Northern Light Health

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Maine Coast Hospital
Mayo Hospital
Mercy Hospital
Northern Light Health Foundation
Northern Light Pharmacy
Sebasticook Valley Hospital

LD 791 An Act Regarding Children with Behavioral Health Needs Awaiting Placement in Residential Care Facilities

Testimony in Support
March 24, 2025

Senator Ingwersen, Representative Meyer and members of the Health and Human Services Committee, my name is Lisa Harvey-McPherson RN. I am speaking today in support of this bill on behalf of Northern Light Health and our member organizations. Northern Light Health member organizations include 10 hospitals located in southern, central, eastern and northern Maine, nursing facilities, air and ground ambulance, behavioral health, addiction treatment, pharmacy, primary and specialty care practices and a state-wide home care and hospice program. Ninety three percent of Maine's population lives in the Northern Light Health service area. Northern Light Health is also proud to be one of Maine's largest employers with more than 10,000 employees statewide.

Northern Light Health actively participated with the stakeholder group established by LD 2009 last session; the group focused on addressing the challenge of long stays for youth in hospital emergency departments. The group met for many weeks resulting in the report you received from the department on January 16th 2025.

Northern Light Health presented youth case scenarios to the group highlighting the significant challenge that youth experience when stuck in emergency departments for weeks and months waiting for discharge to a community-based services – generally a secure psychiatric residential treatment facility out of state. My presentation focused on youth stuck in a Northern Light Health rural hospital to emphasize the fact that the challenge is not limited to Eastern Maine Medical Center, youth are stuck in every emergency department in every community in Maine. I have attached the presentation to my testimony, the slides tell the story of two youth one in our emergency department for 132 days, the other youth for 79 days. I have testified many times for many years about this crisis and the compelling need to establish the level of services that these children need.

As the stakeholder group was completing our work, the hospital participants provided the group with a specific list of recommendations for the final report. The recommendations are through our lens on the issue and focus on reducing length of stay in the emergency department and expanding availability of data on this crisis so there is full picture of what is happening. The bill before you today reflects our recommendations:

- **Crisis Centers** – This proposal creates a discharge location for the youth so they can be in an alternative environment outside of the emergency department while they wait to access the behavioral health services they need. The Department of Health and Human Services shall issue a request for proposals to develop 3 crisis centers in the State to meet the needs of children and adolescents with high levels of behavioral health needs who are located in a hospital awaiting placement in an appropriate residential facility or community service. At least 1/3 of the beds must be available for use by children with intellectual disabilities or autism spectrum disorder.
- **Psychiatric Residential Treatment Facilities** – The lack of a PTRF in Maine is the primary reason for extended emergency room behavioral health youth length of stay. The lack of a PTRF is also increasing the length of stay for children cared for at Acadia Hospital in need of this level of care to continue higher acuity behavioral health services before they can transition back home. This section of the bill once again directs the department to establish a contract for a PTRF no later than April 1, 2025. And if they fail to do so the department must establish a facility owned and operated by the department.
- **Hospital Days Awaiting Placement Payment** – Today hospitals receive payment for the initial acute emergency department clinical service, there are no additional payments for the cost of providing care for weeks and months to long stay youth. This section of the bill directs the department to create a days awaiting placement rate to help cover the cost of care
- **Monthly Data Reports** – Hospitals have been reporting monthly data on long stay youth to the department for a few years, this section of the bill strengthens the data reporting requirement for the department and mandates that the data be reported monthly. This data will advise this committee and stakeholders on a more comprehensive picture of the children in emergency departments thus advising effectiveness of services or gaps in care
- **DOJ Settlement Data** – This section requires the department to provide this committee with copies of de-identified data provided to independent reviewer pursuant to the settlement agreement. We believe transparency on the data provided to the reviewer will advise this committee and stakeholders on the effectiveness of service expansion resulting from the settlement agreement. We expect that data on behavioral health youth will be in the data provided to the independent reviewer.

We ask for that you support this important legislation, thank you.

Long Stay Emergency Department Behavioral Health Youth

- Scenarios represent long stay behavioral health youth in rural hospitals
- For the period Jun 2023-May 2024 - 70 behavioral health children were in a NLH emergency department for longer than 48 hours
- Most of the children are in the following NLH ED's
  - EMMC 27% of Long Stay Youth
  - AR Gould 24% of Long Stay Youth
  - Mayo Hospital – 21% of Long Stay Youth
- Rural emergency departments are small with a limited number of beds, due to the limited size of the unit youth are exposed to sounds 24/7 and at times sight of trauma, violence and death that occurs in the emergency department setting
- Youth "live" in a small emergency department room (generally 8x10) with no windows and generally no TV/electronics. For safety purposes the room has a mattress low to the floor and no movable objects that can be weaponized
- Youth do not leave the emergency department, acute medical service provided if needed otherwise the youth are waiting to access residential behavioral health services
- We are not focusing on youth acts of violence against emergency department personnel, but unfortunately this does occur

Youth A – 132 Days in the Emergency Department

- Presented to the emergency department for an evaluation after altercation in the home
- Medically cleared after patient registered into care. NL Acadia Consult - met in-patient psychiatric level of care for 6 days and then crisis level of care for 5 days. Presented to all inpatient psych and crisis facilities – not accepted into care
- Mother refused discharge to home when no longer crisis level of care
- DHHS CCU/OBHS meeting on day 4 - Day 12 focus transitioned to community placement
  - 48 CCU/OBHS Meetings
  - 2 Child Protective Intake Calls
  - 17 additional contacts with DHHS
  - 8 contacts to Disability Rights Maine for assistance
  - 7 Native American Tribe Contacts for Support/Services
  - 8 Regional Care Team Contacts – Housing, DOJ options (Probation Officer and Lawyer Involvement)
  - 3 Contacts School Administrative Unit outreach for educational support – Delayed Support
  - Residential Care Referrals Statewide- (OBHS initially then transferred to ED SW)
  - Day 70 approval from OBHS to authorize out of state placement
  - Day 103 Patient accepted to out of state Secure Psychiatric Residential Care Unit
  - Day 132 Patient Discharged to out of state placement

Youth B – 79 Days in the Emergency Department

- Youth brought to the ED by State Police, youth involved in violent incident with caregiver. High risk living conditions
- State Police notified child protective services, as did hospital staff
- Child medically cleared, NH Acadia telehealth consult – does not meet inpatient level of care does meet residential level of care.
- Mother resides in geographic distant location, refuses to allow youth to be discharged home
- CPS Care Manager – weekly meetings and referrals to all in state residential care providers. ED advocated for the need to refer to level of service required for this child – Secure residential psychiatric treatment.
- ED outreach to mother, School Administrative District and Dept of Education for education support. After 6 weeks electronic education support provided
- 2 months after admission approval for out of state placement
- 2/12 months accepted into out of state facility
- Youth discharged to out of state facility secure psychiatric residential treatment out of state on day 79