews of facilities out-of-state that are providing services for West Virginia children. Focus will be on all West Virginia Medicaid members. West Virginia's ultimate goal is to solicit services from only facilities having demonstrated success in promoting positive growth and expected outcomes for children as defined within the West Virginia Out-of-State Facilities Standards.

When BMS has identified unnecessary and inappropriate practices through monitoring or other reviews, it may pursue one or more of the following:

- Recoupment of inappropriately paid monies;
- Requirement of a satisfactory written plan of correction;
- Limited participation in the plan that may include:
 - Prior authorization for all services;
 - Prepayment review of all applicable claims;
 - Suspension of payment until a plan of correction is filed and accepted;
 - Suspension of Medicaid admissions in the case of outpatient or inpatient facilities;
 - Ban on approving admissions for inpatient services.

When deficiencies are identified within the facility that constitute an immediate danger of serious harm to the child/children served by the facility, immediate action will be taken to remove the child/children from harm. That state's surveying agency will be notified immediately of the identified deficiencies.

In those instances BMS may pursue exclusion from participation in the West Virginia Medicaid Program through the following actions:

- Suspension;
- Disenrollment;
- Denial, non-renewal, or termination of provider agreements.

Refer to [Chapter 100, General Administration and Information](#) for details regarding compliance issues.

531.1.1.15 Corrective Action Plans

Within ten working days after receipt of the request for a plan of correction, the organization shall submit to the Secretary for approval a written plan to correct all areas of non-compliance that are in violation of this rule, unless a variance is requested by the organization and granted by the Secretary. The plan shall specify:

- Any action taken or procedures proposed to correct the areas of non-compliance and prevent their reoccurrence;
- The date or projected date of completion of each action taken or to be taken; and
- The signature of the chief executive officer or his or her designee.
- The Secretary shall approve, modify or reject the proposed Corrective Action Plan in writing. The organization may make modifications in conjunction with the Secretary.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

- The Secretary shall state the reasons for rejection or modification of any Corrective Action Plan.
- The organization shall submit a revised Corrective Action Plan within ten working days whenever the Secretary rejects a Corrective Action Plan.
- The organization shall immediately correct an area of non-compliance that risks the health or safety of child or other persons.
- The Secretary may determine if corrections have been made.

Once a plan of correction has been accepted by the state educational institution, certification institution, surveying agency, licensing or certifying agency, it must be sent immediately to the following address:

**West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301**

531.1.1.16 Waivers and Variances

A center shall comply with the provisions of West Virginia Code §49-2B et seq., the requirements of this rule, terms of the license or certificate of approval and any plan of correction, unless a written waiver or variance has been granted by the Secretary. A center may not obtain a waiver of the requirements of this rule on the basis of the inability to achieve compliance with the rule.

A request for a variance shall be submitted to the Secretary in writing. The request shall include:

- The specific requirement of this rule to be waived or varied; and
- The reason or reasons for seeking a waiver or variance.

A waiver or variance of a specific provision of this rule may be granted by the Secretary only if the following criteria are met:

- The center has documented and demonstrated that the provision of the rule is inapplicable in a particular circumstance, or that the center complies with the intent of the provision in the rule in a manner not permitted by the rule;
- The health, safety, and well-being of a child is not endangered; and
- The waiver or variance agreement contains provisions for a regular review of the waiver or variance;
- The waiver or variance agreement is subject to immediate cancellation if the center fails to comply with the stated terms of this rule.

531.1.1.17 Notice to BMS and Legal Guardian/Parent of Adverse Action

PRTF's are required to inform BMS within 72 hours of all deficiencies noted by any state educational institution, certification institution, surveying agency, licensing agency or any other state certification entity. Deficiencies include standard and complaint investigations.

The written notification and a copy of any notice, survey, or complaint may be sent to, Attention: Office Director, for Facility Based and Residential Care. Reports must be mailed to:



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301

When there is an adverse review of a facility that identifies moderate potential for harm or direct harm, termination of certification or a provider agreement, the facility must notify all West Virginia Medicaid members legal guardian/parent by regular mail within 72 hours of receipt of the deficiencies or termination notice. A copy of the letter of notification must be included in the West Virginia Medicaid member record.

531.1.2 MEDICAL ELIGIBILITY/MEDICAL NECESSITY

The West Virginia DHHR, BMS, utilizes a Utilization Management Contractor (UMC) to certify West Virginia Medicaid member medical necessity for admission and continued stays in all PRTF's. BMS is not financially responsible for reimbursement of a West Virginia Medicaid member who is not prior authorized for admission or continued stays in any facility by the UMC. The facility may not bill the West Virginia Medicaid member for any charges unless it is specifically documented, signed and dated that the parent/guardian is made aware and understands that West Virginia Medicaid will not reimburse for the service and the parent/guardian understands and agrees to pay for services.

PRTFs provide treatment to individuals under the age of 21 with severe emotional disturbances and/or long term psychiatric illnesses. The service must be provided before the individual reaches 21 years of age. If the individual was receiving services immediately before he or she reaches age 21, the services must cease at the time the individual no longer requires services or the date at which the individual reaches 22 years of age. (42 CFR §441.151(3)(i)(ii)).

Children in parental custody are referred to as non-custodial placements. When parents place their child in a PRTF, documentation must indicate the child has been receiving services in the community for at least **six months** with significant functional deficits in the school, home, and community except as a planned step down from acute care. Participation in the treatment process by the child and support for treatment by the parent must be documented and provided upon request for the prior authorization for services. The referring physician/psychiatrist, not affiliated with the receiving facility, must provide documentation of treatment and/or lack of response to treatment. The referring physician/psychiatrist, not affiliated with the receiving facility, must certify the need for this level of service and complete, sign and date the MCM-1 (Appendix 531.1- MCM-1). The parent retains legal custody and financial responsibility for expenses related to treatment, supervision, room and board, education, etc. not covered by medical insurance/Medicaid. The child must meet all other admission criteria set forth for PRTF level of care also (see admission criteria).

531.1.3 SERVICE PROVISION

PRTFs provide a range of comprehensive services to treat the psychiatric condition of members on an inpatient basis under the direction/order of a physician/psychiatrist. The purpose of such comprehensive services is to provide treatment to individuals under age 21 with severe emotional disturbances and/or long term psychiatric illnesses. Symptoms are complex and of a significant duration, that have not responded to shorter-term interventions and/or community based interventions. Psychiatric care is provided to individuals under the age of 21 that do not require acute psychiatric care, but whose



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

immediate treatment needs require active treatment on a 24 hour inpatient basis to attain a level of functioning that allows subsequent treatment in a less restrictive setting. PRTF services are generally short term (nine to twelve months) inpatient services intended to improve the West Virginia Medicaid member's condition or prevent further regression so that the services will no longer be needed. A PRTF is to provide a less medically intensive program of treatment than a psychiatric inpatient hospital or a psychiatric unit of a general hospital could provide, and must include an on grounds educational component that provides a continuum of the West Virginia Medicaid member's current grade level.

All services must be delivered under the direction and orders of a physician or a psychiatrist. PRTF services focus on the improvement of West Virginia Medicaid member's symptoms through the use of strength and evidence-based strategies which include:

- group and individual therapy
- family therapy
- behavior management
- medication management and medication monitoring
- active family engagement

Services are designed to improve and/or ameliorate the West Virginia Medicaid member's mental health or co-occurring mental health and substance abuse condition. (See Section 531.1.3.2, Admission Criteria in this chapter).

531.1.3.1 Admission

An admission occurs upon the formal acceptance by an enrolled PRTF of a West Virginia Medicaid member who has been prior authorized for admission by the West Virginia Medicaid program UMC. The day of admission is considered a day of care; the day of discharge is not considered a day of care.

PRTF services are appropriate when a West Virginia Medicaid member does not require emergency or acute psychiatric care but does require nursing supervision and meet medical necessity for treatment on a 24 hour basis. A board certified psychiatrist (experienced in child/adolescent psychiatry) or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry with admitting privileges at the PRTF must order and provide oversight for each admission.

PRTF admissions are planned and **not** an emergency admission. Admissions after 5 p.m. on Friday or on holidays require prior authorization for reimbursement for services prior to placement.

Facilities accepting West Virginia Medicaid members into treatment are permitted to accept children within age groups defined by their licensing entity. When accepting West Virginia Medicaid members under age 12, the facility must provide, at time of enrollment application, documentation regarding the ability to provide increased staffing, depending on the acuity of the child, this may be 1 on 1 staffing, etc. to provide for the younger child as well as the policy standards that address therapy, milieu effects, and supervision to ensure the prevention of the child being targeted for abuse. Facilities serving younger children must provide groupings for the child that will provide for "separation according to developmental functioning, sex, social skills, group dynamics, and other variables if appropriate and necessary. Children have the right to be housed with children of the same approximate ages, developmental levels, and social needs. This separation must be a matter of organizational policy." (78-CSR-3.14.12, Groups and



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

Groupings 14.12.b.) The facility must also describe their process to provide educational requirements necessary to serve the younger child.

West Virginia Medicaid members under the age **nine** are not to be placed in an out-of-state PRTF unless there is documentation provided indicating this is the only alternative available for the child because alternative resources have been explored and are not available in state and if the placement is not made the safety/well-being of the child is at risk.

For each West Virginia Medicaid member admitted to a PRTF facility a MCM-1 must be completed by the referring physician/psychiatrist, with no affiliation to the receiving facility, certifying the need for this level of care. A copy of the MCM-1 must be submitted to the UMC along with a request for authorization for admission to the facility. The original signed/dated MCM-1 must be part of the West Virginia Medicaid member record at the receiving facility and must be available for review immediately upon request. The signed/dated MCM-1 is effective for a period of 30 days prior to the request for prior authorization for admission. If prior authorization is not requested within 30 days of the physician's/psychiatrist's signature and date, a new MCM-1 will be required for prior authorization for admission. Prior authorization for admission to the PRTF is effective for 10 days. If the child is not placed within the facility within the 10 day period, a new authorization is required. Children entering care utilizing private medical insurance with the prospect of obtaining a West Virginia Medicaid Card for reimbursement after the insurance has expired are required to have an MCM-1 signed prior to admission to the facility.

The UMC reviews all requests for admission to and continued stay requests in all approved and enrolled PRTF's. The role of the UMC is to determine the medical necessity of PRTF services for child/adolescent members with psychiatric diagnoses, the appropriateness of a particular PRTF setting for each West Virginia Medicaid member, and the number of days reasonably required to treat a child/adolescent's condition.

The following information must be included in the admission packet:

- a. Immunization records (See also Section 531.1.4.3 on Physical Health Services);
- b. Court order(s) if applicable;
- c. Birth Certificate;
- d. Social Security card;
- e. Insurance information/Copy of West Virginia Medicaid Card;
- f. MCM-1; and,
- g. School records, including special education records (where applicable).

531.1.3.2 Admission Criteria

Admission to a PRTF facility requires the West Virginia Medicaid member meet following criteria:

1. West Virginia Medicaid member is under the age of 21 and has a diagnosed DSM IV-TR mental health or a co-occurring mental health and substance abuse condition (42 CFR §456.180). A diagnosis of substance abuse alone will not constitute medical necessity for an admission to a PRTF, **and,**
2. Severe to acute psychiatric symptoms manifested from the qualifying diagnosis or condition. The severity of these symptoms contraindicate treatment at a lower level of care safely occurring **and,**



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

3. Severe functional impairment due to psychiatric diagnosis, in three or more major life domains (school performance, family relationships, interpersonal relations, communication/thought processes, self-care, and community) is documented. Youth's impairments are determined in comparison to same age peers/developmental age, and,
4. Failure in less restrictive levels of care within the past six months, despite active participation in treatment based on clinical pathways addressing their qualifying condition, except as a planned step down from acute care. (Clinical pathways are standardized, evidenced-based, multidisciplinary management plans, which identify an appropriate sequence of clinical intervention, time frames, milestones and expected outcomes.) and,
5. Individual demonstrates the ability capacity to positively respond to treatment services. Child can participate and process information as evidenced by an appropriate IQ for the program to which they have been admitted unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.

When an admission is denied by the PRTF, the facility must notify the referral source of the reason(s) for the denial within 72 hours. The PRTF must keep a log of all denial notifications for review by UMC. If placement is denied because medical necessity is not established, the UMC will notify the referral source, the facility, and the parent/guardian of the denial and the appeal process rights. Refer to Chapter 100, General Administration and Information, for additional information on the appeals process.

531.1.3.3 Resident Rights and Responsibilities

Upon admission to the PRTF, staff must provide the West Virginia Medicaid member and parent/guardian with a statement of rights and responsibilities which must cover at a minimum:

- The member's right to access treatment regardless of race, religion, or ethnicity;
- The member's right to recognition and respect of personal dignity in the provision of treatment;
- The member's right to be provided treatment and care in the least restrictive environment possible;
- The member's right to an individualized treatment plan;
- The member and family's right to participate in planning for treatment;
- A description of care, procedures, and treatment the member will receive;
- The member's right to informed consent related to the risks, side effects, and benefits of all medications and treatment procedures used; and
- The right, to the extent permitted by law, to refuse the specific medications or treatment procedures and the responsibility of the facility if the member refuses treatment.

Discipline measures must be fully explained to each West Virginia Medicaid member and the member's parent/guardian. PRTF's must prohibit all cruel and unusual disciplinary measures including the following:

- Corporal punishment;
- Forced physical exercise;
- Forced fixed body positions;
- Group punishment for individual actions;
- Verbal abuse, ridicule, or humiliation;



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

- Denial of three balanced meals per day;
- Denial of clothing, shelter, bedding, or personal hygiene needs;
- Denial of access to educational services;
- Denial of visitation, mail, or phone privileges for punishment;
- Exclusion of the West Virginia Medicaid member from his/her assigned living area; and
- The use of restraint or seclusion as a punishment or implemented for the convenience of staff.

531.1.3.4 Interstate Compact on the Placement of Children (ICPC)

All approved admissions to out-of-state facilities require the completion of Interstate Compact on the Placement of Children (ICPC) prior to the placement. In every state, the Compact office and personnel are located in an office that is part of the department of public welfare or the state's equivalent agency. In West Virginia, the Compact Administrator is the Commissioner of BCF. All out-of-state placements (DHHR custody and non-custodial placements) into PRTF's require approval prior to placement. Non-custodial placements require a signed/dated Statement of Assurance indicating the parent/guardian retains legal and financial responsibility for the child while in placement. The Statement of Assurance is kept by the ICPC office as part of the ICPC record.

531.1.3.5 Assessment

The initial assessment contains information concerning the child's initial treatment needs. Information will come from referral packets, intake information, family members, previous placements, and information forwarded in the referral packet.

The assessment process must be initiated within 24 hours of admission. The initial treatment plan completed within 72 hours of admission and will document minimally one primary treatment goal/problem listed on the MCM-1. A more comprehensive treatment plan in the first 14 days after admission to a PRTF must document the need for the PRTF level of care by the Multidisciplinary Team (42 CFR §441.155(b)(1)). The assessment process must include, but is not limited to, the following:

- A psychiatric evaluation;
- A medical history and examination;
- A psychosocial assessment which includes a psychological profile, a developmental profile with a validity statement;
- A behavioral assessment;
- An assessment of the potential resources of the West Virginia member's family (42 CFR §441.156(b)(2));
- A Child and Adolescent Needs and Strengths (CANS) assessment, or other nationally recognized functional assessment;
- An educational evaluation;
- A nursing assessment;
- A nutritional assessment; and,
- An occupational/physical/speech assessment as indicated.

The facility will maintain a policy to ensure the transfer of educational records, information, and individual support when a West Virginia member enters the PRTF within seven days of admission. The transfer of



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

records from one school to another is vital to proper and prompt placement in a new school system. The facility will obtain and review previous educational records for each student prior to admission to the facility. West Virginia members who require special education services must be identified, and the facility must ensure that those services are provided according to the rules and regulations of the West Virginia Department of Education.

Upon admission, an academic assessment must be administered by a qualified instructor that measures (at a minimum) math, reading, and written expression skills. A nationally recognized vocational assessment must be administered to any student at least 14 years of age who has not been previously assessed.

531.1.3.6 Treatment Planning

The treatment planning process is a collaborative process through which the members of various disciplines jointly develop a comprehensive, individualized plan for the treatment of each member. Providers must provide services in accordance with an individualized treatment plan under the direction of a physician/psychiatrist. The treatment plan charts a course designed to help the member move to a less restrictive level of care as quickly as possible. (42 CFR §441.154(b)) The activities included in the service must be intended to achieve identified treatment plan goals and objectives and be designed to achieve the beneficiary's discharge from inpatient status at the earliest possible time. Services to be provided must be in accordance with 42 CFR Sections §441.154 through §441.156.

The treatment plan process begins within 24 hours of admission with implementation of the initial assessments/interviews defined above. A preliminary treatment plan must be completed within 72 hours of admission and will document minimally one primary treatment goal/problem, the member's treatment schedule, and preliminary treatment goal objectives. A more formalized initial treatment plan must be developed and implemented no later than 14 days after admission to the facility. The treatment plan document must contain evidence of the member's and his/her parent/guardian's active participation in the treatment planning/review/revision process. The multidisciplinary treatment team will meet to staff each member and review/revise his/her treatment plan as often as necessary to provide optimum treatment but at least once during the first 14 days following admission and monthly (30 days) thereafter. The West Virginia Medicaid member will participate to the maximum extent feasible in the development of the treatment plan. Participation (or lack of participation) by the member and the family in the treatment planning process must be documented in the member's record. Repeated failure to participate after attempts to engage must be documented in the member record.

531.1.3.7 Treatment Team Composition

The individual plan of care under (42 CFR §441.155) must be developed by the multidisciplinary team of physicians/psychiatrists and other personnel who are employed by, contracted by, or provide services to member's, in the facility.

Based on education and experience, including competence in child psychiatry, the team must be capable of (42 CFR §441.156(b)):

- Assessing the member's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

- Assessing the potential resources of the member's family;
- Setting treatment objectives; and,
- Prescribing therapeutic modalities to achieve the planned objectives.

The mental health treatment team must include at a minimum the following:

- A Board-eligible or Board-certified Psychiatrist (experienced in child/adolescent psychiatry);
- A Licensed Psychologist (as indicated by needs of child);
- A Registered Nurse(s);
- A Psychiatric social worker(s), LPC;
- A Certified Teacher(s); and,
- An Occupational/Physical/Speech Therapist (as indicated by needs of child).

531.1.3.8 Treatment Team Development

The treatment plan delineates all aspects of the West Virginia Medicaid member's treatment and includes, at a minimum: (42 CFR §441.156):

- A multi-axial diagnosis,
- An assessment of the member's immediate therapeutic needs;
- An assessment of the member's long-range therapeutic needs;
- An assessment of the members' personal strengths and liabilities;
- Identification of the clinical problems that are to be the focus of treatment;
- Measurable and realistic treatment goals for each identified problem;
- Observable, measurable treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement;
- Specific treatment modalities and/or strategies that will be employed to reach each objective, e.g. psychotherapy (individual, family, group), medication, behavior modification programs, etc.;
- Special procedures (i.e. those providing for the seclusion or restraint of a West Virginia Medicaid member) must not be included in the treatment plan unless justified by evidence (current or historical) of aggressive behavior which cannot be controlled by less restrictive interventions. If special procedures become necessary, the treatment plan must be amended or modified within one working day of the first incident to reflect the use of the least restrictive necessary measures;
- The clinician identified as responsible for each aspect of treatment;
- Identification of goals, objectives and treatment strategies for the family as well as the member, and identification of the clinician responsible for treatment;
- When a continued stay at the facility is needed, it is the responsibility of the member's Multidisciplinary Treatment Team and the Clinical Director to establish that the requirements for a continued stay have been met;
- An individualized discharge plan that includes:
 - Discharge criteria, indicating specific goals to be met, and
 - An estimated discharge target date.
- Prior to discharge the discharge plan must also include an aftercare plan that addresses coordination of family, school/vocational and community resources to provide the greatest possible continuity of care for the member. ("at an appropriate time") (42 CFR §441.155(b)(5)).



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

The member's treatment plan must include a specific strength-based family integration/reintegration treatment plan when appropriate. It must also include guidelines for family participation while the member is at the facility. These family participant guidelines must contain frequency of family visits, whether visits are supervised, and location of visitations. Family counseling and family visits must not be contingent on the West Virginia Medicaid member's behavior.

531.1.3.9 Treatment Plan Review and Revision

The treatment team reviews and revises the treatment plan for each West Virginia Medicaid member as often as necessary to provide optimum treatment but must meet at least once during the first 14 days following admission and monthly (every 30 days) thereafter. (42 CFR section §441.155(c))

The treatment review team will assess the member's progress in treatment by:

- Documentation of treatment successes/failures (which objectives and/or goals have been achieved and when) and explaining treatment outcomes;
- Documenting changes in the treatment plan as needed;
- Documentation of the re-assessment of the member's need for continued residential care, as opposed to less restrictive treatment, and;
- Documentation of the member's measurable progress towards discharge, reviewing/revising the discharge criteria and/or target date as needed.

531.1.4 ACTIVE TREATMENT

Inpatient psychiatric services must involve "active treatment," (42 CFR §441.154), which means implementation of a professionally developed and supervised individual plan of care, described in 42 CFR §441.155 that is;

- a) Developed and implemented no later than 14 days after admission;
- and
- b) Designed to achieve the member's discharge from inpatient status at the earliest possible time.

Active treatment: The use of the term "treatment" in this manual refers to the active treatment of the West Virginia Medicaid member. Active treatment is a process comprising:

- Multi-disciplinary diagnostic assessment;
- Interdisciplinary treatment planning;
- Therapeutic intervention;
- Treatment evaluation/revision;
- Discharge/aftercare planning, and;
- Provision of Educational services in an on grounds school.

531.1.4.1 Mental Health Services

Psychotherapy is defined as the intentional, face to face interaction (verbal and/or non-verbal encounters) between a mental health professional and a client (an individual, family, or group) in which a therapeutic relationship is established to help resolve symptoms of the member's mental and/or emotional



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

disturbance. It is required that all individual therapy, family therapy and group therapy must be provided by master's level therapists.

- **Individual therapy** is defined as psychotherapy that takes place between a mental health therapist and a member. A minimum of one hour of individual therapy must be provided each week unless its contraindication is documented in the treatment plan. It is required that providers of individual therapy must be a master's level therapist.
- **Family therapy** is defined as psychotherapy that takes place between a mental health therapist and a member's family or guardian, with or without the presence of the member. If a member is in the custody of the Department of Health and Human Services (DHHR), family therapy may also include, DHHR representatives, foster family members acting *in loco parentis*.

Each member's family, guardian, or person acting *in loco parentis* must participate in family therapy at least twice a month unless its contraindication is documented in the treatment plan. If the Medicaid member's family is more than a two hour drive from the PRTF, one face-to-face family therapy session and one therapeutic conference call will be acceptable. Both of these contacts must be therapeutic in nature, (i.e. to discuss the member's functioning, treatment progress, goals and objectives). Social visits or phone calls are not considered family therapy.

Members who are in the custody of the Department of Health and Human Services (DHHR) should complete one face-to-face family therapy session at the PRTF facility and complete the second family therapy session via telephone. In the case of non-custody placements, the facility is required to make every effort to accommodate the member's family in therapy sessions. Documentation of attempts and the family's ability to participate or noncompliance with attempts to involve the family must be recorded in the member's record and available for review.

It is required that providers of family therapy will be master's level therapists.

- **Group therapy** is defined as psychotherapy that takes place between a mental health therapist and at least two but not more than twelve members at the same time. Groups of more than 12 participants are allowed if the primary therapist for the group is assisted by a co-leader. Group co-leaders are not required to be master's level therapists. Possibilities for groups include, but are not limited to, those which focus on relaxation training, anger management and/or conflict resolution, social skills training, self-esteem enhancement, etc.

Each member must participate in a minimum of three hours, each week unless contraindication is documented in the treatment plan. The manner in which services are delivered (length, frequency, and timing of sessions) should be determined by what is developmentally appropriate for each member. It is required that providers of group therapy must be master's level therapists although larger groups (more than 12 participants) may be co-led by a person with a lesser level of training.

- **Milieu therapy** is defined as residential psychiatric treatment that occurs in the total environment of the closed setting, also referred to as the "therapeutic community." Emphasis is placed on clear, healthy, respectful communication between member/member, staff/staff, and staff/member,



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

and on shared problem-solving and decision-making. The entire environment, not just the limited time spent with an identified therapist, is considered vital to the treatment process.

One essential component of milieu therapy is the community meeting. This is a time when all members and most, if not all, professional and direct care staff meet together to discuss and solve problems that arise in community living, make community decisions (i.e. planning recreational activities for the group, etc.), set goals, and resolve conflicts. More than on community meeting may be held during the day. As a group function, participation and outcomes of the group must be documented.

Milieu therapy must be available.

- **Occupational/Physical/Speech Therapy** is defined as the use of purposeful activity, designed and guided by a qualified professional, to help the member achieve functional outcomes that promote the highest possible level of independence. Occupational therapy must be provided by an Occupational Therapist Registered (OTR).

531.1.4.2 Therapeutic Behavior Management

Behavioral Management Services are specific activities that have been planned and tailored to eliminate inappropriate (maladaptive) behaviors and to increase or develop desired adaptive behaviors for an individual member. These services result from areas of need identified on the member's service plan. Behavior management is a time-limited service that must end when the desired outcomes have been achieved (i.e., targeted behaviors have been acquired or eliminated).

The use of behavior management interventions, (e.g. time out, behavioral contracts, point systems, logical and natural consequences, incentive programs, level systems, positive behavioral reports, etc.) with members must be guided by policies and procedures developed by the facility. Policies must indicate the intent to maintain a safe, nurturing, and therapeutic environment that protects the rights of all members and that respects the ethnic, religious, and identified treatment parameters for each individual member in care. Policies must comply with DHHR licensing rules and applicable state/federal statutes and generally accepted best practice standards promulgated by national accreditation organizations.

Therapeutic Behavioral Services - Development includes four major components:

- Behavior Assessment
- Plan Development
- Implementation Training
- Data Analysis and Review of the Behavior Management Plan after implementation

Therapeutic Behavioral Services - Implementation is an integral component of Behavior Management services (refer to *Chapter 503, Behavioral Health Rehabilitation Services.*)

531.1.4.3 Physical Health Services

PRTF facilities must provide physical health services as part of their treatment of West Virginia Medicaid members. Physical health services may be provided directly by the facility or may be provided by a



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

vendor outside the facility. Physical health services must be addressed on the member treatment plan and must include:

- Assessments and evaluations as required in (42 CFR §441.155(b)(1)).
- Diagnosis, treatment, and consultation for acute or chronic illnesses occurring during the West Virginia Medicaid member's stay at the facility or for problems identified during an evaluation.
- Preventative health care services to include periodic assessments in accordance with the periodicity schedule established by the American Academy of Pediatrics.
- Completion of immunizations if a West Virginia Medicaid member's immunization is not complete.
- Routine medical care for all West Virginia Medicaid members (i.e. care during outbreaks of flu, non-complicated lacerations, scrapes, burns, etc.)
- Dental examination within six months of admission with periodic screenings. If the West Virginia Medicaid member has dental work that is ongoing (i.e. braces) the treatment plan must include plans to ensure the necessary follow-up dental care/exams are completed as needed.
- Speech, language and hearing services to meet the identified needs of the West Virginia Medicaid members.
- Vision screening and follow-up as indicated.

If physical health services are provided outside the PRTF, the facility must track:

- The referral of West Virginia Medicaid members;
- Qualifications of staff providing services;
- Exchange of clinical information must be provided.

531.1.4.4 Pharmacy Services

Medication is an important cornerstone of psychiatric treatment. Documents pertaining to this aspect of treatment (patient/family education and consent, medication orders, administration, monitoring) must be accurate, readily located and available for review. When medication is a prescribed intervention for a problem identified in the member's treatment plan, it must be noted as such in the treatment plan. When medication changes are made, they should be made during treatment planning meetings whenever possible. When circumstances preclude this, the changes must be reviewed for all team members' updated at the next available staffing opportunity.

Psychotropic medication must be used only as one component of a total therapeutic program, and the diagnosis and projected/targeted behaviors must be included in a written treatment plan. Psychotropic medication must not, under any circumstances, be prescribed or administered for the purposes of program management control, for discipline or punishment reasons, for convenience of staff, or for experimentation or research purposes.

A facility director or designee must provide pharmaceutical services as outlined in (42 CFR §483.60) to accurately and safely provide or obtain pharmaceutical services, which include the provision of routine and emergency medications and biologicals and consultation of a licensed pharmacist, in order to meet the needs of its members. The facility director or designee shall ensure the development and implementation of written procedures based on policies approved, signed and dated, by the governing body, related to the provision of pharmaceutical services, including procedures that assure the accurate acquisition, labeling, receipt, dispensing and administration of all medications and biologicals. The facility



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

director or designee shall assure that pharmaceutical services are provided in accordance with this rule and all other applicable federal, state and local laws and the rules of the states' Board of Pharmacy. The facility director or designee must employ or contract the services of a Licensed Pharmacist who is licensed to practice in the state in which the facility is located and is currently registered as a consultant pharmacist with the states' Board of Pharmacy. A pharmacist providing pharmacy consulting services in a PRTF must comply with all applicable federal, state and local laws and the rules of the state's Board of Pharmacy. In review of best practice, the consultant pharmacist must not be an employee of the pharmacy servicing the facility and operate independently as a consultant.

The consultant pharmacist must review the medication regimen of each member once a month or more frequently based on the member's needs. The consultant pharmacist must document the results of each member's medication regimen review in the member's medical record. The medication regimen review must include substances that are regarded as herbal products or dietary supplements. The consultant pharmacist must report any irregularities in the medication regimen review along with documented recommendations to the clinical director and the psychiatrist. The PRTF's pharmacist consultant must be available to advise the PRTF staff regarding questions or concerns. The consultant pharmacist recommendations must be reviewed within seven days by the psychiatrist with changes made in the medication regimen. If the decision is not to follow the recommendations, the psychiatrist must document the decline on the same form as the recommendations with signature and date of decision.

Drugs and biologicals used in the PRTF must be labeled in accordance with the requirements of federal, state and local laws, rules and regulations. The labels must include the appropriate accessory and cautionary instructions with the expiration date and time to be administered per physician's/psychiatrist's order. All over the counter medications must have the date opened and initiated by the employee administering the medication.

In accordance with state and federal laws, the facility director or designee must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility director or designee must provide separately double-locked, permanently affixed compartments for the storage of drugs subject to abuse and controlled drugs as identified by federal regulations. The PRTF may also use single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

The facility director or designee and the dispensing pharmacy must maintain prescription records in accordance with state and federal laws, and provide such prescription records upon request by the West Virginia Medicaid agency or its representatives.

531.1.4.5 Consent for Medication

When medications are prescribed or changed, a member of the professional staff will review with each member's parent/guardian and document in the medical record the following information:

- The name/class of medication;
- The method of administration (oral, injection, etc.);
- The symptom(s) targeted/expected outcomes;
- Possible side effects of the medication;
- Possible long-term effects of the medication;
- Treatment alternatives;



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

- Likely outcomes of using/not using the medication.
- The minimum and maximum dose to be administered.

When a face-to-face encounter cannot be held with a parent/guardian prior to starting a medication regimen, the "informed consent" conference may be held by telephone, with the parent/guardian's responses noted and dated. This form must be signed by the parent/guardian within 30 days after the telephone consent is obtained. The PRTF professional staff must document this telephone consent obtained with one witness signature/date on the form after talking with the parent/guardian. Documentation regarding the parent's verbal consent must be located in the member record. Documentation of efforts to obtain the above signature must also be contained in the member record if the parent fails to return the form within the 30 day period.

Documentation that the education was presented and consent to proceed must be provided when parents/guardians are informed of all drugs being prescribed off-label (diagnosis not approved by the FDA, dosage outside the FDA guidelines, or if the drug has not been approved for the age of the West Virginia member). Decline in consent by the parent/guardian must be documented along with physician/psychiatrist notification.

531.1.4.6 Administration of Medication

Only licensed professionals may administer medications to WV Medicaid members. Examples of licensed staff include physicians, physician assistants, nurse practitioners, registered nurses and licensed practical nurses. No unlicensed or certified individual may administer medications to West Virginia Medicaid members in a PRTF facility, regardless of whether they are certified to do so by the state where the PRTF facility is located or are supervised by a professional staff member when administering medications.

Documentation must substantiate that medications have been accurately administered in accordance with the physician's or other licensed practitioner's orders. Any variances must be justified in the record by licensed medical staff. A Medication Administration Record (MAR) for monitoring medication side effects must be identified and includes all medications that are routinely administered to each member who is prescribed medication and will have documentation review by the psychiatrist upon admission, as medically necessary and at least every 30 days during his/her stay, and again at discharge.

"Standing Order PRN medications" are not permitted. Over the counter medications (PRN's), for each member must be prescribed for the member by a physician with prescribing privileges, with clear indications for use and start and stop dates for each medication prescribed.

531.1.4.7 Medication Errors

Medication errors will be tracked and quantified as part of the continuous quality improvement program of BMS to ensure that children in DHHR custody and non-custodial placements are receiving the best care possible.

Medication errors will be analyzed in terms of the type of error (e.g., wrong dose, omission, wrong time, etc.) and the severity of the error. All documentation related to medication errors will be readily available upon request by BMS.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

The physician/psychiatrist must be notified immediately of a medication error and the physician/psychiatrist order (if any) be obtained by nursing personnel or the physician/psychiatrist themselves.

531.1.4.8 Dietary Services

The PRTF must have written policies and procedures approved by the governing body for the provision of dietetic services for members. Adequate staff, space, equipment, and supplies must be provided for safe sanitary operation of the dietetic services, the safe and sanitary handling and distribution of food, the care and cleaning of equipment and kitchen area, and the washing of dishes. Nutritional aspects of member's care will be planned, reviewed, and periodically evaluated by a qualified dietician. Food must be served to members and staff in a common eating place and:

- Must account for the special food needs and tastes of members;
- Must not be withheld as punishment, and;
- Must provide for the special dietary needs of each member.

At least three meals per day must be served with no more than a 15 hour span between the substantial evening meal and breakfast. The facility must arrange for and make provision for between-meal and unscheduled snacks.

531.1.4.9 Visitation with Parents and Extended Family

Visitation arrangements must be agreed upon as soon as possible after placement of the child and documented in the member's record. These arrangements must be made in agreement with the family/guardian, the residential facility and the member's DHHR caseworker. Any restrictions on visitation arrangements by the DHHR caseworker or the court must be noted in the member's treatment plan. All visits will be coordinated through consultation with the parent/guardian and the member's DHHR caseworker.

The facility must design and implement services in a manner that supports and strengthens family relationships and empowers and enables parents and family members to assume their roles. When a member's presenting problem affects or is affected by a member's family, the facility will provide coordination of social services to children, adults, and families that may be necessary to achieve family reunification, stabilize family ties, or obtain a permanent family for a member receiving out-of-home care. The family of a member in out-of-home care is expected to participate in making case plans, is kept advised of ongoing progress, and is invited to case conferences. When a member is in out-of-home care, the agency fully involves the family or individuals identified in the permanency plan as permanency options with a focus on timely permanency as the primary goal. The facility cannot deny visits, telephone calls, or mail contacts with a DHHR approved family. The facility is responsible for coordinating visitation with the member's family including provision of transportation as available to enable the visitation to occur.

In instances of non-custodial placement, transportation arrangements must be made with the facility, and the parent involved to ensure that the visitation does take place. Non-Emergency Medical Transportation



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

(NEMT) **cannot** be used to transport the child to a facility located out of- state. The use of NEMT to transport a parent to the facility for visitation with the child is **not** a covered service.

531.1.4.10 Life Skills

Facilities providing care to members has the responsibility to help them develop into self-sufficient adults. In addition, all facilities and individuals who provide substitute parental care for members are charged with helping to ensure that their social, emotional, and intellectual development is achieved to each member's highest potential.

The facility must ensure that all adults entrusted with the care of West Virginia children and youth demonstrate appropriate social behavior; respond properly to stressful situations; and promote good physical, emotional, and intellectual well-being. It is through the observation of positive adult behavior and through interaction with positive adult role models that children and youth develop and demonstrate positive attributes.

531.1.4.11 Therapeutic Leave

Therapeutic leaves are a necessary and integral part of a member's treatment. Therapeutic leaves allow for an evaluation period to determine the member's ability to adjust to the transition back into the home setting and/or to a lesser level of care facility. Therapeutic leaves of absence would occur when clinically appropriate, particularly toward the end of a member's placement to ensure adequate transition into the family/foster family home. A therapeutic leave day is defined as a day of absence when the member spends a night away from the PRTF without support from direct staff. The maximum allowable and reimbursable therapeutic leave days (absences) per PRTF shall be limited to eight (8) days per calendar year.

The medical record must contain a physician's/psychiatrist's order for therapeutic leave, the date and time of the beginning of the therapeutic leave, and the date and time the member returns to the PRTF. For therapeutic leave, the date the member leaves the PRTF is counted as a leave day and the day the resident returns to the facility shall not be counted as a leave day.

Documentation must include:

- The date/time of check-out
- The required time of return
- The name(s) of the person(s) with whom the leave will be spent
- The member's physical/emotional condition at the time of departure (including vital signs)
- The types/amounts of medication being provided and instructions (in lay terms) for taking them
- Therapeutic goals for the leave. Goals must relate to the goals established in the treatment plan.
- The name and signature of the person with whom the member is leaving
- The signature of the staff person checking the member out.

Documentation upon return must include:

- The date/time of check in



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

- The member’s physical/emotional condition at the time of return (including vital signs and notation of any physical injury or complaint)
- Whether or not any contraband was found
- The types/amounts of medication being returned, if any, and explanation of any missed doses
- An explanation of any early return from leave
- A brief report on the outcome of the leave by the parent or guardian (were therapeutic goals achieved? Was the member’s behavior appropriate?)
- The name and signature of the person returning the member to the facility
- The signature of the staff person checking the member in
- An assessment of the outcome of the leave must be documented by the member’s therapist within seventy-two (72) hours of the member’s return from leave.

531.1.4.12 Billing and Reimbursement for Therapeutic Leave

The following revenue codes are to be utilized to bill Therapeutic Level:

REVENUE CODE	CODE DESCRIPTION
0183	Leave of Absence - Therapeutic
0185	Leave of Absence - Hospitalization

531.1.5 CONTINUING STAY CRITERIA

When West Virginia Medicaid members are prior authorized for PRTF admission by the UMC, they are authorized a limited number of days for that admission. It is the PRTF’s responsibility to help the member accomplish treatment goals within that time frame or to justify to the UMC why a longer stay should be prior authorized. When a continued stay is needed, it is the responsibility of the member’s Multidisciplinary Treatment Team and the Clinical Director to establish that the requirements for a continued stay have been met.

No later than seven days prior to the end of a member’s authorized stay, the treatment team must have;

- developed a detailed discharge/aftercare plan for the member;
- or
- applied to the UMC for additional treatment time.

In reviewing requests for extended treatment, the UMC reviews the appropriateness and quality of the member’s ongoing treatment as planned, provided, evaluated, revised and documented by the treatment team.

The following criteria must be met in order for a continued stay prior authorization:

- Individual is still under the age of 21 and has a confirmed DSM IV-TR mental health or co-occurring mental health and substance abuse diagnosis,
 and

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

- Psychiatric symptoms manifested by the qualifying diagnosis or conditions continue to be severe and/or complex and the severity of the symptoms contraindicate treatment occurring safely at a lower level of care. The treatment plan has been modified to address barriers to achieving goals,
or
- New symptoms have emerged or previously unidentified symptoms have manifested that require continued treatment and the severity of symptoms contraindicate treatment occurring safely at a lower level of care,
and
- Multiple symptoms and functional impairments due to psychiatric diagnosis continue to be present despite progress being documented,
and
- Individual and/or family continues to be actively engaged and participating in the care plan.

When discharge problems arise because of the lack of an appropriate placement for the member (ex: unsuitable family environment, foster home unavailability, no group home vacancies), it is the responsibility of the PRTF, together with the party having legal responsibility of the member, to locate and/or arrange an appropriate placement. **The lack of post-discharge options alone will not be considered a valid basis for continued PRTF stay.** The discharge process begins on the day of admission and must be finalized at a minimum of seven days prior to discharge.

531.1.6 DISCHARGE

Discharge planning begins during the intake and placement process, for the member. When plans for the member are being developed with the member and the family, discharge plans are made, and continue as part of ongoing discussion throughout placement. After determining a tentative date for discharge, the multi/interdisciplinary treatment team is responsible for developing and implementing the discharge plan within the projected time frame. This may involve preparing the family for reunification, preparing a foster/adoptive family for the placement, coordinating the member's enrollment in the appropriate education program, keeping the group care facility informed of the plan, informing the member of the plan, or helping the member prepare for emancipation.

Discharge criteria would indicate that the symptoms and functioning have improved and a lower level of care can be safely provided or that a higher level of care is required to meet the member's needs.

Discharge planning is also initiated when the member's treatment plan goals and objectives have been substantially met and the discharge plan with appropriate, realistic and timely follow-up care is in place. When the care being provided at the facility no longer meets medical necessity, the member is discharged.

Discharging also occurs when the member is not making progress toward treatment goals despite persistent efforts to engage him/her and there is no reasonable expectation of progress at this level of care related to their psychiatric condition nor is it required to maintain the current level of functioning. The discharge plan must also include an aftercare plan that addresses coordination of family/legal representative, school/vocational and community resources to provide the greatest possible continuity of care for the member "at an appropriate time." (42 CFR §441.155(b)(5)) The plan's content will include, but not be limited to:



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

- The planned discharge date;
- The date of the member's admission and discharge;
- The name of the person/agency expected to assume care and custody of the member;
- The physical location/address where the member is expected to reside; and,
- A list of the member's psychiatric diagnoses.

At the time of the member's discharge from the facility, the PRTF will provide the parent/guardian with:

- A written copy of the final aftercare plan;
- A supply of all current medications prescribed for the member, equal to the amount already stocked for that member by the PRTF but not less than a seven day supply; (When dispensing to a Long Term Care Facility, if the medications are not in the hands of the patient, they have reduced labeling requirements. If they are to be able to be taken home, the pharmacy would have to do full labeling. That would have to be spelled out for the pharmacy ahead of time so they can make sure any unit dosing system or unit of use system they are using to dispense would be able to do full labeling on the packaging, etc. if the patient is only to be gone one or two doses (That are unit dose packed) the nurse might give to caregiver with time instructions. Otherwise pharmacy must re-label to contain instructions for use.);
- Prescriptions for a 30 day supply of all medications prescribed for the member; and,
- Documentation of communication between the facility physician/psychiatrist and the community physician/psychiatrist assuming responsibility for the ongoing treatment to discuss the member's treatment plans while in the facility as well as the discharge plan.

The PRTF will seek the parent's/guardian's consent to release copies of the member's educational summary and recommendations to the member's school. When this consent is obtained, the educational information must be mailed to the member's school within one week following the member's discharge.

The PRTF must not send the member's complete aftercare plan, but must provide only information pertaining to education.

The PRTF will seek the parent/guardian's consent to release copies of the member's aftercare plan and discharge summary to the providers of follow-up mental health services. When this consent is obtained, copies of the aftercare plan and discharge summary must be mailed to the mental health aftercare provider within two weeks following the West Virginia member's discharge.

531.1.6.1 Emergency Discharge

Occasionally an emergency discharge/exit from a PRTF that are not in accordance with the West Virginia Medicaid member's case plan, are unavoidable. The facility must provide the West Virginia Medicaid member's caseworker with at least 72 hours' notice of discharge; parent/legal guardian notification must occur immediately when the decision is made. Upon receipt of such notice, the worker will begin locating and developing an alternative placement that is appropriate for the West Virginia Medicaid member's current and immediate situation and needs. The facility must work with the parent/guardian to ensure a safe and appropriate discharge is available to the non-custodial West Virginia Medicaid member and the member's family.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

If the member is discharged for medical reasons (i.e., medical needs not provided by the facility such as surgery, etc.), the parent/guardian must obtain a new MCM-1 and make a request for prior authorization for services prior to re-admission to the facility. The child must meet all other admission criteria set forth for PRTF level of care (see admission criteria).

There must **not** be any instance when a West Virginia Medicaid member is discharged immediately for his safety or the safety of others while the member is placed in a PRTF. The facility is required to provide sufficient staffing 1:1 if necessary to allow for a safe and appropriate discharge.

531.1.6.2 Elopements/Run Away

A member is considered in elopement/run-away status if the West Virginia Medicaid member leaves without authority/supervision. If the member is under the age of 12 or is a member with mental or physical issues that, without supervision may pose a child safety or community safety risk, the elopement/run-away incident is reported immediately. As soon as staff determines that a member has eloped/run-away from the facility that person will immediately call the local law enforcement agency and law enforcement may choose to enter the member into the National Crime Information Center (NCIC) data base. Members in custody as a status offender or with child abuse/neglect issues may be listed by local law enforcement as a Missing Person. The facility will notify the parent/guardian immediately. A member charged with juvenile delinquency must be reported to local law enforcement. Members in custody as an adjudicated juvenile delinquent may be listed by local law enforcement as a Wanted Person. A complete incident report form must be initiated to include the time of discovery along with all processes implemented to assist with locating and returning of the member to the facility and the outcome.

Reimbursement is not available when a child has eloped or is missing and is not in residence at the facility for more than 24 hours.

In cases of elopement/run-away incidents where the member has a history of "repeat run-away incidents," the facility must develop a safety plan for the member in their treatment plan. Consideration should be given to the member's history of running away, safety concerns (for both the member and the community), need for additional supervision, and/or need for a more secure facility placement.

Upon the return of a West Virginia Medicaid member from an elopement/run-away incident, the facility will notify the parent/guardian and law enforcement of the return so any alerts can be cancelled and documented. The incident report must have attached all written accounts of all processes implemented to assist with locating and returning the member to the facility. The documentation must contain the written account as well as written statements, names and times of all persons involved including the physician/psychiatrist.

If a West Virginia Medicaid member has been on elopement/run-away status and has missed his/her medication(s) for 48 hours or longer, the physician/psychiatrist must be notified for instructions/orders before restarting the medication(s) on the member's return to the facility.

531.1.7 DOCUMENTATION REQUIREMENTS

Documentation and record retention requirements governing the provision of all WV Medicaid services



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

will apply pursuant to Chapter 100, General Administration and Information and Chapter 300, Provider Participation Requirements of the Provider Manual.

Documentation must also include a physician/psychiatrist's order for admission, the results of the evaluation which establishes medical necessity for this level of service and the West Virginia Medicaid MCM-1. A permanent clinical record maintained in a manner consistent with applicable state and federal licensing regulations and agency record keeping policies. The clinical record is an essential tool in treatment. It is the central repository of all pertinent information about each member. It provides an accurate chronological accounting of the treatment process: assessment, planning, intervention, evaluation, revision, and discharge. Clinical records must be complete, accurate, accessible, legible, and organized. Records must contain five broad categories of information: Administrative, Assessments, Treatment Planning, Therapeutic Interventions, and Medications. The following sections identify the information that must be located in the record for each of these categories.

531.1.7.1 Administrative

This portion of the record contains all information related to the West Virginia Medicaid member's identification. It must include, at a minimum, a copy of the member's birth certificate and/or social security card, a recent photograph of the member, a copy of any legal documents verifying custody or guardianship of the member when the responsible party is anyone other than the members' legal parent(s). The name, address and phone number of the party bearing legal responsibility for the member must be clearly identified, along with his/her relationship to the child, e.g. "mother", or "paternal aunt, legal guardian". If the member is in the custody of the West Virginia Department of Health & Human Resources (DHHR), the county of custody must be specified and the caseworker identified as an agent of DHHR. The original MCM-1, with physician/psychiatrist signature/date and supporting documentation that establishes medical necessity for this level of service must be contained in this section of the record and available for review.

531.1.7.2 Documentation of Assessments

This portion of the record contains information gathered through history taking, observation, testing and examination of the member. It must include, at a minimum, all assessments identified as necessary in Section 531.1.3.5, Assessments of this chapter. Assessments must be updated as needed to provide current and continued treatment planning and provision of therapeutic services.

531.1.7.3 Treatment Planning

This portion of the record contains the individualized multi/interdisciplinary treatment plan, as well as all reviews and revisions. It must be noted that the treatment planning process is intended to take place in a multi/interdisciplinary forum where many points of view may be expressed and consensus reached, rather than through a process of serial communication among professionals. Treatment planning documents must reflect the collaborative nature of the process. The treatment team will meet to staff each member and review/revise his/her treatment plan as often as necessary to provide optimum treatment but at least once during the first 14 days following admission, again prior to the conclusion of the first month of stay, and monthly thereafter.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

531.1.7.4 Therapeutic Interventions

All interventions attempted/provided during the course of the West Virginia Medicaid member's treatment must be appropriately, accurately and legibly documented. Documentation for individual services must include at a minimum:

A. Psychotherapy Notes

Essential elements that must be documented for each therapy session are as follows:

- The date and time of the session (time in and time out);
- The type of therapy (individual, family or group);
- The person(s) participating in the session;
- The length of the session;
- The goals of the session with the member;
- Clinical observations about the member (demeanor, mood, affect, mental alertness, thought processes, risks, etc.);
- The content of the session;
- Therapeutic interventions attempted and the member's response to the intervention(s);
- The member's response to any significant others who may be present in the session;

The outcome of the session;

- A statement summarizing the member's degree of progress toward the treatment goals;
- Periodic (at least monthly) reference to the member's progress in relation to the discharge criteria; and the estimated discharge date; and
- The signature (and printed name, if needed for clarity) of the therapist.

Monthly summaries are not acceptable in lieu of psychotherapy session notes.

B. Milieu Therapy Notes

Milieu notes must present a clear picture of the member's participation and interactions in the therapeutic community. Milieu notes for each day should describe the West Virginia member's actions, staff interventions, and the West Virginia member's response to those interventions. Milieu notes are completed by direct care staff. If a checklist is used, it must be accompanied by a brief narrative. Milieu notes must be behaviorally focused. Behavior and events must be described rather than labeled. For example:

- Behavior labeled: member was oppositional;
- Behavior described: member refused to make up bed when asked.

Milieu notes must be maintained in a professional manner and must accurately document any communication between staff and the member. The notes should emphasize the member's level of involvement and collaboration in his/her own treatment.

C. Community Meeting Notes

Participation in community meetings must be documented for each member and a brief narrative maintained for each community meeting describing the goals and achievement.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

531.1.8 RECORDS MAINTENANCE

Clinical records must be maintained for a period of five years from the date of discharge. The facility must ensure that the clinical record is not lost, destroyed or put to unauthorized use. The facility must ensure the confidentiality of all information contained in the member's record except when its release is authorized by the member's parent/legal guardian or required by State or federal law.

531.1.9 SPECIALIZED PROCEDURES/SECLUSION/RESTRAINT

Special procedures, **seclusion and restraint**, must be used as an immediate response only in emergency safety situations (42 CFR §483.356) when needed to help a member regain control of his/her behavior. At all times, the least restrictive effective intervention must be used. Documentation indicates that the more restrictive techniques, while relieving stress for the adults in charge, usually increase stress for the youths with whom they are applied. The potential therapeutic effects (prevention of self- and other-injury and reinforcement of behavioral boundaries) must be weighed against the counter-therapeutic effects which include loss of dignity, increased feelings of impotence/helplessness, increased resentment/rage towards authority figures, and, for member's in recovery from physical/sexual abuse, the subjective experience of re-enacting their victimization.

531.1.9.1 Staff Training

When a facility provides for the use of seclusion/restraint, all staff who have direct member contact must have prior education, training, and demonstration of knowledge of the proper and safe use of seclusion/restraint and alternative techniques/methods for handling the behavior, symptoms, and situations that traditionally have been treated through seclusion and restraint. Training in the application of physical restraint must be a professionally recognized method which does not involve restraining a member in a face-down or spread-eagle (legs apart) position.

531.1.9.2 Member/Parent Notification

When a facility provides for the use of seclusion/restraint, the facility must inform, with documentation evidence, the prospective member and the parent/guardian at the time of admission of the circumstances under which these special procedures are employed. In the event that a member requires either seclusion or restraint, the PRTF must notify the parent/guardian as soon as possible, but no later than 24 hours after the initiation of the procedure. Documentation must include notification was provided with date and time of notification and the name of the staff person providing the notification. (42 CFR §483.366(a))

531.1.9.3 Types of Seclusion and Restraints

Seclusion is the involuntary confinement of a member in an area, including rooms without locks or doors, from which they are physically prevented from leaving. It is used to ensure the physical safety of the member or others and to prevent the destruction of property or serious disruption of the milieu.

Restraint is the restriction of a member's freedom of movement or normal access to their body through physical, mechanical or pharmacological means, in order from the least to the most restrictive method. It is used to ensure the member's physical safety.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

- **Personal/Physical Restraint** is the restriction of a member through human physical action using a standard technique or method designed and approved for such use. It is used to prevent a member from causing harm to self or others or to prevent destruction of property.
- **Mechanical Restraint** is the restriction of a member through the use of any physical or mechanical device, material or equipment attached or adjacent to the member's body that they cannot easily remove.
- **Pharmacological Restraint** is the limited use of a medication, which is not a standard part of the member's treatment regimen, to control or alter the member's mood or behavior or to restrict freedom of movement on a short term basis. Pharmacological restraint is used to ensure the safety of the member or others through a period of extreme agitation when less restrictive measures have not been effective. Pharmacological restraint may be initiated only by medical staff acting on a physician's/psychiatrist's orders. At the time of the order, the physician/psychiatrist must identify a specific time when the procedure is expected to end (i.e., the expected duration of the medication's effects).

Medication Adjustment refers to the process of medication reduction attempts including anti-psychotics, hypnotics, anti-depressants, narcotics, sedatives, and all schedule II drugs. Medication adjustment is not considered to be a special procedure. When an additional physician/psychiatrist order is provided to increase a member's routine medication in a *non-routine* way to help the member through a period of heightened stress or agitation, e.g., ordering the administration of an extra dose (usually in a lower amount) of the same (or similar, from the same class) medication that is already part of the member's treatment program, or ordering that the regular medication be administered sooner than the routine time, without making a permanent change in the member's treatment plan. When physician/psychiatrist orders for medication increase due to a period of heightened stress or agitation up to three times in a 30 day period, the physician/psychiatrist must determine if the increase in medication needs to become a change in the member's medication regime. If this does not occur then the medication must be considered a pharmacological restraint and the treatment plan must be updated. Unlike medications administered for the purpose of pharmacological restraint, medication adjustments are not sedating, are only administered orally, and must be taken voluntarily by the member (and in some cases may be requested by the member).

531.1.9.4 Appropriate Use

Seclusion or restraint must be used only in situations where less restrictive interventions have been attempted and determined to be ineffective. Documentation in the record must reflect the attempted use of less restrictive interventions date/time/signature of staff responsible for use of the interventions. Neither procedure may be used as a method of coercion, discipline or retaliation as compensation for lack of staff presence or competency, for the convenience of staff in controlling a member's behavior, or as a substitute for individualized treatment. (42 CFR §482.356(a)(1)) Any use of seclusion or restraint must be:

- In accordance with the member's treatment plan (if the treatment plan does not provide for the use of seclusion/restraint prior to its use, the plan must be modified within one working day of the first occurrence)
- In accordance with the policy and procedures restraint/seclusion may only be applied by staff who have been trained and approved to use such techniques (42 CFR §482.356(a)(3));
- Implemented in the least restrictive manner possible (CFR §483.364(b)(2));



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

- In a room where the member will be constantly viewed and monitored, that is safe and sanitary, with adequate lighting, ventilation and temperature control;
- All vital signs must be obtained every hour, times 12 hours unless documentation by licensed physician/psychiatrist indicates this can be modified;
- Access to fluids and toilet facilities must be offered and provided hourly with clear documentation of fluids ingested;
- Evaluated on a continual basis and ended at the earliest possible time based on the assessment and evaluation of the member's condition (42 CFR §483.356(a)(3)(ii)).

531.1.9.5 Prohibited Practices

Restraint and seclusion must not be used simultaneously. (42 CFR §482.356(a)(4))

- Any personal or mechanical restraint of a member in a face-down position is prohibited;
- Any personal or mechanical restraint of a member in a "spread-eagle" (legs and arms apart) position is prohibited;
- Standing or "as needed" (PRN) orders for seclusion or restraint are prohibited. (42 CFR §483.356(a)(2))

531.1.9.6 Procedural Requirements

The following actions are required and must be documented for **any form of special procedure** with the exceptions as noted below. (42 CFR §483.358(a))

- Orders for restraint or seclusion must be by a physician/psychiatrist, or other licensed practitioner permitted by the State Law and the facility to order restraint and seclusion and trained in the use of emergency safety interventions.
- If seclusion or personal/mechanical restraint is initiated verbally by order from a physician/psychiatrist or other licensed practitioner, a verbal or telephone order must be obtained from the physician/psychiatrist or other licensed practitioner and documented in the chart as soon as possible, but no later than one hour after the start of the procedure. If the physician's/psychiatrist's or other licensed practitioner order cannot be obtained within the one hour, the procedure must be discontinued.

The physician's/psychiatrist's or other licensed practitioner's order for seclusion or personal/mechanical restraint may under no circumstance exceed one hour for members younger than nine years of age, or two hours for members nine to 17 years of age and four hours for members ages 18 to 21.

The staff person responsible for terminating seclusion must be physically present in or immediately outside the seclusion room throughout the duration of the procedure. (42 CFR §483.364(a))

Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the member, and the safe use of restraint throughout the duration of the emergency safety intervention. (42 CFR §483.362(a))



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

Within one hour of the initiation of the emergency safety intervention, a physician/psychiatrist or other licensed practitioner must conduct a face-to-face assessment of the physical and psychological well-being of the member, to include but not be limited to the following:

- The member's physical and psychological status,
- The member's behavior,
- The appropriateness of the intervention measures, and any complication resulting from the intervention. (42 CFR §483.358(f))

Even if the intervention is terminated in less than one hour, the face-to-face assessment must be conducted within 60 minutes of its initiation.

The health and comfort of the member must be assessed every 15 minutes by direct observation, and staff must record their findings at the time of observation.

There must be a policy and procedure for ending the special procedure (except for pharmacological restraint, which has an end-time identified by the physician/psychiatrist or other licensed practitioner), and the member must be made aware of them when the procedure is initiated and at follow-up intervals as appropriate. A physician/psychiatrist or other licensed practitioner must evaluate and document the member's well-being immediately after the seclusion or restraint is terminated. (42 CFR §483.362(c))

No later than 24 hours following the conclusion of the special procedure, the member must be given the opportunity to discuss with all staff involved in the procedure the antecedents, emotional triggers, and consequences of his/her behavior and any learning that occurred as a result of the intervention. (42 CFR §483.370(a)) The goal is to enable the member to understand the precursors to loss of control and to rehearse acceptable means of handling frustration and emotional distress.

Within 24 hours after the use of restraint or seclusion, documentation must indicate that all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, conducted a debriefing session that included, at a minimum, a review and discussion of the emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention, alternative techniques that might have prevented the use of the restraint or seclusion, the procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and the outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion. (42 CFR §483.370(b))

The Registered Nurse or other licensed personnel in the PRTF must notify with documentation of the same, the member's parent/guardian as soon as possible, but no later than 24 hours after the initiation of any special procedure. The documentation will include the name/date/time the parent/guardian was contacted and the content of the conversation.

If the member's treatment plan does not already provide for the use of seclusion/restraint, then it must be amended or modified within 24 hours following the first use of any special procedure to reflect the use of that method as a part of the member's treatment.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

531.1.9.7 Documentation of Seclusion/Restraint

Documentation of each incident of seclusion or restraint (personal, mechanical and pharmacological restraint) will include, but not be limited to, the following information: [\(42 CFR §483.358\)](#)

- The date/time the procedure started and ended;
- The name of the physician/psychiatrist or other licensed practitioner who authorized it, the name(s) of staff who initiated the procedure, were involved in applying or monitoring, and were responsible for terminating;
- The reason the procedure was initiated;
- Which less restrictive options were attempted, and how they failed;
- Criteria for ending the procedure (except for pharmacological restraint, when the end time is identified by the physician/psychiatrist or other licensed practitioner);
- The results of a face-to-face assessment conducted by a physician/psychiatrist or other licensed practitioner within one hour after initiation of the procedure to include:
 1. the member's physical and psychological status,
 2. the member's behavior,
 3. the appropriateness of the intervention measures and
 4. any complications resulting from the intervention;
- The member's condition at the time of each 15 minute reassessment and at the end of the procedure;
- The signature/date of the person documenting the incident;
- A record/documentation of both debriefing sessions (staff/member and staff only) which are required to take place within 24 hours of the use of seclusion/restraint, to include the names of staff who were present for or excused from the debriefing and any changes to the member's treatment plan that resulted from the debriefings. [\(42 CFR §483.370\(c\)\)](#); and,
- The facility must provide notification of the member's parent/guardian within 24 hours of the initiation of each incident, including the date and time of notification and the name of the staff person providing the notification. [\(42 CFR §483.366\(b\)\)](#).

This documentation must be part of the West Virginia member's permanent record.

A separate log documenting all episodes of seclusion/restraint in the PRTF must be maintained. [\(42 CFR §483.358\(i\)\)](#) A multidisciplinary team must review the seclusion/restraint log monthly and must maintain documentation of such meetings in the form of minutes signed and dated by the participants.

Information regarding the number of times seclusion or restraint have been employed by a facility must be included **monthly** as part of the facility's census report.

531.1.10 EDUCATION

When caring for children in out-of-home placement it is necessary to provide services outside those identified as meeting medical necessity. These services are considered necessary for the health and safety of the member. Provision of education is a necessary component for all out-of-home placements. DHHR is committed to ensure all members receive educational services and continue educational goals. It is the responsibility of all involved parties to support each member's school placement and educational



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

plan. The West Virginia Department of Education oversees the provision of educational services for West Virginia members.

For information regarding educational standards for West Virginia members, the West Virginia Department of Education can be reached at:

**West Virginia Department of Education
Office of Assessment and Accountability
State Capitol Complex
Building 6, Room 330
Charleston, West Virginia 25305
Telephone: (304) 558-7805
<http://wvde.state.wv.us>**

531.1.11 TRANSPORTATION AND VEHICLE MAINTENANCE

Transportation of members to and from medical appointments, court appearances, emergency transportation and transportation to family visits is a requirement of the PRTF. It is considered included in the PRTF per diem rate and not separately reimbursable.

- All vehicles must be maintained and operated in a safe manner.
- The facility provides adequate passenger supervision, as mandated by level of care.
- All facility-owned and staff-owned vehicles used for transportation of members **must be adequately covered by vehicular liability and comprehensive insurance** for personal injury to all occupants of the vehicles in the maximum amount allowed recommended by the state in which the facility is located. Documentation of such insurance coverage must be maintained in the facility's records, updated yearly, and readily available for review upon request by DHHR or designee. Staff providing transportation must possess a valid driver's license. Documentation of the license must be maintained in the facility's records and must be validated annually.
- All facility-owned and staff-owned vehicles used for transportation of members have a current license, registration and inspection, as required by the county of residence.
- Age-appropriate safety restraints must be used as required by state and federal law.
- The facility maintains the responsibility for and must be willing to provide transportation to members in the program including transportation to and from all medical/dental appointments, court appearances, emergency transportation, and transportation to family visits.
- No member must access public transportation unless supervised by a staff person or designee of the facility.

In instances of non-custodial placement, the cost of transportation must be provided by the facility and/or the parent. NEMT cannot be used to transport the child to a facility located out-of-state. The use of NEMT to transport a parent to the facility for visitation with the child is **not** a covered service.

531.1.12 CLOTHING

Members in DHHR care enter custody through the judicial system, or through the actions or inactions of adults in their lives. Therefore, DHHR urges child care facilities, whenever possible, to afford members the freedom to dress in ways that preserve their dignity, their freedom of expression, and their cultural



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

identity. At the very least, agencies are to refrain from using uniforms, outfits, or identifying visual markers according to the children's disabilities, diagnoses, or referral behaviors. To do so classifies and stereotypes members in ways that add to the stigma associated with being in the custody of the DHHR. Wearing one's own clothing should not be held out as a reward but as a basic right. Additionally, any facility policy which requires uniform or identifying clothing when a member is in a community setting must be eliminated.

DHHR recognizes the need for facilities to utilize dress codes in order to maintain standards of hygiene and decency or to maintain accountability to the member at certain times. If dress code policy exists, it must be explained to the member and the parent/guardian at the time of admission to the facility. DHHR challenges facilities to involve members as much as possible in decisions about reasonable limits of clothing or dress codes.

The facility must supply any special clothing required for the member to participate in a certain program (i.e. camping, hiking, equine therapy, etc.)

The facility is responsible for program and normal age-related personal incidental costs for members in the program such as bedding, diapers for infants, toiletries, and personal feminine hygiene items for females, etc.

531.1.13 REIMBURSEMENT METHODOLOGIES

BMS will reimburse PRTFs according to the WV Medicaid State Plan, Attachment 4.19-A-2, *Payment for Medical and Remedial Care and Services*.

"Reimbursement will be based on a cost-based retrospective reimbursement system determined by applying the standards, cost reporting periods, cost reimbursement principles, and method of cost apportionment used under Title XVIII of the Social Security Act, prior to the Social Security Amendments of 1983 (Section 601, Public Law 98-21).

At final settlement a provider's total interim reimbursement for the reporting period will be reconciled to total allowable WV Medicaid program cost to an assigned WV State agency. Allowable WV Medicaid program cost will be determined using tests of reasonableness, appropriateness, and medical necessity, as demonstrated in Medicare Regulations. Final settlements will be calculated based upon a provider's filed cost report, appropriate supporting financial documentation, including the State's processing and statistical claims reports. Each provider, which does not request or qualify for a low utilization exemption, will be required to file a CMS 2552 cost report with the State. All filed cost reports will be subject to final settlement determinations utilizing internal desk review (un-audited) or full or partial financial audit procedures. Final payment determinations will not consider the incentive and cost sharing amounts provided for in the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (public Law 97-248).

Development of a facility's initial interim per diem payment rate may be based upon one of the following: a documented host states' Medicaid reimbursement rate, a pro forma cost report, a similarly sized facility within close proximity. For established providers, interim per diem rates may be based upon a provider's most recent settled cost report or host state's PRTF approved rate. For interim cost rate reviews and rate update requests, a provider must submit their most recent fiscal year cost report to WVDHHR-Office of Accountability & Management Reporting Division of Audit & Rate Setting. Providers are responsible for



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

adherence to cost reporting requirements as established in Chapter 300, Provider Participation Requirements.

531.1.13.1 PRTF Services Included in the Daily All Inclusive per Diem Rate

The West Virginia Medicaid daily per diem rate provides reimbursement for all medically necessary services identified on the child's treatment plan during the child's placement at the facility.

The PRTF agrees to:

- File appropriate claims for reimbursement in accordance with established BMS procedures. The submission by or on behalf of the PRTF of any claim for payment under the Medicaid program shall constitute certification by the PRTF that the services or items for which payment is claimed were actually provided by the PRTF to the person identified as the West Virginia member;
- File claims that do not exceed the PRTF's daily per Diem rate.
- File claims for items provided to persons who are West Virginia Medicaid members only;
- File claims which are correctly coded in accordance with billing instructions prescribed by BMS and file them in a timely manner in accordance with federal and state regulations; and
- Submit all information, with or in support of the information, in a true, accurate and complete manner.

531.1.13.2 Prerequisites for Payment

All PRTF's must have a current accurate signed and dated agreement with the Title XIX Medicaid Program on file with BMS' fiscal agent. The PRTF agrees to comply with all applicable rules, regulations, rates and fee schedules promulgated under Federal and West Virginia State laws. The PRTF represents and acknowledges that provider shall obtain a copy of those portions of the regulations and plans which bear on the providers of medical services of the type furnished by the PRTF. The PRTF further agrees to assure that all Medicaid services comply with Title VI of the Civil Rights Act of 1964; services shall be made available without discrimination due to race, religion, color, sex, national origin, age, ancestry, handicap or inability to pay, and all buildings and services shall comply as applicable, with Section 504 of the Rehabilitation Act of 1973 and the American With Disabilities Act (ADA).

The PRTF agrees to provide methods and procedures as required by Title XIX standards to safeguard against unnecessary or overutilization of care and services and assure that charges will be consistent with efficiency, economy and quality of care.

The PRTF agrees to maintain records in accordance with federal regulations for a period of five years, or three years after audits, with any and all exceptions having been declared resolved by the Department of Health and Human Resources. All supporting documentation for services provided to a member, including education, must be maintained in the individual members' cumulative record for a minimum of five years after discharge from the facility. Files must be stored in a secure manner. Appropriate measures must be taken to ensure the confidentiality of records, as well as safety from physical threats (e.g., fire, flood, etc.).

The PRTF agrees to make all records and documentation available upon request to DHHR, and/or the United States Department of Health and Human Services (HHS). Such records and documentation shall include, but not be limited to:



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

- Financial Records;
- West Virginia Medicaid member Information;
- Description of Medical Services Implementation;
- Identification of Service Sites;
- Dates of Service for Each Service Component by member, client records, personnel records; and,
- MCM-1

The PRTF agrees, subject to appropriate procedural standards, to assume responsibility for repayments for state and/or federal funds which are subsequently disallowed or deferred by the state or federal government.

The PRTF agrees to participate in evaluations and audits authorized by the West Virginia DHHR and the United States HHS, the Comptroller General of the United States, or their duly authorized representatives relative to evaluation of the quality, appropriateness, and the timeliness of services pursuant to this agreement.

The PRTF agrees that payment and satisfaction of provider claims by BMS will be from federal and state funds, and that any false claims, statements or documents or concealment of material fact by a provider may be prosecuted by the Department under applicable federal or state law.

The PRTF agrees to permit regular medical reviews of each member, including a medical evaluation of the individual's need for PRTF services and to cooperate with state and federal personnel who make inspections, medical reviews and audits.

The PRTF must maintain in the member's medical record all information regarding the Interstate Compact Placement of Children (ICPC) and the 100-A form.

The PRTF's located out of state agree to inform BMS of all deficiencies received by that state's surveying licensing agency including annual and complaint investigations. The PRTF must have documentation of receipt that the member's parent/guardian(s), (non-custodial placement) and DHHR caseworker (custody placement) have received the results of the state surveying agency with deficiencies and complaint investigations. The state surveying agency's results will be easily accessible for all DHHR caseworkers West Virginia members/parent/guardian(s), and state personnel at all times and must be kept current.

The PRTF will provide to BMS' fiscal agent the results of the new nationally recognized accreditation when completed/updated.

The PRTF agrees to keep current with BMS' fiscal agent a new signed and dated Attestation/Certification letter by the Facility Director for all programs/sites when changes occur from information previously supplied. A completed attestation statement must be submitted to BMS annually by July 21st.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

Child and Adolescent Needs and Strengths Assessment (CANS): A multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

Child and Adolescent Functional Assessment Scale (CAFAS): The CAFAS is the gold standard for assessing a youth's day-to-day functioning across critical life domains (subscales) AND for determining whether a youth's functioning improves over time. The CAFAS is a professionally-rated measurement tool designed to assess the level of functioning in children and adolescents with emotional, behavioral, or substance use symptoms or disorders (Hodges, 1990).

Clinical Pathways: Standardized, evidenced-based, multidisciplinary management plans, which identify an appropriate sequence of clinical intervention, time frames, milestones and expected outcomes.

Guardian: A person who has temporary or ongoing legal responsibility to care for another person or to manage that person's property and affairs, in whole or in part. Courts appoint guardians to protect the interest of minors or legally incompetent adults.

Individualized Education Program (IEP): A written statement for an eligible student with an exceptionality that is developed, reviewed and revised in accordance with Policy 2419: Regulations for the Education of Students with Exceptionalities and IDEA 2004. The IEP is a product of collaboration between a parent or adult student and educators who, through full and equal participation, identify the unique needs of the student with a disability or giftedness and plan the special education and related services to meet those needs. It sets forth in writing a commitment of resources necessary to enable the student to receive needed special education and related services. In addition, the IEP is a management tool that is used to ensure that each eligible student is provided special education and related services appropriate to the student's special learning needs. It serves as an evaluation device for use in determining the extent of the student's progress toward meeting the projected outcomes. The IEP is a compliance/monitoring document that may be used by authorized monitoring personnel from each governmental level to determine whether an eligible student is actually receiving the free appropriate public education agreed to by the parents and the school.

Interdisciplinary Team (IDT): Team intervention or collaboration on behalf of a specific client or client system, which involves members of various professions or disciplines who develop an individualized plan for the treatment and discharge of each member. The treatment plan charts a course designed to help the member move to a less restrictive level of care as quickly as possible. Discharge planning begins on admission and is carried through on the initial treatment plan and each revision of the plan during the entire stay of the West Virginia Medicaid member.

Interstate Compact on the Placement of Children (ICPC): The Compact is a uniform law that has been enacted by all 50 states, the District of Columbia, and the U.S. Virgin Islands. It establishes orderly procedures for the interstate placement of children and fixes responsibility for those involved in placing the child. The Compact law contains 10 articles. They define the types of placements and placers subject to the law; the procedures to be followed in making an interstate placement; and the specific protections, services, and requirements brought by enactment of the law.

Loco Parentis: Latin word meaning, "in the place of a parent" or "instead of a parent." Refers to the legal responsibility of an adult or institution assuming the relationship toward an infant or minor of whom the



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

adult is not a parent, but to whom the adult or institution owes the obligation of care and supervision of making legal decisions. It refers to an individual who assumes parental status and responsibilities for another individual, usually a young person, without formally adopting that person.

Milieu Therapy: A form of treatment and rehabilitation for people with social and mental disorders who usually live in institutional settings. Treatment is not restricted to individual hours with a professional therapist but also occurs in the total environment of this closed setting, which is also referred to as the "therapeutic community." Those being treated attend group sessions for everyone in the facility, elect their own leaders and provide one another with social and emotional support throughout the day. The entire environment is considered vital to the treatment process.

Multidisciplinary Treatment Team (MDT): A group of individuals from different disciplines who work together to:

- Access, plan and implement a comprehensive individualized service plan for a child involved in a court proceeding either because of abuse/neglect or status or juvenile delinquency proceedings
- Work with a child and family to develop a service plan and coordinate services.

Be the central point for decision making during the child's stay at the PRTF.

MCM-1: A form developed and used by the BMS to meet Federal Regulation (42 CFR) Subpart D, Inpatient Psychiatric Services for Individuals Under the Age of 21 in Psychiatric Facilities or Programs, 42CFR §441.151. General Requirements, Inpatient psychiatric services for individuals under age 21, must be certified in writing to be necessary in the setting in which the services will be provided. The West Virginia Medicaid Program utilizes the MCM-1 to meet the requirements for certification of inpatient services in the Medicaid-approved psychiatric facility for individuals under the age of 21 years. The MCM-1 must be certified by an independent team that includes a physician/psychiatrist, has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and has knowledge of the individual's situation.

Non-Custodial Placement: The placement of a child into a PRTF by physician/psychiatrist order utilizing the West Virginia Medicaid Card as reimbursement for services provided the child. The attending physician/psychiatrist must provide documentation of treatment and lack of response to treatment. The physician/psychiatrist must certify the need for this level of service and complete and sign the MCM-1. The parent retains legal custody and financial responsibility for expenses related to treatment, supervision, room and board, education, etc. not covered by medical insurance/Medicaid. Non-custodial placements must meet all eligibility requirements for this level of care.

Variance: A written declaration by the Secretary that a certain requirement of this rule may be satisfied in a manner different from that set forth in the rule.

Waiver: A written declaration by the Secretary that a certain requirement may be treated as inapplicable in a particular circumstance.



531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter			TBD

DRAFT

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.