Draft Meeting Summary
Residential Treatment Center Workgroup Meeting
Tuesday, April 9, 2024
Maryland Health Care Commission (MHCC)
4160 Patterson Avenue, Baltimore, MD 21215

Workgroup Members Attendees

Claudette Bernstein, M.D.
Ezra Buchdahl
Sarah Fegan
Bryan Fracchia
Mary Gable
Angela Gray
Shannon Hall
Shawn Lattanzio
Tammy Loewe
Alyssa Lord
Jennifer Maehr, M.D.
Bryan Mroz
Shelby Schestag
Maria Schweitzer
Tennille Thomas
Elizabeth White

Other Attendees

Cathy Baker
Brooke Fox
Catherine Gray
Marie Liddick
Sadie Liller
Frederick Polce
Karen Powell
Victoria Poss
Cheyenne Stern
Tina Thomas
Stephanie Trice

MHCC Staff Attendees

Rachel Bervell
Eileen Fleck
Wynee Hawk
Katie Neral
Uzoma Nwachukwu
Ben Steffen
Caitlin Tepe

Introduction and Overview

The meeting began with Eileen Fleck opening the session. She asked those attending the meeting in-person, Katie Neral, Uzoma Nwachukwu, and Bryon Fracchia to introduce themselves. She then she read out names from the roster of workgroup members to confirm who was present and asked other MHCC staff attending remotely to introduce themselves.

Ms. Fleck next asked if there were any suggested changes to the February workgroup meeting summary. No one had suggested changes. She proposed finalizing it unless further review was needed. Tennille Thomas suggested approval of the meeting summary, and Tammy Loewe agreed. Ms. Fleck thanked workgroup members for their feedback.

Ms. Fleck noted that the discussion of the need standard for establishing a new residential treatment center (RTC) was not concluded at the prior meeting and further staff work is needed before revisiting it. As a result, it was not included on the current agenda. She explained that the workgroup meeting will instead focus on other standards that apply to RTC Certificate of Need (CON) projects.

Project Impact

(f) Project Impact: The Commission shall consider the impact of the proposed project on the costs and charges of existing providers of the facilities and services included in the project and on access to those facilities and services in the service area of the project.

Ms. Neral explained how the project impact standard is applied for a CON application. She explained that an applicant must analyze the impact of a new project on service volume, payer mix, and access to healthcare in the service area. She asked what considerations should be given to existing RTC providers when a new facility or expansion of an existing facility is proposed. She also asked whether existing RTC providers should be given an opportunity to update or improve their programs to meet the community's needs before new providers are established.

Ms. Thomas asked whether current providers are given an opportunity to adapt their services to meet new requirements before alternatives are explored. In response, Ms. Fleck noted that the Maryland Health Care Commission (Commission or MHCC) does not proactively search for new providers; instead, applicants submit their proposals to MHCC staff who then evaluate the proposals based on established criteria.

Ms. Fleck explained that sometimes an existing provider feels threatened by a new provider, in terms of financial losses or staff retention. The Commission sometimes considers these impacts, and it could be a reason to not approve a CON project. Ms. Fleck noted that historically, the Commission has favored competition and has been reluctant to safeguard incumbent providers from new entrants. However, the recent changes in the Commission's composition could lead to a shift in perspective on these matters.

Ms. Fleck encouraged workgroup members to consider when the impact on an existing provider should be considered. Factors that might be relevant include the distance between

providers, the overlap in services or target populations, and whether competition among multiple providers would be beneficial.

Bryan Mroz commented that challenges facing RTCs should be considered from both a local and systemic perspective. Instead of just focusing on issues for an individual facility, he suggested considering the capacity and staffing situation across the entire system. This broader view would help uncover patterns and trends that might not be apparent when looking at a single facility. For example, if multiple facilities are struggling to hire and have excess capacity, it indicates a deeper, systemic problem. By recognizing these broader trends, decision-makers can better understand the root causes and implement more effective solutions. Additionally, Mr. Mroz highlighted the potential impact on operational stability. When staffing shortages and excess capacity are widespread, they pose a significant risk to the organization's ability to function smoothly. Addressing these challenges early on is crucial to prevent disruptions that could lead to shutdowns and other operational issues.

Ms. Fleck stated that sometimes the quality of service influences the level of consideration given to an existing facility in a CON review. For instance, if a provider consistently delivers subpar service, then should it matter less if a new provider negatively impacts it? Opening the door for a new provider may be beneficial to the population to be served. On the flip side, a provider that consistently delivers high-quality care might merit protection from competition.

Bryon Fracchia asked what would define a bad track record. Ms. Fleck responded that a bad track record, for instance in the context of nursing homes, can be defined by a facility's performance on various quality metrics or indicators provided by entities like the Centers for Medicare and Medicaid Services (CMS). For cardiac surgery hospitals, the Society of Thoracic Surgeons' star ratings of programs and risk-adjusted mortality rates provide crucial data used by MHCC staff.

Ms. Fleck asked if there are quantitative performance metrics for RTCs. Mr. Fracchia concurred with Mr. Mroz's earlier suggestion to examine provider vacancies for specific populations. Ms. Fleck asked if quantifying when staff vacancies become a concern is possible. Mr. Fracchia noted that the RTC Coalition's monthly meetings include updates on vacancies and available beds, based on current staffing and facility conditions. That information could be useful. He was unsure if it included details by specialized population or just overall capacity.

Ezra Buchdahl commented that the total capacity of the program is considered in terms of both operational and licensed capacities. The three primary challenges preventing programs from being fully operational involve staffing, physical improvements, and acuity levels. Mr. Buchdahl explained that he collects monthly updates from all RTCs and compiles them into a report. Ms. Fleck asked if the monthly collection of data from RTC had been helpful in identifying problem areas. Mr. Buchdahl responded that it has been helpful in identifying a lack of capacity in Maryland. Another workgroup member agreed.

Ms. Fleck asked whether quality should be considered when considering the impact on another facility or only staffing and vacancies. She also asked if quality varies significantly

between providers and if this variability should be factored into evaluations. Mr. Fracchia responded by expressing a need for greater clarity on the definitions and metrics for quality.

Ms. Fleck concurred, noting that measurable standards would have to be established. She explained that there would need to be a transparent system where measurements are publicly accessible, like data registries mandated by the federal government. Mr. Fracchia expressed concerns about introducing additional layers of monitoring, noting that providers are already subject to extensive regulation by bodies such as the Joint Commission and the Office of Health Care Quality (OHCQ), which include mandatory audits and accreditations. Another workgroup member agreed.

Mr. Mroz agreed that there is not a unified rating system for RTCs at the state or national level. There are mechanisms for accreditation and handling complaints, but the information is not consolidated into a comprehensive rating system. Instead, the existing protocols focus solely on ensuring facilities meet all regulatory and accreditation standards. He also suggested that there is a need for recognizing specific service demands, such as managing complex behaviors like fire-setting, which poses significant risks. Mr. Mroz proposed that identifying such specific needs could prompt providers to specialize in or expand their services, thus filling service gaps and enhancing the quality of care.

Ms. Neral noted that the comments from Mr. Mroz tie back to measuring the need for RTC services and the need for specialized services. She acknowledged that to some extent the Adolescent Hospital Overstay Program is a way of tracking unmet needs and Mr. Mroz and the interagency committee have relevant data on this issue.

Health Equity

(g) The Commission shall consider how a proposed project will address health care disparities in availability, accessibility, and quality of care among different populations within the service area. The Commission shall consider how social determinants of health within the service area of the proposed project create disparities in the delivery of health care.

Ms. Fleck noted that health equity is a new criterion in procedural regulations and had not yet been applied to an RTC project. She read the health equity standard in the procedural regulations. She suggested that it would be beneficial to discuss the existing disparities in access to RTCs, especially among specific subpopulations. She emphasized the need to focus on defining which populations had difficulty accessing these services and to prioritize health equity for them.

Mr. Mroz suggested collecting data on the demographics of those who were either rejected or not accepted by facilities. He pointed out that every facility records these demographics and that analyzing them could reveal underlying health disparities. Ms. Fleck agreed. She also commented that it often sounded like the clinical picture of youth who need RTCs services results in barriers to access.

Ms. Thomas agreed that the clinical picture is crucial and that Brian's suggestion of examining denials was a good strategy. She mentioned that education was a major reason for

denial. She suggested that education needs should be considered and maybe the reason youth cannot access in-state RTCs. Mr. Fracchia added that cognitive levels were a significant factor as well. Ms. Fleck asked whether that was distinct from developmental disabilities, or if they were discussing the same population. Mr. Fracchia responded that they are not necessarily the same. He explained that a person could have a lower IQ without being developmentally disabled and noted that he saw many such cases seeking out-of-state facilities due to denials.

Dr. Jennifer Maehr commented that considering denials due to severe substance use is important. She noted that Hispanic youth in the District of Columbia metropolitan area are disproportionately affected by opiate use disorders, which lead to disparities in RTC admissions. She also mentioned that in the past, pregnant girls were frequently rejected, but not recently.

Ms. Fleck commented that the workgroup had also discussed whether it was better to have specialized programs for harder-to-serve populations versus expecting all facilities to serve them. She noted that the answer should influence how an application for an RTC is evaluated by MHCC, in terms of the population that an RTC should be expected to serve.

Mr. Fracchia responded that when considering a new RTC application, MHCC staff should determine whether facilities are needed to serve everyone or specifically the harder-to-serve populations. He stressed that there were groups with access issues that should be served. He further expressed that for specialized groups, particularly those with complex clinical diagnoses, specialized programs are essential. For example, youth with pervasive developmental disabilities need tailored physical structures, sensory accommodations, occupational therapy, and more. He emphasized that each group's needs, like those with substance abuse or pregnant young women, are distinct and require specialized approaches.

Dr. Claudette Bernstein commented that there are access issues within an RTC, particularly for families visiting their children or attending family therapy sessions. She noted that a remote session through an online meeting is possible, but it is not the same. Mr. Fracchia agreed with Dr. Bernstein. He added that there is a financial burden for subsidizing transportation for families from wider geographic areas, and it may be difficult for family members to take time off work for therapy sessions.

Ms. Fleck commented that it seemed like the issue of providing transportation assistance may be common and applicable across RTCs. Rachel Bervell suggested that equity considerations could be categorized and listed out, with an applicant only responding to categories that are applicable to its RTC. Frederick Polce, from the Garrett County Behavioral Health Authority, suggested considering insurance status, for example, private insurance versus Medicaid. Ms. Loewe emphasized the importance of assessing social determinants of health and asked which social determinants should be identified as relevant to recommendations. She suggested that understanding what needs had been addressed prior to admission was important and ensuring a comprehensive referral process to minimize wait times. It is important to consider whether the right RTCs are being considered and if the right pathways are being used. In some jurisdictions, if a child has a more severe developmental disability, then nothing may be done. There are also regulations that can affect who the lead agency is for obtaining admission to an RTC. Mr. Fracchia added that the educational status of youth without agency involvement should be considered,

especially regarding nonpublic individual education plans (IEPs) because funding may be an issue. He noted that this is a small number of youths, but it is still relevant.

Ms. Fleck commented that it seems like youth with Medicaid insurance have easier access to an RTC. She asked if there is a role for RTCs to address access for youth without Medicaid insurance. Ms. Loewe noted the importance of planning for discharge from the time of admission. She emphasized that this approach ensures that adolescents do not stay longer than necessary and helps smooth their transition back into the community. She also noted that it is crucial to involve relevant agencies for a coordinated approach.

Ms. Fleck commented that Ms. Loewe's insights were helpful. Addressing barriers to both admission and discharge from an RTC are both important. Mr. Fracchia underscored that sometimes the main challenge is the limited number of options available post-discharge from an RTC, for those adolescents who cannot return home. Ms. Neral inquired about the percentage of adolescents unable to return home. Mr. Fracchia responded that it varies, but he estimates that at least 50% end up in group homes or Therapeutic Foster Care (TFC), which is always full. Ms. Fleck asked if anyone had additional feedback, and there were no additional comments.

Ms. Fleck suggested that the next step should probably be drafting something more specific based on the feedback received. She highlighted the need to clarify expectations for applicants to reduce uncertainty and ensure consistency in MHCC staff's recommendations.

Cost-Effectiveness

(c) Alternatives to the Project. The Commission shall consider the alternative approaches to meeting the needs identified for the project that were considered by the applicant in planning the project and the basis for the applicant's choice of the project among considered alternatives. In a comparative review of applications within the same review cycle, the Commission shall compare the costs and the likely effectiveness of alternative projects in meeting identified needs, improving the availability and accessibility of care, and improving the quality of care.

Ms. Neral commented that this criterion, as outlined in the procedural regulations, requires an applicant to consider alternatives for meeting the project's identified needs. She reminded everyone that applicants must describe all alternative approaches considered, detailing their effectiveness in achieving the project's goals and the costs associated with each alternative. She noted that for the Board of Child Care of the United Methodist Church's CON application, it only considered existing RTCs and hospitals as alternatives. She asked if there were other options available to youth who need RTCs that should be considered.

Mr. Mroz responded that the placement of youth should depend on a clinical assessment. It should not be a shopping-around process, although sometimes that may happen. Mr. Fracchia noted that when considering placement in an RTC, it should be recommended only after exhausting all other community options. He emphasized the importance of considering the physical, psychological, and psychosocial aspects in these decisions.

Ms. Loewe suggested that there is a need to expand services for children and adolescents who don't meet the typical criteria for supportive programs due to insurance restrictions. She suggested that enhancing wraparound services for children with private insurance could be more cost-effective and reduce the need for RTCs. Children with private insurance are often not eligible for existing services.

Ms. Fleck explained that when evaluating an application for a new RTC, MHCC staff need to consider whether existing RTCs can accommodate more patients before establishing new ones. She explained that if MHCC staff saw that there were licensed beds not in use or low occupancy rates based on staffed beds, then staff would likely question the new for additional RTCs. She suggested that MHCC staff in evaluating the cost-effectiveness criterion would primarily consider whether existing facilities could meet the need identified by an applicant because there is not really a substitute for an RTC. The burden, she noted, is on the applicant to demonstrate the need for a new facility, especially in areas where other RTCs might have capacity.

Ms. Thomas suggested that the current methodology, as described by Ms. Fleck, be reassessed because there has been a decrease in providers in Maryland despite unmet needs in geographically challenging areas. She underscored the importance of accessibility, and the challenges families face when traveling long distances for treatment in remote areas such as the Eastern Shore or Western Maryland. She stated that someone in Western Maryland does not really have access to an RTC; residents in all parts of Maryland should have access to an RTC. Ms. Fleck agreed with Ms. Thomas that geographic access should be considered. Ms. Fleck suggested that health planning regions and service areas should be defined to account for reasonable travel distances for patients.

Ms. Neral asked how MHCC should define what is a reasonable travel distance, when MHCC staff are evaluating a proposed RTC program. Dr. Maehr commented that RTCs vary in their services, noting that proximity does not guarantee that a nearby RTC can meet specific patient needs if it offers different or niche services. Mr. Fracchia added that factors such as community involvement or legal circumstances may be relevant to determining the best RTC for youth.

Mr. Buchdahl suggested that a maximum of 60 minutes' travel time is reasonable. Mr. Fracchia asked if this measurement should be in time, considering that time and distance could vary greatly depending on the location, such as for youth from the District of Columbia or Somerset County. Ms. Neral noted that MHCC staff has previously assessed travel times at different points of the day and taken averages for multiple routes. Mr. Fracchia recommended considering seasonal variations as well, such as differences between winter and summer.

Ms. Fleck invited further thoughts on setting 60 minutes as a reasonable travel time. Ms. Thomas felt that while 60 minutes was reasonable, measuring in miles might be more appropriate. Mr. Fracchia emphasized that this decision would significantly impact on his community, where many are located more than 60 minutes away. He noted the specific challenges faced by youth coming from Western Maryland, the Eastern Shore, and the District of Columbia.

Ms. Neral stated that she wanted to revisit the concept of health planning regions, as implemented in other chapters of the State Health Plan (SHP). For instance, she noted that the SHP

chapter for acute psychiatric services divides the State into four regions. The Western region is comprised of Garrett, Allegany, Washington, and Frederick counties. Montgomery County, due to its large population, is its own region. The Southern region is comprised of Calvert, Charles, Prince George's, and Saint Mary's counties. The Baltimore Upper Shore region is comprised of Baltimore City and Anne Arundel, Baltimore, Carroll, Cecil, Harford, Howard, Kent, Queen Anne's, and Talbot counties. Finally, the Lower Eastern Shore region is comprised of the remaining five counties.

Ms. Neral mentioned that some SHP chapters use five regions. It varies based on the service. For the RTCs licensed in Maryland, she noted that most were concentrated in the central part of Maryland.

Mr. Fracchia commented that he is curious about the availability of specialized staff, like licensed therapists, in the broader regions, particularly in Western Maryland. Ms. Fleck commented that it is not required that health planning regions be established. If the population a facility aims to serve is likely to be within an hour drive, or if someone proposed a different definition, she noted that could work too.

Ben Stephen commented that ensuring good geographic distribution should be a goal whether planning regions are defined or undefined. He pointed out that Ms. Neral had outlined typical planning regions used across various service areas, but there are other approaches. With drug treatment facilities, for instance, MHCC considers those facilities to be statewide resources. He stated that geographic distribution is a useful framework for considering access, but it is not the only factor that matters. Sarah Fegan then mentioned that access to the Eastern Shore is a problem.

Sex Specific Programs

(b) Sex Specific Programs. Each applicant shall document sex specific programs, and provide a separate therapeutic environment and, to the extent necessary, a separate physical environment consistent with the treatment needs of each group it proposes to serve.

Ms. Fleck read the standard for sex specific programs. She noted that the regulations have not been updated in over 20 years, and over time there likely has been an increase in the number of transgender and non-binary individuals being served. She noted that the existing standard may not adequately address their needs. She noted that someone who is transgender may or may not be placed with other youth with the same gender identity; it depended on the specific circumstances. She requested feedback on the standard.

Mr. Fracchia emphasized their practice is to place a youth based on the youth's gender identity, regardless of biological sex. This includes making accommodations for non-binary and gender-neutral individuals. Ms. Thomas stated the Social Services Administration uses the same approach. The discussion also touched on the difficulties of placing biologically male, female-identified youths in male RTCs, with Mr. Fracchia noting that exceptions were made only in the context of specialized programs when no other options were available in Maryland.

Shannon Hall and Dr. Maehr both supported the idea of co-ed units with single rooms to provide flexibility for youths with fluid gender identities. They suggested that such accommodations are beneficial in handling the complexities of gender identification in a supportive environment. A couple of workgroup members noted that it is complicated to handle non-binary individuals, in a system which still largely defaults to binary gender categories. Ms. Loewe brought up that local behavioral health authorities may be given information from a parent that contradicts a youth's self-identified gender.

Dr. Maehr suggested that instead of referencing sex in the standard, gender should be referenced. Mr. Fracchia emphasized the importance of acknowledging the fluidity of gender identity. Dr. Maehr questioned the need for separate physical environments based on gender and expressed uncertainty about whether it aligns with the actual needs of the children. Mr. Buchdahl stressed the importance of respecting the gender identity of the youth.

Ms. Fleck asked if providing individual rooms for children who are non-binary to accommodate their varying identities is essential. Mr. Fracchia stated that his facilities only have single rooms for various reasons, including considerations beyond gender identity. Dr. Maehr suggested updating the title of the standard for sex-specific programs to something more inclusive and relevant to current discussions on gender. Mr. Buchdahl suggested there should be gender-sensitive programs. Another workgroup member suggested the inclusion of "gender affirming" language in the discussion. Other workgroup members agreed with including the term "gender affirming." Ms. Fleck noted that there seemed to be consensus on this issue, but workgroup members are welcome to provide additional feedback. There will be an opportunity to comment on draft language later. Caitlin Tepe suggested incorporating the discussion into the health equity standard.

Special Clinical Needs

(c) Special Clinical Needs. Each applicant shall document treatment programs for those youth with a coexisting mental health and a developmental disability.

Ms. Neral next read the standard for special clinical needs. She noted that in the previous workgroup meeting, it was suggested that the term "mental health" be replaced with "behavioral health" to convey a broader scope of services. There was also a consensus that specialized programs or units might be necessary for hard-to-treat populations, such as those with co-occurring developmental disabilities. She asked if the standard was realistic or if additional special clinical needs should be referenced in a standard.

Mr. Fracchia expressed concern about mandating all RTCs to have specialized programs without proper investment in infrastructure, training, and services. He emphasized the risk of substandard care if requirements lack adequate support. He also stressed the importance of considering the safety of youth within RTCs who may interact with those with co-occurring disabilities.

Ms. Neral asked how many of the Maryland RTCs have programs for individuals with developmental disabilities. Mr. Mroz explained that statutory limitations restrict the ability of the RICAs to serve certain populations. Mr. Fracchia responded that those with a primary diagnosis

for a developmental disability cannot be served in an RTC under Medicaid. Mr. Buchdahl stated that the was also the case for his facility. Ms. Neral again asked about new populations that should be referenced in a standard.

Mr. Fracchia proposed a more general requirement focused on documenting treatment programs for a specialized population defined as underserved or as defined in a health equity standard. Ms. Fleck explained that the reasoning behind the standard is that all RTCs should be meeting the needs of specialized populations. She noted that approach seems to conflict with the idea of concentrating investment in special programs in a small number of facilities because it is not realistic to expect all facilities to serve certain populations with specialized needs. Ms. Fleck asked for confirmation that minor issues like a secondary developmental disability that is not severe are manageable for most RTCs. She also asked if the focus should instead be on meeting the needs of youth with very high needs who require specialized resources. Mr. Buchdal and Mr. Fracchia responded that the later population should be prioritized.

Mr. Fracchia explained that was his reason for suggesting the language be revised to specify that any new RTCs should target a particular special population. He emphasized the need for flexibility, noting that adding a few more beds to existing facilities should not necessitate a complete overhaul of programming. Ms. Fleck mentioned that the approach seemed analogous to the approach taken with acute psychiatric services. All hospitals are required to accept involuntary psychiatric patients, but there are exceptions. She also asked whether to incorporate considerations for other special populations, such as those with secondary substance abuse issues, into this standard.

Mr. Fracchia proposed referencing underserved populations as defined under health equity, suggesting that this would provide a more adaptable framework for future needs. Ms. Fleck suggested defining underserved populations and then also referencing underserved populations to a health equity standard to provide clarity and flexibility over time. They both agreed on the importance of accommodating evolving needs over the long term.

Dr. Maehr asked whether to categorize substance use concerns within the framework of special clinical needs or minimum services. Ms. Fleck suggested that it should fall under special clinical needs. Ms. Neral then raised the question of whether issues such as youth absent without leave (AWOL) or aggressive behaviors among youth could be considered clinical needs addressed through regulation.

Ms. Thomas emphasized the importance of addressing behavioral challenges among youth, noting instances where increased supervision, such as one-on-one staffing, was requested. However, she also highlighted the need for comprehensive understanding behind documented aggressive tendencies in youth, urging for clarity on precipitating factors. Despite reports on the prevalence of aggressive tendencies in youth, there is often a lack of documentation to substantiate those assertions.

Minimum Services

(d) Minimum Services. Each applicant shall propose and document services which include, at a minimum: patient supervision, assessment, screening, evaluation including psychiatric evaluation, psychological testing, and individual treatment plan; ward activities; individual, group and family treatment; patient and family education; medication management; treatment planning; case management; placement and aftercare/discharge planning.

Ms. Fleck read the minimum services standard. She opened the discussion by asking whether the detailed list of services was too exhaustive and might be better managed through accreditation or licensing processes. She asked whether it was important to have CON staff review and validate that information. Dr. Maehr asked what was meant by "family education." Ms. Neral responded that her understanding is that it refers to behavioral health rather than general education. A few workgroup members suggested the word "ward" should be removed because the term is outdated.

Dr. Maehr brought up additional essential services not listed, such as nutrition and physical activities, stressing their importance in residential programs. She queried how detailed the requirements needed to be, suggesting that while some aspects might be covered under accreditation, others should be explicitly stated in the application criteria. Ms. Fleck referenced the feedback received, acknowledging that maintaining a standard in the application process was favored over removing it, as it ensured applicants demonstrated their ability to meet each service requirement. Mr. Buchdahl s introduced the idea of including a suicide risk assessment as a specific criterion. Ms. Fleck asked if psychiatric assessment was too general. Mr. Buchdahl stated that a suicide risk assessment should be mentioned specifically.

Mr. Fracchia supported the retention of detailed standards in the application, emphasizing the need for applicants to demonstrate comprehensive service provision. He confirmed that food service and physical activities, although not explicitly listed, were crucial and should be evaluated as part of the application.

Dr. Maehr commented that the term "screening" is too broad and needs to be more specific to ensure screening includes critical areas like substance use, suicidality, and medical issues. Ms. Fleck agreed that Dr. Maher's point was valid. Mr. Fracchia commented that all screenings are covered by JACHO and are heavily monitored. From his perspective, it would be duplicative. Ms. Fleck asked if the screening should be removed. Mr. Fracchia responded that it should be removed, unless it is defined.

Treatment Planning and Family Involvement

(e) Treatment Planning and Family Involvement. Each applicant shall document that the required minimum services will be provided by a coordinated multi-interdisciplinary treatment team that addresses daily living skills within a group setting; family involvement in treatment to the greatest extent possible, restoration of family functioning; and any other specialized areas that the individualized diagnostic and treatment process reveals is necessary for the patient and family.

Ms. Neral read the standard for treatment planning and family involvement. Ms. Neral asked how well the current standard is working. She also asked about the extent of family involvement required and the necessity of specific aftercare or discharge planning activities.

Ms. Thomas responded by emphasizing the need to include discharge and aftercare planning as part of the standard requirements. Ms. Fleck asked if transportation should be mentioned in the standard. Mr. Fracchia stated that transportation cannot be mandated because of funding limitations.

Mr. Fracchia expressed his approval of the comprehensive nature of the family involvement aspect in the standard and supported the addition of aftercare discharge planning. Ms. Neral then proposed the idea of tracking successful discharges in the future, prompting Mr. Fracchia to point out that the definition of a successful discharge would need to be established. He suggested that it could involve various factors like education, housing, medical necessity, or recidivism.

Education

(f) Education. Each applicant shall document that it will:

(i) Provide a comprehensive educational program that includes general, special education, pre career and technology instruction consistent with COMAR 13A.05.01 and COMAR 13A.09.09 Educational Programs in Nonpublic Schools and Childcare and Treatment Facilities.

(ii) Provide educational services for Level V non-public and Level VI students on the same campus as the treatment facility.

(iii) Enter into agreements with local education agencies for the education of all other students; and

(iv) Provide a pre-vocational and vocational program that provides a variety of training programs for students who require job training.

Ms. Fleck read the educational standard requirements for applicants. She asked whether there were aspects of the standard that seemed outdated or unnecessary and if additions were needed. Dr. Maehr questioned whether physical education needed to be separated from these requirements. Mr. Fracchia responded that it did not need to be separated. He noted that physical education would be included under the educational services for level V nonpublic schools, as required.

Ms. Fleck asked whether it was crucial for applicants to document these details upfront rather than verifying them just before licensing a facility. Dr. Maehr commented that it would be beneficial to see this information on the application. Mr. Fracchia provided clarification on the standard. Ms. Fleck stated that based on the lack of feedback, she concludes that the standards are adequate.

Staff Training

(h)Staff Training. Each applicant shall document that it will:
(i) Provide a minimum of 40 hours of training to new employees prior to their assuming full job responsibilities.
(ii) For each category of direct service personnel provide the curriculum for this training and show how the training will help staff meet the clinical needs of this population; and
(iii) Provide a continuing education program for all categories of direct service personnel.

Ms. Neral read this standard. She asked whether the standard was effective and if specific training topics should be mandated. Ms. Thomas expressed interest in feedback from current providers about this requirement. Mr. Fracchia noted that his organization included suicide risk and de-escalation in their training and wanted to check if these topics were covered under other regulations. He suggested revisiting the training components to ensure they were comprehensive.

Mr. Buchdal emphasized the importance of training in behavior management, suicide risk, and trauma-informed care for all RTCs, suggesting these topics were critical across the board. Ms. Hall inquired about Crisis Prevention Institute (CPI) training and mentioned that adult services included crisis and de-escalation training. Mr. Buchdahl from Catholic Charities responded that his RTC uses the Therapeutic Crisis Intervention (TCI) model from Cornell University. In response to a question from Ms. Thomas, he added that both the residential childcare (RCC) and RTC staff underwent similar training. Ms. Fleck asked if other RTCs had comments on this standard. There were no additional comments.

The conversation shifted to the specific training for different categories of direct service personnel. Ms. Neral asked if the training curriculum is tailored to meet the clinical needs of the population, including various disciplines such as registered nurses, physical therapists, social workers, and psychiatrists. Mr. Buchdahl highlighted that the specialized training was primarily for direct care staff, not other disciplines. Mr. Fracchia noted that for his RTC all staff working with youth participate in general training, with additional specialized training based on their specific disciplines. This approach ensures that staff are well-prepared to address the diverse needs of the youth they serve.

Staffing

(i) The applicant shall document that it will provide, either directly or by agreement, sufficient number of qualified professional, technical, and supportive staff to provide services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident as determined by a comprehensive assessment and individualized treatment and education plan.

(ii) The applicant shall document how the level of staffing will provide active treatment and fulfill the goals of its proposed treatment programs and meet the needs of the patients.

Ms. Fleck read the standard for staffing. Mr. Fracchia commented that the standard still functions effectively. Ms. Fleck asked if anyone else had comments. There were no additional comments.

Accreditation and Certification

(k) Accreditation and Certification. 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 Centers (COMAR 10.07.04).

Ms. Neral read the accreditation and certification standard. She noted that Senate Bill 403, which passed in the 2024 legislative session, allows RTCs to be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and the Council on Accreditation, in addition to the Joint Commission.

Ms. Neral further inquired whether accreditation and Medicaid certification are required prior to licensure by the Office of Health Care Quality or after licensure. She also asked for confirmation that only Sheppard Pratt and no other RTCs are licensed as a Special Hospital Psychiatric Facility. Mr. Fracchia confirmed Ms. Neral is correct. Additionally, Ms. Neral asked if there were other certifications that RTCs pursue beyond Medicaid. Dr. Maehr commented that their facilities require a DEA registration, a controlled Substance Administration (CDS) registration for telepsych services, and stock CDS medications, as well as Clinical Laboratory Improvement Amendments (CLIA) waivers for rapid testing. Another workgroup member noted that for the RICA facilities, both the facilities and individual providers need to maintain a current CDS and DEA certification along with a CLIA waiver. Dr. Maehr also mentioned the importance of having a Medicaid provider number for both the individual and the facility.

Security

(m) Each applicant shall document it can provide capacity to provide care in secure units, as necessary.

Ms. Fleck initiated a discussion on security requirements for care facility applicants, emphasizing the necessity for them to document their capability to provide secure units. She queried whether there was a need to modify these standards. Ms. Thomas expressed concerns about the specificity of the requirements, suggesting a broader approach to facility security rather than focusing solely on secure units. Mr. Fracchia supported this idea, advocating for security measures that encompass the entire facility.

Ms. Thomas further differentiated between hardware-secured and staff-secured facilities, with Ms. Neral confirming that currently, only one RTC operates with hardware security on the detention campus of Hickey. The conversation also touched on the importance of detailing security measures. Ms. Fleck asked if there were specific details that should be required from applicants to ensure the security of a facility. This led to a broader discussion, with Mr. Fracchia suggesting that security plans should include strategies to manage AWOL risks and unauthorized access to the facility.

Ms. Fleck highlighted the value of clarifying standards to assist applicants and regulatory staff in understanding what is required for compliance, thereby making the standards more meaningful and effective. Mr. Fracchia thanked the committee for their inclusive approach and for seeking feedback from RTCs.

Ms. Fleck concluded the meeting by acknowledging the need for another meeting to address unresolved issues, including the identification of the need for an RTC. She proposed scheduling the next meeting in early June and stated that a meeting summary would be circulated. She encouraged additional feedback from participants, and she thanked everyone for their contributions and active participation.