# Pediatric Patients Awaiting State Agency Services

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MHA
MASSACHUSETTS
Health & Hospital
ASSOCIATION

MASSACHUSETTS ASSOCIATION
OF BEHAVIORAL HEALTH SYSTEMS

# Pediatric Patients & Behavioral Health

As the behavioral health crisis persists, healthcare providers are reporting sustained challenges in access to care for pediatric patients who are state agency-involved*, ready to be discharged, and require services outside of inpatient level of care (IPLOC) or the emergency department (ED).

The Massachusetts Health & Hospital Association (MHA) and the Massachusetts Association of Behavioral Health Systems (MABHS) surveyed acute care hospitals and freestanding psychiatric facilities in May and December 2022 to understand the challenges facing state agency-involved pediatric patients who are ready for discharge to other care settings beyond IPLOC or the ED; these patients are typically referred to as "stuck."** This has shown to be a significant driver in the rise of behavioral health boarding.

**The survey is intended to:**

1. Provide insight into the challenges of medically and/or behaviorally complex pediatric patients in accessing state agency services in the context of the ongoing statewide pediatric behavioral health crisis; and
2. Inform a collaborative conversation on how to address the needs of pediatric patients in the short- and long-terms.

*State-agency-involved patients are those whose disposition planning requires the participation of a state agency and/or access to state agency services, including, but not limited to the Department of Children and Families (DCF), Department of Mental Health (DMH), Department of Developmental Services (DDS), and Department of Youth Services (DYS).

**Patients who are typically referred to as "stuck" are those facing barriers transferring to care environments that are not IPLOC. Pediatric patients who are *stuck waiting for a discharge disposition* are distinct from patients who are *boarding for an inpatient bed*.

# State Agency-Involved Pediatric Patients

## In December 2022, MHA and MABHS solicited reporting for point-in-time data to evaluate changes since May.

Acute care hospitals and freestanding psychiatric facilities were asked for:

1. Their total number of DPH licensed pediatric beds
2. Their total number of DMH licensed pediatric beds
3. The total number of agency-involved "stuck" pediatric patients in three settings within their facilities:
   - ✓ Emergency Department (ED)
   - ✓ Medical Surgical Units (MS)
   - ✓ Inpatient Psychiatric Unit (IP)
4. Demographics for each DCF-involved* "stuck" patient, including:
   - ✓ ethnicity, race, sex;
   - ✓ other agency involvement; and
   - ✓ number of days the patient has been awaiting transfer

**Survey results showed:**

**69** total agency-involved stuck pediatric patients across settings

**Respondents included:**

**36** facilities:
**29** acute care hospitals,
**5** freestanding psychiatric facilities

**Responding facilities represent:**

**817** DPH licensed pediatric beds

**328** DMH licensed pediatric beds

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NOTE: survey respondents may not have answered every question. The data in this report are based on the number of responses to each specific question.

*Survey Results:*

# DCF-Involved Pediatric Patients

57 of 69 (83%) state-agency-involved pediatric patients were DCF-involved:*

- 13 were DCF and **DMH involved**
- 8 were DCF and **school district involved**
- 5 were DCF and **DYS involved**
- 2 were DCF and **DDS involved**

28 of 57 (49%) DCF-involved pediatric patients were stuck in an Emergency Department (ED)

21 of 57 (37%) were stuck in an Inpatient Psychiatric (IP) unit

8 of 57 (14%) were stuck in a Medical Surgical (MS) unit

* DCF-involved patients are those whose disposition planning requires the participation of DCF and/or access to DCF services. State agency involvement in addition to DCF is not mutually exclusive.

| ALL AGENCY-INVOLVED PEDI PATIENTS | | | | |
|---|---|---|---|---|
| | **TOTAL** | **ED** | **MS** | **IP** |
| | **69** | **28** | **9** | **32** |
| **DCF & OTHER AGENCY INVOLVEMENT** | | | | |
| DCF | **57** | 28 | 8 | 21 |
| DCF and DMH | **13** | 8 | 3 | 2 |
| DCF and DDS | **2** | 2 | 0 | 0 |
| DCF and DYS | **5** | 3 | 1 | 1 |
| DCF and School | **8** | 5 | 0 | 3 |
| DCF and Other | **11** | 5 | 2 | 4 |
| **DAYS WAITING** | | | | |
| <10 days | **21** | 7 | 2 | 12 |
| 10 to 30 days | **15** | 4 | 2 | 9 |
| 31 to 60 days | **7** | 4 | 1 | 2 |
| 61 to 100 days | **3** | 2 | 0 | 1 |
| 101 to 200 days | **0** | 0 | 0 | 0 |

NOTE: survey respondents may not have answered every question. The data in this report are based on the number of responses to each specific question.

*Demographics:*

# DCF-Involved Pediatric Patients

**Demographics reported for the DCF-involved patients:**

- 35 were non-Hispanic and 16 were Hispanic
- 34 were White, 11 were Black, and 0 were Asian
- 19 were male and 31 were female

| DCF-INVOLVED PATIENT DEMOGRAPHICS* | | | | |
|---|---|---|---|---|
| ETHNICITY | TOTAL | ED | MS | IP |
| Yes - Hispanic/Latinx | **16** | 8 | 1 | **7** |
| No - Hispanic/Latinx | **35** | 15 | 7 | **13** |
| RACE | | | | |
| White | **24** | 10 | 5 | **9** |
| Black | **11** | 3 | 1 | **7** |
| Asian | **0** | 0 | 0 | **0** |
| SEX | | | | |
| Male | **19** | 9 | 2 | **8** |
| Female | **31** | 16 | 4 | **11** |

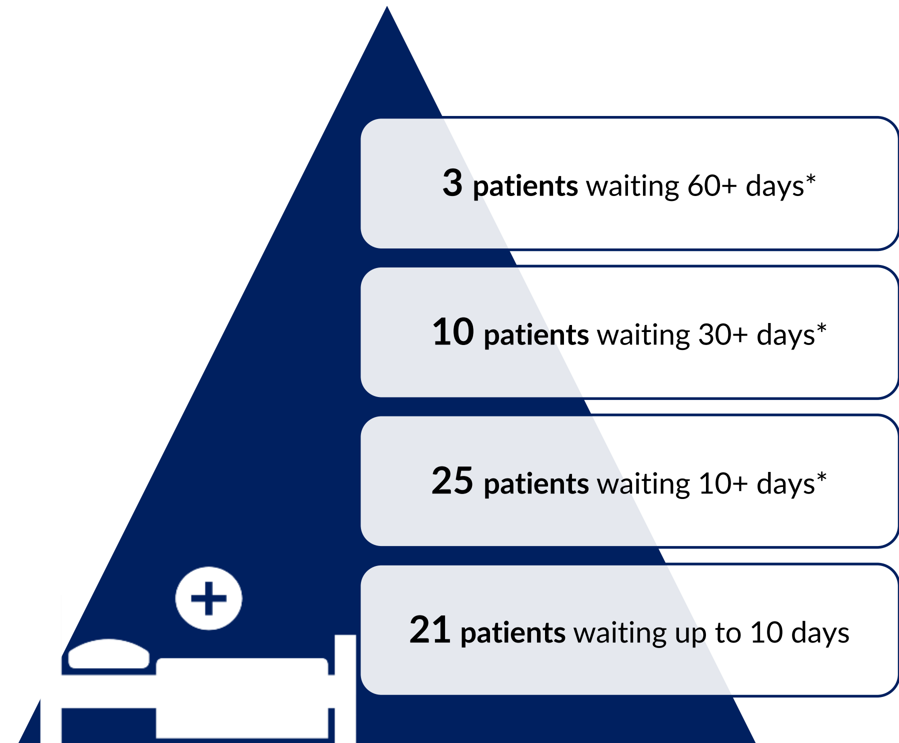
*Ethnicity and race are not mutually exclusive categories (i.e.: a patient can be non-Hispanic black or non-Hispanic white)

NOTE: survey respondents may not have answered every question. The data in this report are based on the number of responses to each specific question.

*Wait Times:*
# DCF-Involved Pediatric Patients

**Across all settings, the wait times reported for DCF-involved patients showed:**

- 21 patients had been waiting for up to 10 days
- 25 patients had been waiting 10 or more days
- Maximum wait time reported was 61-100 days




* Categories for more than 10 days are not mutually exclusive

NOTE: survey respondents not have answered every question. The data in this report are based on the number of responses to each specific question.

# *Wait Times:*
# DCF-Involved Children Stuck in 2022

## December

**36** facilities responded

**69** state agency-involved children

- 83% were DCF involved
- 49% were stuck in the ED
- 37% were stuck in an inpatient psychiatric unit

**50** children were awaiting residential-education*

## May

**41** facilities responded

**78** state agency-involved children

- 88% were DCF involved
- 46% were stuck in the ED
- 43% were stuck in an inpatient psychiatric unit

**54** children were awaiting residential-education*

*Children who are stuck awaiting residential-education are mutually exclusive from state agency-involved children

# Additional State Agency Resources

**Two additional questions about DCF and Office of the Child Advocate (OCA) processes were asked to understand the use of these agencies' resources:**

1. **Has your facility used the new DCF escalation protocol which included key state agency contacts that MHA circulated in January 2022?**

   **18 out of 36 (50%) answered yes.**

   Additional comments included:
   - The staff tried to be helpful but there was no impact on resolution. The patients involved are clinically complicated and there were very few programs appropriate.
   - The biggest challenge for our stuck DCF patients for the past several months has been pediatric patients who have diabetes. This has been the biggest hurdle for DCF as well.

2. **Has your facility involved the OCA to help with placements for any of the stuck patients in any capacity?**

   **8 out of 36 (22%) answered yes.**

   Additional comments included:
   - [Escalation protocols] have not achieved the goal of assisting in the placement of children with acute mental health needs.
   - We have used the OCA for highly complex patients with medical and psychiatric needs. We were still unable to place these patients.

NOTE: survey respondents may not have answered every question. The data in this report are based on the number of responses to each specific question.

# Additional Barriers to Placement

**Additional barriers to timely access to care include:**

- Capacity challenges for **children with co-occurring eating disorders and behavioral health needs.** There are two units that provide support for children with eating disorders.
- Capacity challenges for **children who are transgender and/or non-binary.** Children who are transgender and/or non-binary are often placed in single rooms, creating additional wait times for them to be placed in community-based settings that are not able to provide single rooms.
- Difficulty accessing community-based settings, such as residential settings and group homes, for **children with co-occurring diabetes and behavioral health needs.** Regulatory requirements pose a challenge to returning diabetic children needing insulin to these settings.

# Mental Health ABC Act

**The Massachusetts legislature enacted Chapter 177 of the Acts of 2022, *An Act addressing barriers to care for mental health* (the Mental Health ABC Act), which included important provisions addressing children's mental health and access to behavioral healthcare.**

**Final legislation passed included the following provisions:**

- ✓ A fund to support the operation of the new Complex Cases Interagency Review Team, require EOHHS and Department of Elementary and Secondary Education (DESE) to issue regulations for the Team and allow hospitals to elevate complicated cases to the Team.
- ✓ An online portal by EOHHS to facilitate placements for pediatric boarders and children who are awaiting residential disposition, or in the care or custody of a state agency and are awaiting discharge to an appropriate foster home or a congregate or group care program.
- ✓ An Office of the Child Advocate (OCA) ombudsperson and complaint process which provides an opportunity for complex pediatric behavioral health situations to be resolved.

# Additional Proposed Solutions

**MHA and MABHS continue to work in collaboration with legislators, state agencies, and partners across the continuum of care to address the challenges associated with children's behavioral healthcare. In addition to supporting the components of the Mental Health ABC Act, MHA and MABHS propose the following:**

## SHORT-TERM SOLUTIONS

- ✓ Centralizing the DCF process to escalate cases, including convening an emergency team to coordinate care for the child and determine an appropriate setting
- ✓ Funding the complex case resolution panel to eliminate financial barriers to placement
- ✓ Reimbursing congregate care programs to hold a bed while a child from said program receives treatment in another setting
- ✓ Conducting a study to determine system needs, including alternative models for children with complex and/or chronic medical and psychiatric needs

## LONG-TERM SOLUTIONS

- ✓ Expanding behavioral health competencies for community based-settings, including DCF and DDS group homes
- ✓ Eliminating regulatory barriers to supporting community-based settings for children with co-occurring behavioral health and medical needs, including diabetes
- ✓ Funding and/or developing care models and settings for children that are not adequately addressed through inpatient psychiatric hospitalizations, Community Based Acute Treatment (CBAT) services, or existing residential or community treatment models