Pappas Working Group
Final Report

Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619
The Commonwealth of Massachusetts

October 21, 2025

Maura Healey
Governor
Massachusetts State House
24 Beacon St.
Boston, MA 02133

Kim Driscoll
Lieutenant Governor
Massachusetts State House
24 Beacon St.
Boston, MA 02133

Dear Governor Maura Healey,

On February 24, 2025, you instructed the Department of Public Health (DPH) Commissioner Dr. Robert Goldstein to conduct a review of the pediatric care offered at Pappas Rehabilitation Hospital for Children (PRHC) and make viable assessments about the best provision of high-quality pediatric care within the public health hospital system (PHHS).

In response, please find enclosed a report from the Department of Public Health entitled "*Pappas Working Group Final Report 2025*"

Sincerely,

Ted Constan
Deputy Commissioner, Public Health Hospital System
Department of Public Health (DPH)
Working Group co-chair

Charlie Doody
Town Administrator
Town of Canton
Working Group co-chair

Executive Summary

- The Governor appointed the Pappas Working Group (PWG) **to conduct a review of the pediatric care offered at Pappas Rehabilitation Hospital for Children (PRHC) and make viable assessments about the best provision of high-quality pediatric care within the public health hospital system (PHHS).**

- Seven meetings were held virtually with strong member attendance and engagement. In addition, since the PWG was committed to hearing directly from those most impacted by the potential closure of PRHC and to see the state of the campus infrastructure and programs in person, DPH organized an on-site listening session and campus tour on May 28, 2025 for the PWG to hear testimony from staff, families and patients in person.

- Of the 340,000 children with special physical, emotional, developmental and behavioral needs in the Commonwealth, 12,000 children face complex medical needs. Children with medical complexity (CMC) and their families face significant unmet medical, therapeutic, educational, socio-emotional, and habitational challenges. Though a relatively small percentage of these patients need rehabilitative hospitalization in any given year, the options are extremely limited when the need is the most critical.

- The most impactful public health program to address this unmet need would be a modernized medical inpatient ~50 bed unit providing short- and long-term lengths of stays as clinically needed while serving as many children as possible. These beds would be in addition to the pediatric beds on the Canton campus.

- Though medical care was identified as the most acute need that should be offered by such an inpatient unit, the PWG found that therapeutic interventions such as physical, occupational, speech, behavioral, and recreational therapies have enormous value to the patient and to the care system, including measurable functional gains, patient satisfaction and engagement, reduced hospitalizations, a better chance of succeeding in their home communities and schools upon discharge, and cost-effectiveness.

- The antiquated and deteriorating physical conditions on the Canton campus severely limit PRHC from delivering care at hospital level of medical and/or behavioral complexity.

- The Commonwealth faces significant challenges to fit major construction projects into its capital improvement plan. Many of the 300 buildings across EOHHS campuses statewide are 50-100 years old, in poor condition, and in need of replacement.

- The PWG discussed five potential programmatic options for future pediatric services on the Canton campus and one option to serve CMCs elsewhere in the public health hospital system. Each of these options have been evaluated across a set of criteria, including alignment to need, equity, quality of life, quality of care, capital and operating costs, timeframe, and labor impact. After gaining a deeper understanding of the Commonwealth's capital constraints, the PWG began to explore potential project delivery alternatives, including public/private partnerships, and agreed that more investigations are warranted.

- Intervening legislative action has resulted in continued operations for PRHC with service level reporting requirements. A legislative commission has also been established to continue exploring the options for the future. The PWG stands ready to conduct a knowledge transfer to the special legislative commission as it begins work.

- With no pediatric bed alternative available within the public hospital system, the Commonwealth is vulnerable to a significant infrastructure failure at PRHC that may require a highly disruptive set of emergency discharges, potentially off hours and under adverse weather conditions, to the private sector. The PWG suggests three actions for the near term to address this concern:
    - Make targeted facility investments in life safety, quality, and accreditation standards at PRHC to strengthen the environment to deliver at least current level of care.
    - Develop a pediatric service at Western Massachusetts Hospital (WMH) to create additional pediatric beds in the Commonwealth.
    - Support the efforts of the legislative commission to conduct its study on the future of the Canton campus.

Working Group Background

On January 22, 2025, the Governor filed a fiscal year 2026 (FY26) budget proposal, known as House 1, including an initiative of the Department of Public Health (DPH) to relocate and modernize Pappas Rehabilitation Hospital for Children (PRHC) from its current Canton location to the campus of Western Massachusetts Hospital (WMH) in Westfield. The proposal was driven by a deep commitment to serving children with multiple disabilities and complex medical needs who have been unable to find the medical support they need and deserve in their home or community.

In subsequent weeks, the Governor heard directly from patients, families and staff about the important role that PRHC plays in the delivery of care. Deeply grateful for their feedback, as well as for the hard work of the teams at DPH focused on providing all patients with the high-quality, modernized, specialized care they need and deserve, the Governor directed DPH to pause the plan to relocate PRHC on February 25, 2025.

To move forward, the Governor brought together a diverse group of stakeholders-- including patients, families, labor, state and local officials, and medical professionals-- to conduct a review of the care offered at PRHC and make assessments on the best path forward to providing the highest quality of care with the resources at hand.

Charter & Membership

The Governor appointed the Pappas Working Group (PWG) with the **charge to conduct a review of the pediatric care offered at PRHC and make viable assessments about the best provision of high-quality pediatric care within the public health hospital system (PHHS)**.

It is important for the PWG to note that its charge did not include a review of potential uses of the Canton campus if the PRHC were to close operations.

Co-Chaired by DPH Deputy Commissioner Ted Constan and Canton Town Administrator Charlie Doody, the committee is an impressive group of stakeholders with a great deal of lived and work experience across multiple disciplines, in alphabetical order:

First	Last	Role	Title/Affiliations
Ted	Constan	Co-Chair	Deputy Commissioner of Public Health Hospitals System, DPH
Charles	Doody	Co-Chair	Town Administrator, Canton
Shakirat	Bamidele	Family/Caregiver	
Peter	Brigham	Healey-Driscoll Admin	Deputy Commissioner, Planning, Division of Capital Asset Management and Maintenance (DCAMM)
Kevin	Brousseau	Labor	American Federation of Labor and Congress of Industrial Organizations (AFLCIO)
Vincent	Chiang	Hospital Sector	Interim President at Franciscan Children's Hospital
Naomi	Chedd	Family/Caregiver	Child and Family Therapist, Board Certified/Licensed Behavior Analyst
Chris	Cook	Labor	National Association of Government Employees (NAGE)
Jim	Durkin	Labor	American Federation of State, County and Municipal Employees (AFSCME)
Paul	Feeney	MA Senate	Senator, Bristol and Norfolk
Maria	Figueroa	Family/Caregiver	
Dave	Foley	Labor	Service Employees International Union (SEIU)
Cindy	Friedman	MA Senate	Senator, Fourth Middlesex
Jay	Livingstone	MA House	Chairman, State Representative, 8th Suffolk
Stephen	Lynch	US House	US Congressman, District 8, MA
Joanne	Marqusee	Healey-Driscoll Admin	Assistant Secretary, Executive Office of Health and Human Servies (EOHHS)
Jack	Maypole	Clinical	Medical Director of the Boston Medical Center Pediatric Comprehensive Care Program
Mary	McGeown	Healey-Driscoll Admin	Undersecretary, Human Services, EOHHS
Katie	Murphy	Labor	Massachusetts Nurses Association (MNA)
Pam	Nourse	Disability Community	Executive Director, Federation for Children with Special Needs
Matt	Sadof	Clinical	Pediatrician; MA Chapter of the American Academy of Pediatrics CYSHCN Committee Member
Dana	Sullivan	Healey-Driscoll Admin	Chief of Strategy and Operations, Executive Office of Administration and Finance (A&F)
Maura	Sullivan	Disability Community	CEO, The Arc of Massachusetts
Lauren	Woo	Healey-Driscoll Admin	Acting Deputy Commissioner, Department of Elementary and Secondary Education (DESE)

Process

The PWG met eight times (seven virtual, one in person at PRHC) from April to July 2025 with these themes:

Date	Theme
April 16, 2025	Introductions and Charter Review
April 30, 2025	In-depth review of care provided at PRHC
May 14, 2025	Care needs of children and youth with special health needs including those with medical complexity
May 28, 2025	Listening session and tour at PRHC
June 4, 2025	Financial and infrastructure challenges in the Commonwealth Potential Western MA pediatric program
June 11, 2025	Development of options
June 25, 2025	Discussion of options
July 30, 2025	Report review & finalization

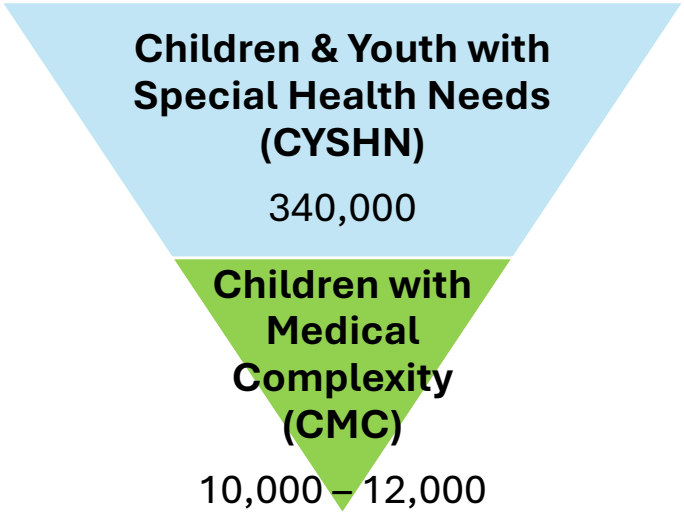
Seven of the meetings were held virtually with strong member attendance and engagement. Beyond this, the PWG was committed to hearing directly from those most impacted by the potential closure of PRHC and to see the state of the campus infrastructure and programs in person. DPH organized a listening session on May 28, 2025 for the PWG to hear testimony from staff, families and patients in person. Over two dozen people spoke and a set of written comments were received. PWG members were also able to tour the campus including the clinical and therapeutic facilities and the school and athletic buildings. Along the tour, PWG members were able to speak with and ask questions of the clinical, facility, therapeutic, and educational personnel as well as patients along the way. PRHC also conducted staff focus groups to gain input and shared feedback with the PWG.

The meetings equipped members with the data needed and subject matter expertise, including invited guest speakers, to objectively review clinical and programmatic capacity relative to patient needs in the Commonwealth. PWG members were able to ask the state staff to research some more complex questions and report back. The PWG dedicated the last few meetings to brainstorming options and evaluating those options across a set of agreed upon criteria. The PWG was able to develop a shared understanding on a set of findings, which are described in the following sections.

Needs of Special Needs Population

Patient Population

There are roughly 2,000,000 children in the Commonwealth. Of these, approximately 340,000 have special needs. Within those, there are roughly **12,000 children with medical complexity (CMC).**



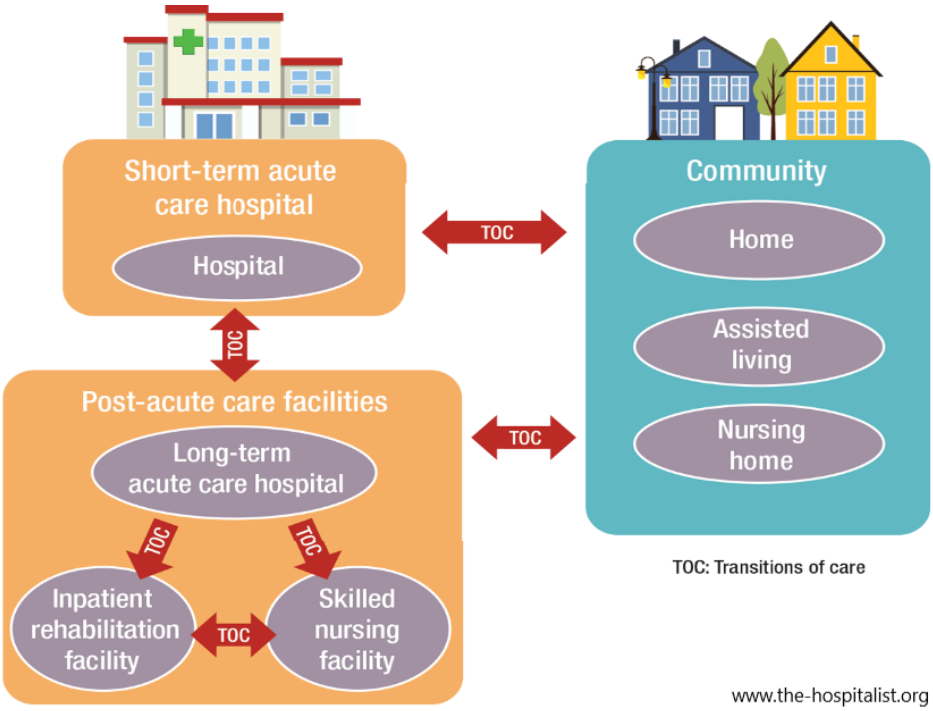
- Growing population with high needs - medical, behavioral, emotional, developmental
- Chronic condition(s) that involve multiple organ systems, including severe neurologic conditions
- Functional limitations, often needing medical technology
- Significant family impact (emotionally, financially, logistically)

CMCs and their families face significant unmet medical, therapeutic, educational, social-emotional, and habitational challenges.

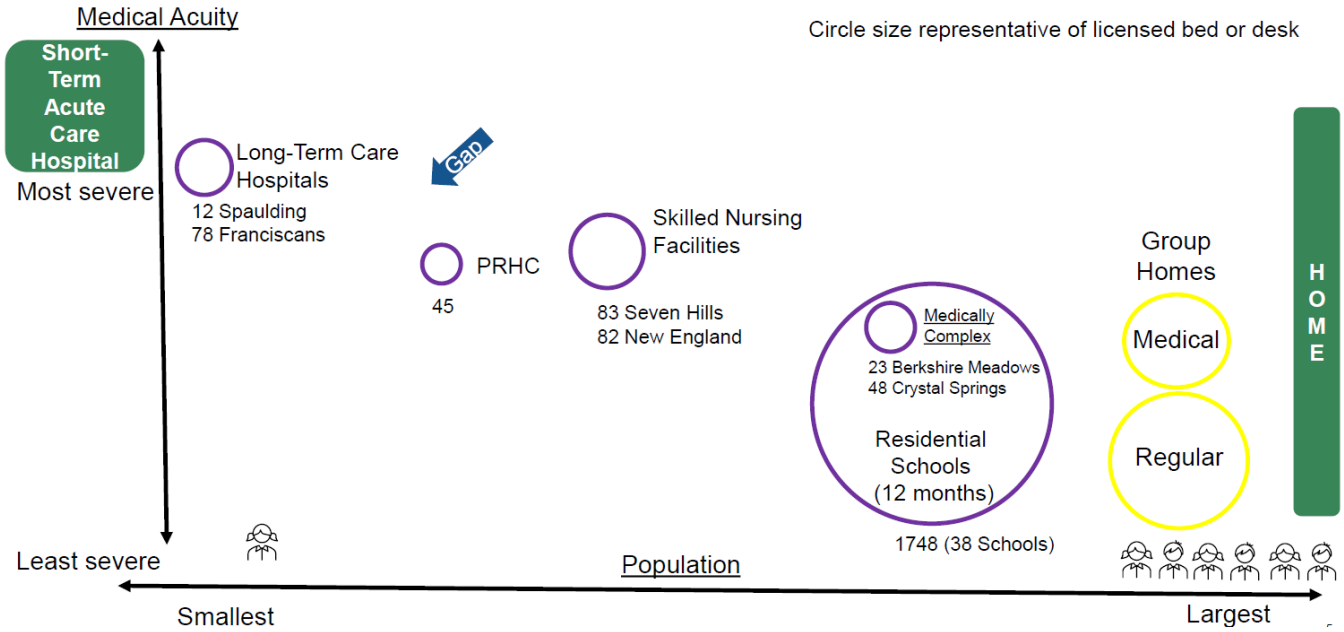
Medical Care Needs

The CMC group has compelling needs for **periodic episodes of hospital level of care**:

- Frequent hospitalizations / high healthcare utilization
- Multiple pediatric sub-specialists
- Complex behavioral health challenges
- Emergency placements
- Respite for caregivers



Many CMCs are currently "stuck" on inpatient floors and EDs in the private short-term acute system and require a level of post-acute care higher than available at either PRHC or either of the two pediatric skilled nursing facilities in the Commonwealth (New England Pediatric and Seven Hills). Hospital-level care provided by long-term care hospitals (LTCH's) like PRHC benefit patients and the health system by providing the right care at the right time, freeing up short-term acute (higher cost) beds for more acute patients, and reducing re-admissions from settings with less clinical support. Unfortunately, there is a demonstrable gap in the continuum of care in post-acute hospitalizations, as illustrated by this chart:



As the medical complexity of patients increases, the population in need decreases as expected, but the beds available with hospital level of care for long-term stays become extremely scarce. That is, while fewer children require hospital level care, finding a bed for those children is very challenging. Options for patients stepping-down from acute care hospitals who are still in need of hospital-level, physician-ordered level of care are limited to two private facilities (Spaulding and Franciscans) and PRHC, while PRHC's level of care capacity remains constrained by facility challenges. All three of these facilities are in the eastern part of the state.

Among a large set of needs facing this population, the PWG identified programming that would most directly meet the needs of this population.

Medically Complex Care: Patients admitted primarily for management of medical and rehabilitative needs that require hospital level care.

- Access to at least daily physician intervention or the 24-hour availability of medical services and equipment available only in a hospital setting.
- Attended by pediatric/family medicine hospitalist with targeted access to pediatric specialist care.
- Multi-disciplinary approach with appropriate levels of nursing, therapy, social work, and nutrition support.
- Discharge planning with a focus on community integration starts on the day of admission.
- Lengths of stay are between 3-12 months, or as long as clinically indicated.

Medical / Behavioral Service**:** Patients admitted with combined medical complexity and behavioral health challenges

- Serves patients that might require step-down from Community Based Acute Treatment (CBAT) level care or who are boarding in pediatric emergency departments.
- Short-term stabilization program in lieu of acute hospital care while addressing medical rehabilitation needs.

- Lengths of stay are between 3-9 months, or as long as clinically indicated.

Caregiver Short-Term Respite: Patients are admitted to provide respite for both patients and families currently cared for at home.

- Addresses planned and unplanned/emergent care givers respite needs of pediatric patients with complex medical care but who remain in the community
- Patients 5-21 years old, residing with their legal guardians in their homes in the Commonwealth
- Top request by caregivers, as reported by the EOHHS Office of Complex Case Management Parents of CMCs would be more amenable to taking child home if respite is part of ongoing care plan.
- Complex behavioral health
- Predefined admission lengths of stay 5-14 days

To fully accomplish these three programs, the appropriate hospital facilities are necessary.

The most impactful public health program to serve the unmet needs of CMCs would be a modernized medical inpatient ~50 bed unit providing short- and long-term lengths of stays as clinically needed, while serving as many children as possible. These beds would be in addition to the pediatric beds on the Canton campus.

Therapeutic / Rehabilitative Care Needs

A large subset of CMCs is cognitively capable of benefiting from rehabilitative care. Therapeutic interventions are tailored to restore function, promote independence, and improve quality of life across physical, cognitive, and emotional domains. These interventions are delivered by interdisciplinary teams and vary based on patient needs, diagnoses, and recovery goals.

Needed interventions include:

- Physical Therapy: Targets mobility, strength, balance, and pain reduction through exercise, manual techniques, and other modalities.
- Occupational Therapy: Focuses on daily living skills, adaptive strategies, and environmental modifications to support independence.
- Speech-Language Therapy: Addresses communication, cognition, and swallowing disorders, often critical after stroke or brain injury and for those with degenerative conditions (e.g., MD).
- Psychosocial Support: Includes counseling, instruction in self-regulatory techniques, and behavioral therapy to manage emotional challenges and promote mental well-being.

These interventions provide enormous value for the patient and to the care system, including measurable functional gains, patient satisfaction and engagement, reduced hospitalizations, and cost-effectiveness. Therapy goes beyond recovery to the restoration of dignity, purpose, self-regulation, and meaningful participation in life.

The PWG found that PRHC excels in its therapeutic care, arguably providing an unmatched level of service due to the quality, experience and dedication of the staff as well as a unique set of physical amenities including dedicated rehabilitation rooms, an aquatic center, a stable for horses and other animals, garden/farmlands, an adaptive play park, and an athletic center including a bowling alley. Throughout the year, the team holds meaningful events in the lives of children including theatrical performances, managing a campus canteen, a prom, and a high school graduation. Moreover, a hidden gem on campus is the Rehabilitation Engineering program which provides patients with adapted equipment and assistive technology services and perhaps most important, timely repairs. This includes custom design and fabrication to empower youth to live as independently as possible.

PRHC delivers on the pillars of therapy by developing physical abilities, helping kids get out of wheelchairs when possible, building social relationships, and connecting with community resources outside the hospital.

The PWG assessment is that any medical / behavioral service must honor the commitment, quality, and capacity for a strong therapeutic program.

Educational Needs

Local school districts typically provide both general education and special education to students who reside in their districts. School districts ordinarily must identify, evaluate, and provide or arrange the provision of special education programs. In some circumstances, a student's Individualized Education Program (IEP) Team may determine that the student requires an out of district placement. Parent/guardians have procedural rights regarding the provision of special education services. Eligible students 3-21 years of age with a disability are entitled to a free appropriate public education.

Under a statutory requirement, the Department of Elementary and Secondary Education (DESE) makes special education available in institutional settings, including PRHC. DESE retains the discretion to determine, based upon resources, the type and amount of special education and related services that it provides in institutional settings. School districts are not relieved of their obligation to students in such settings (including in PRHC). School districts must still ensure that the students receive special education services as identified by the Individualized Education Program (IEP).

DESE's work at PRHC is guided by these principles:

- All students are known and valued;
- Have equitable opportunities to excel in all content and future ready areas across all grades;
- Receive individualized support and special education services designed to meet their unique needs and that prepare them for further education, life-long learning and exploration, employment, independent living, and transition to be involved members of their communities.

The special education services are made available through DESE's Special Education in Institutional Settings (SEIS) which provides a basic academic program and special education services aligned to each student's IEP goals and objectives in coordination with each student's school district.

Required by law, the provision of special education for children in a pediatric facility operated by the Department of Public Health is a necessary component of any future pediatric care programming.

Habitation Needs

One of the more challenging needs for CMCs is the provision of suitable habitation. As demonstrated in the earlier bubble chart, residential options for the 12,000 CMCs are quite limited, numbering under 2,000 beds. The vast majority of CMCs live at home. Families coping in these circumstances are under great stress, which is the impetus for the caregiver respite initiative. Basic standards for habitation are contained in the Sanitary Code, which require structural integrity, working utilities, ventilation and light, privacy and accessibility, and sanitation. For CMCs, the needs are often far greater, including mobility aids, adaptive furniture, and an accessible and safe environment.

Broader Context of Patient Need

Though this report is focused on CMCs facing a need for hospitalization, the PWG reached a general agreement on two areas of unmet need of the larger population of students with disabilities:

1) Children with disabilities have limited care settings with robust services. Indeed, many children who do not require inpatient level of care are living at home and desperately need the beneficial therapeutic services described. The PWG heard much testimony regarding the transformative impact of these supports on lives of children who have been cared for at PRHC in the past.
2) Prospects for special needs care transitioning to adult care at age 22 are limited. Each year, over 200 young adults with disabilities turn 22 and struggle to find placements in the community. The PWG supports the development of transitional group homes where people with disabilities can develop skills to better prepare for transition into community settings, when ready. Such group homes would cater to clients who are medically complex but do not require hospital level of care and may never be able to be placed at home.

Though outside of the scope of this workgroup, the PWG assessment is that the Commonwealth further study and respond to these compelling statewide needs.

History

The Pappas Rehabilitation Hospital for Children (PRHC), as it is known today, was originally established in 1904 by Chapter 446 of the Acts of 1904, as the Massachusetts School and Home for Crippled and Deformed Children. From the very outset, under the guidance of Dr. Edward H. Bradford, the mission was to serve as a **public residential facility** with **hospital** and **school** facilities available to all disabled children of the Commonwealth.

The campus was designed specifically for children with physical disabilities with its covered walkways which connect all the major buildings and allow for unobstructed movement for the children to travel between them. In 1907, the facility was renamed the Massachusetts Hospital School by Chapter 226 of the Acts of 1907 and opened its doors with the admission of 104 children under the direction of Dr. John E. Fish who served as the school's superintendent until 1946.

In 1906, the first buildings erected were the Administration Building, Powerhouse, Laundry Building, Barn, Dormitories, Assembly Hall and 2 cottages. More buildings were added over the decades, including Ellis, Ross, and Baylies in the 1930s, Gates and Bradford in the 1950s, Nelson and Brayton High School in the 1960s, and the athletic/aquatic center in the 1980s.

In 1999, the hospital became Joint Commission accredited. The Joint Commission is an independent, nonprofit organization that serves as the oldest and largest standard-setting and accrediting body in healthcare. The mission of the Joint Commission is to enable and affirm the highest standards of healthcare quality and patient safety for all. It does this by evaluating health care organizations to help guide them to provide safe and effective care of the highest quality and value.

It is important to note for any future evolution of work on the campus that PRHC's independent accreditation with the Joint Commission designates it as a hospital, subject to all the standards the Joint Commission applies to Long-Term Care Hospitals. Further, PRHC is funded by MassHealth as a Chronic Care Hospital. Any potential shift away from medical care on campus would involve significant restructuring of PRHC licensure, funding, and regulatory compliance.

Following the enactment of a bill sponsored by Representative William C. Galvin of Canton, in April of 2016, Governor Charles D. Baker signed Chapter 87 of the Acts of 2016 into law, renaming the facility to the Pappas Rehabilitation Hospital for Children. The Act acknowledged Dr. Arthur Pappas as a long-standing advocate for children and for his vast contributions to the hospital's mission as well as to the Commonwealth.

Mission

The current mission statement of PRHC incorporates the special needs of CMCs:

> To provide **medical**, **rehabilitative**, **educational**, **recreationa**l, **habilitative**, **transitional, and complementary alternative medical services** to children and young adults with multiple disabilities, assisting them to achieve their optimal level of independence in all aspects of life.

Hospital Level of Care

PRHC, along with the other DPH public hospitals, are required to follow MassHealth reimbursement regulations (130 CMR 435.00) which states that services at PRHC are reimbursable only when the patient (MassHealth member) meets the level-of-care criteria within the regulation. To be medically necessary, an admission to or continued stay must meet one of the following two Level of Care criteria in section 130 CMR 435.409(B)(1) and (2):

1. The member must require services that: (a) can be provided safely and effectively at a chronic disease hospital level. Such services **must be ordered by a physician and documented in the member's record; and (b) include at least daily physician intervention or the 24-hour availability of medical services and equipment available only in a hospital setting.**
2. The member's medical condition and treatment needs are such that no effective, less costly alternative placement is available to the member.

Despite the habitation element of PRHC's mission, as currently licensed and accredited with the Joint Commission, it is not a permanent home for children with disabilities to age 22. PRHC is currently staffed with physicians and nurse practitioners who provide 24-hour availability of attending provider coverage. To substantiate medical necessity, this team conducts a review of medical records, including significant past medical history, ongoing problems, physician notes, and test results prior to offering

admission and on an ongoing basis. National organizations (MCG, InterQual) publish evidence-based guidelines establishing the necessity and appropriateness of medical services, procedures, tests, medications, and other healthcare interventions for a patient's condition. PRHC makes this comparison to determine if the patient will be able to respond to its interventions. This process is known as Utilization Review:

- CMS and the Joint Commission mandated
- Insurers reimburse based on these standards
- Providers must attest to the level of intervention
- Audits occur regularly

As discussed below, there is a serious limitation on the ability for PRHC to make available the medical services and equipment of a typical hospital setting. Moreover, while the placement of PRHC patients in less medically acute settings is difficult, experience has proven that many can find effective and less costly alternatives. From January 2024 to March 2025, PRHC's inter-disciplinary care teams, collaborating with other state agencies and the private sector, found placements for 21 PRHC patients.

DCAMM Report

The PRHC facility is comprised of approximately 166 acres which supports the 30+ campus buildings totaling 457,000 square feet of space for clinical, educational, residential, recreational, administration/office, and infrastructure uses. The campus has a pastoral appearance with a combination of flat areas and gently rolling hills. Of the 166 acres of available land on campus, Pappas Rehabilitation Hospital for Children has approximately 110 acres of undeveloped wooded and open land. Design capacity is 90, though staff report historical occupancy as high as 120.

In 2023, DCAMM commissioned a study:

- To evaluate PRHC site infrastructure and building systems.
- To ensure applicable standards are met in an appropriate rehabilitative setting for the existing programs.
- To analyze space usage efficiency in critical buildings and identify existing buildings that are best positioned for campus improvement in the short and long term.

There were many significant findings from the report, which is available at 20230927_DCAMM Pappas Report Final. Deficiencies were outlined in program and design, exterior conditions, HVAC, building infrastructure and envelopes, and accessibility. A particularly alarming finding is that existing doors are not wide enough for beds to fit through during bed evacuations such as in a fire. Staff have instead been trained to pull patients out on boards or sheets to be prepared.

Renovations in a building that represent 30% or more than the replacement value of the building, will require full compliance with current accessibility code including the Americans with Disabilities Act. Because no renovation of this magnitude has occurred in any building since initial construction, today PRHC would not be deemed in compliance.

Many structures exhibited deteriorating physical conditions, and some did not comply with current codes and healthcare facilities standards. These buildings complied with the building codes and health care standards at the time they were constructed, they now qualify as pre-existing non-confirming structures and uses. This means that if upgrade projects are initiated, significant code and health care standards will be required. These outdated buildings were found to impede the staff's ability to maintain the ideal level of care.

As a result of the study, PRHC closed the Gates Building on January 14, 2024 and the Ross Building on April 3, 2024. All patients residing in those two buildings were either discharged to other settings (14) or transferred to the Nelson Building.

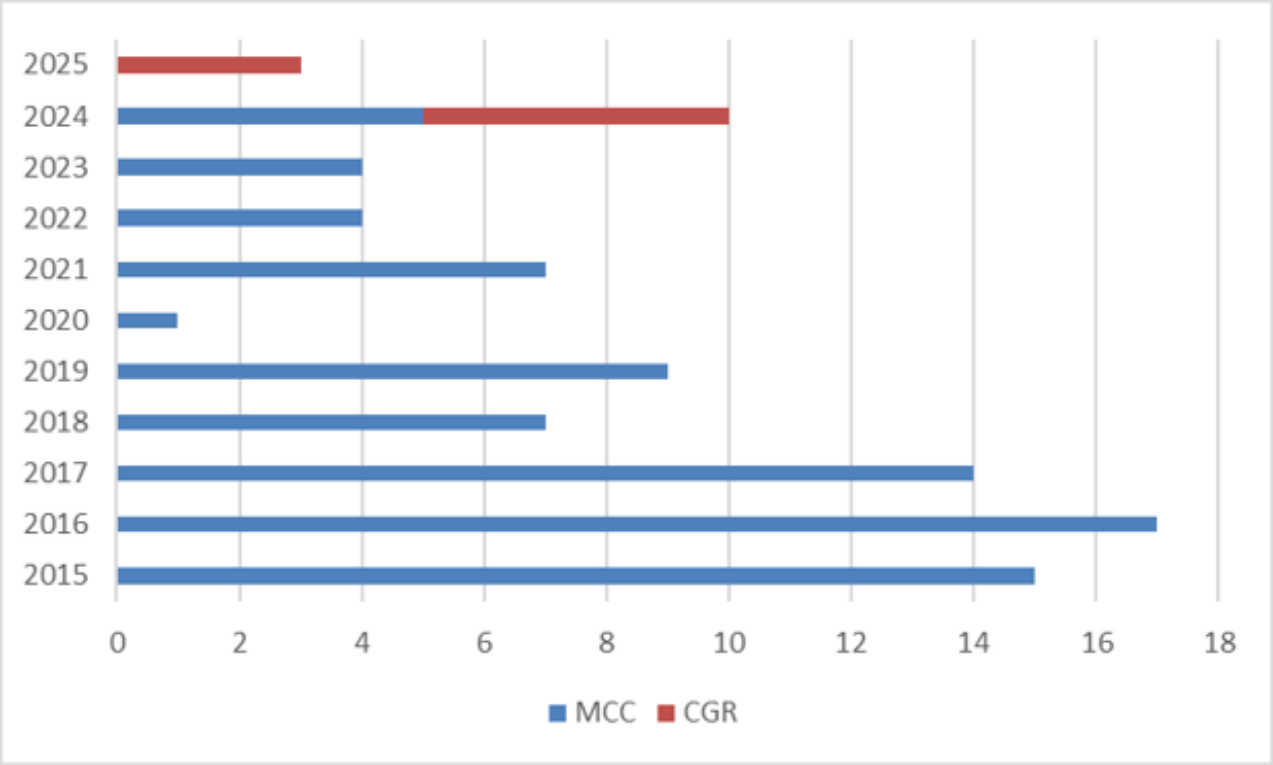
Admissions Challenges

The antiquated and deteriorating physical conditions on the Canton campus severely limit PRHC from delivering care at hospital level of medical and/or behavioral complexity. The resulting narrow set of admissions criteria restricts the impact PRHC can have on addressing needs of the population and on filling gaps in the care continuum.

Condition	Limitation
Patient room head walls do not provide the appropriate equipment to support more complex patient care (such as oxygen, suction)	No patients on mechanical ventilation No patients requiring bedside procedures
Patient rooms are not modernized with anti-ligature technologies. Campus (including pond) is sprawling with inadequate limits on movement.	No patients with challenging behavioral health issues due to safety concerns. Any patient with active suicidal ideation must be transferred to a more suitable facility.
Most areas rely on passive ventilation using open windows for air change in warmer months. No "negative pressure" patient rooms are available.	No patients actively infectious with respiratory conditions.
No monitoring systems in place at nursing station	No patients that require 24-hour oxygen or other intensive monitoring
Infrastructure does not include radiology service	No patients that require NG insertion to test for proper placements or have episodic intestinal obstruction for work up
No laboratory onsite	No patients that require multiple, regular labs
With the exception of one clinical room, all patient rooms are double	Loss of bed capacity to accommodate a patient that requires single room status for various medical diagnosis

To respond to the declining enrollment given clinical limitations and, more important, to respond to the strong demand for this service from CMC families as described above, the PRHC team launched a caregiver respite program (CGR) in 2024.

Admissions for complex medical and behavioral care (MCC) has trended down in the past decade. The introduction of the caregiver respite program has helped stabilize census:



PRHC has worked to raise awareness about its services with regular meetings with referral hospitals and specialists reviewing patients, but referrals suitable for admission remain limited. The major reasons for declined/withdrawn applications are:

- Too medically complex for PRHC to serve
- Too behaviorally complex for safe care
- Does not meet hospital level of care
- Rehabilitative improvement unlikely at hospital

The PWG discussed ideas to increase referrals, including strengthening communication with providers, as well as connecting better to school systems.

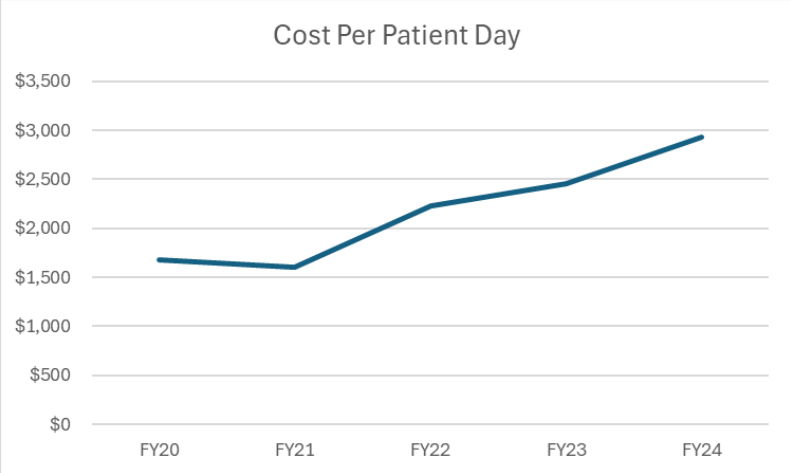
Finances

As reported to the Center for Health Information and Analysis (CHIA), PRHC total expense was $42.8M in state fiscal year 2024. The Commonwealth claimed federal reimbursement from Medicaid for that year of $17.2 M, for an operating loss of $25.6 M, covered fully by state appropriations. These figures do not include the additional cost of running the school, which is approximately $2.5 M state funding and $206 K federal funding, for a total operating cost of $2.7 M annually.

With all the overhead of running a full campus while capped in admissions to the 45 remaining viable beds in the Nelson Building, PRHC's per patient cost is significantly higher than other facilities in the pediatric care continuum, approaching $1.4 M per patient per year (exclusive of education cost), while delivering a significantly lower level of medical services than needed.

	FY20	FY21	FY22	FY23	FY24
Total Expenses	$34,703,313	$33,704,450	$39,694,486	$39,143,294	$42,846,492
Total Patient Days	20,695	21,054	17,823	15,911	14,629
Average Client Count	57	58	49	44	40
Cost Per Patient Day	$1,677	$1,601	$2,227	$2,460	$2,929
Cost Per Patient Year	$612,066	$584,313	$812,910	$897,951	$1,069,039

With 12,729 patient days (the total days spent by all patients in a facility over a specific period) projected and increasing costs, PRHC FY25 cost is trending to $3,750 per day or ~$1.4 M per year.



The continuum of care for children with disabilities and complex medical needs includes a variety of post-acute facilities with different levels of service, staffing, and funding.

Pediatric Chronic Disease & Rehabilitation Hospital

MassHealth Rate: ~$2,500 per day / $912 K per year

Ancillary, professional service billed separately

Supplemental MassHealth payments made

Pediatric Nursing Home

MassHealth Rate : ~$300-$900 per day depending on acuity, plus ~$50-$400 add-ons such as dialysis, ventilation, trach, homelessness / $438 K per year

Pappas Rehabilitation Hospital for Children

Cost (FY25 projection): $3,750 per day / $1.368 M per year

Exclusive of educational costs

Residential School (365 day)

Operational Services Division (OSD) established tuition: ~$900 per day / $328 K per year

PRHC is an outlier in total cost relative to services rendered.

Larger Context of Challenges Facing Commonwealth

State Capital Investment Plan

The Commonwealth's Capital Investment Plan (CIP) is the primary mechanism through which the Commonwealth funds state facilities improvements, roads and bridges, housing production, climate-change mitigation and adaptation, and information technology infrastructure. The CIP is funded primarily through borrowing. The state is limited in how much it can borrow – increased borrowing risks hurting our credit rating and has the potential to drive up borrowing costs (i.e., interest rates.)

Several safeguards exist to protect against excessive borrowing, including the state's Debt Affordability Committee bond cap recommendation, a self-imposed **$125 M cap on year over year bond cap growth**, and a debt limit set by the legislature. As a result, borrowing for capital improvements across the Commonwealth is limited to just over $3 B annually.

Bond Market

Credit ratings are often viewed as independent validators of good governance. Massachusetts has one of the **highest debt loads** of any state by every measure. The state's ability to sell its bonds is dictated by demand from investors – it is possible to "saturate" that market and make Massachusetts less competitive.

Budget Constraints

Borrowing money by issuing bonds will cost the state in subsequent years' budgets to repay the debt. Every additional $1 B of bonds issued results in ~$85 M in additional annual debt service payment cost to the budget (subject to interest rate changes.) High year-over-year debt service increases put pressure on other budget programs and make Massachusetts less affordable for taxpayers over time.

An unfavorable revenue environment *(tax revenue and federal funding, especially Medicaid)* could exacerbate the impact of additional debt service: a decrease in revenues, coupled with higher fixed annual debt service payments could squeeze other areas of the operating budget and limit future investment

EOHHS Campus Infrastructure

EOHHS maintains over 300 buildings serving over 75,000 clients and patients per year. Many buildings across EOHHS campuses are 50-100 years old, in poor condition, and in need of replacement. Aging infrastructure presents challenges to patient care. EOHHS has a deferred maintenance backlog of over $150M, funded by only ~$9M per year

An extensive look is underway into all existing campus programs, space types and campus layouts to assist in master planning efforts. With limited resources EOHHS is looking to prioritize cost-effective investments that support the people it serves.

The next graphic presents a general overview of the state of EOHHS's facilities. Replacement cost for some of these facilities could individually approach $1 B.

City	Site Name	Area (GSF)	Major Buildings
Department of Developmental Services (DDS)		**1,103,000**	**111**
Danvers	Hogan Regional Center	328,000	8
Wrentham	Wrentham Developmental Center	515,000	36
Statewide	DDS Group Homes (State Owned)	260,000	67
Department of Mental Health (DMH)		**1,902,000**	**44**
Boston	Lindemann Mental Health Center	214,000	1
Boston	Solomon Carter Fuller Mental Health	295,000	1
Bourne	Cape Cod - Islands Mental Health Center	33,000	1
Brockton	Brockton Mental Health Center	55,000	1
Fall River	Corrigan Mental Health Center	61,000	1
Greenfield	Franklin County Mental Health Association	15,000	1
Lowell	Harry C. Solomon Mental Health Center	68,000	1
Northampton	Northampton Center For Children - Family	29,000	5
Northampton	Western Massachusetts Area Office	80,000	1
Quincy	Quincy Mental Health Center	66,000	1
Taunton	Taunton State Hospital	353,000	14
Westborough	Westborough State Hospital	145,000	2
Worcester	Worcester Recovery Center & Hospital	428,000	1
Statewide	Choice Housing Group Homes (State Owned)	60,000	13

City	Site Name	Area (GSF)	Major Buildings
Department of Public Health (DPH)		**2,467,000**	**74**
Boston	Lemuel Shattuck Hospital	611,000	2
Boston	State Public Health Laboratory	213,000	3
Canton	Pappas Rehabilitation Hospital for Children	453,000	27
Tewksbury	Tewksbury State Hospital	1,023,000	37
Westfield	Western Massachusetts Hospital	167,000	5
Department of Youth Services (DYS)		**758,000**	**78**
Boston	Judge Connelly Youth Center	56,000	1
Boston	Metropolitan Youth Service Center	74,000	3
Brewster	Brewster Multiservice Center	40,000	27
Grafton	DYS - Grafton	38,000	7
Middleton	DYS Middleton-Ne Reg Youth Serv Ctr	70,000	1
Springfield	Western Youth Service Center	137,000	7
Taunton	DYS - Taunton	77,000	1
Taunton	Murray Community Services	30,000	1
Westborough	Central Youth Service Center	133,000	3
Westfield	Westfield Youth Service Center	58,000	4
Worcester	Paul T. Leahy Center	45,000	23

Building Conditions	
	Poor
	Average
	Good

Programmatic Options

The PWG interprets its charge by drawing a distinction between two separate questions:

1) What are the options for pediatric care at PRHC?

2) What are the options for the best provision of pediatric care within the public health hospital system?

On the first question, the PWG explored five potential programmatic options for the future of care on the Canton Campus. Each of these options have been evaluated across a set of criteria, including alignment to need, equity, quality of life, quality of care, capital and operating costs, timeframe, and labor impact.

OPTION: RE-IMAGINE CANTON

The most ambitious of the options envisioned by the PWG is to "reimagine" the campus as a **center of excellence for the care and development of children with medical complexity**. The project would include a new, modern 56-bed long-term care hospital facility with capacity to deliver complex medical, behavioral, and respite care services. A new elementary/secondary school and athletic/aquatic recreational facility would be constructed suited to the needs of children with disabilities. Group homes with 24 beds would be added to address the needs of medically complex 22-year-olds transitioning into adulthood. The site itself and all other existing amenities on campus would be renovated to bring up to modern standards. This would be a major, site-wide construction project that would require the closure of the campus for 5+ years.

Alignment to need		56 beds at LTCH level of care, 24 group home beds, full educational offerings
Equitable access		Capable of admitting patients with a wide range of needs
Quality of life		Maintenance of therapeutic and recreational options
Quality of care		Provides clinicians with the needed tools
Operating costs		Upon re-opening: ~$60 M, upgraded services
Per-bed cost		Upon re-opening: ~$950 K hospital, ~$250 K group home, efficiency challenge of small hospitals
Capital required		~$250 M (hospital and group homes.) An additional $130 M for school/athletic complex, and $60 M for site.
Timeframe		Phase 1: Funding, procurement, design Phase 2: Discharge all patients, close facility, break ground Phase 3: Construction Estimated time frame for 3 phases is 7-8 years
Labor impact		Phase 1, no change. Phase 2, significant dislocation of staff. Phase 3, net increase in staff, with increased skillsets
Other		Requires WMH pediatrics or other facility to discharge patients

OPTION: PHASED INVESTMENT IN CANTON

The "phased investment" plan maintains the vision and level of service of the "re-imagine" option but would follow **a multi-year plan to build the modern infrastructure in multiple, more affordable projects over time**. Existing services would be maintained on the site as the additions progress.

Alignment to need		56 beds at LTCH level of care, 24 group home beds, full educational offerings
Equitable access		Capable of admitting patients with a wide range of needs
Quality of life		Maintains therapeutic and recreational options
Quality of care		Provides clinicians with the needed tools
Operating costs		On achievement of LTCH beds, ~$53 M, upgraded services
Per-bed cost		On achievement of LTCH beds, ~$950 K, efficiency challenge of small hospitals
Capital required		10-year program at ~$27 M each year. It depends on phasing. Longer duration means additional escalation, so $270 M total. Includes capital for planned and reactive maintenance of existing buildings. An additional $130 M for school/athletic complex, and $60 M for site.
Timeframe		Maintenance of status quo, until each building opens, 10 years
Labor impact		Limited until higher acuity units open, then expanded staff with expanded skill sets
Other		Risk and disruption for patients and staff during construction, prolongs disconnected services

OPTION: STATUS QUO

The "status quo" option **indefinitely maintains the existing medical, therapeutic, and education services** for the current 45 bed facility, but does not envision a major infrastructure investment nor an increase in services. Moderate investment is necessary to ensure life safety, quality, and regulatory standards on an annual basis.

Alignment to need		Inability to care for patients with greatest need
Equitable access		Narrow set of admissions criteria
Quality of life		Maintenance of therapeutic and recreational options
Quality of care		Limited clinical tools
Operating costs		~$48 M
Per-bed cost		~$1.1M, maintains inefficiency of small hospital with narrow admissions
Capital required		~$5-7 M per year for life safety and quality concerns.
Timeframe		Ongoing operations, ongoing combination of planned and reactive maintenance
Labor impact		Limited adjustments to staff to volume
Other		Infrastructure risk: **not a sustainable solution**, systems will fail eventually. As examples, backup generator failed in May, the recently filled pool failed in June, and Nelson clinical building HVAC failed in June, and the Nelson building basement flooded in July. All are under review.

OPTION: LOWER LEVEL OF CARE

The "lower level of care" option recognizes the limits the archaic infrastructure on campus imposes on the complexity of medical care feasible. The existing educational, therapeutic, and educational services would be maintained, but **the site would no longer be a long-term care hospital**. The campus would convert to a **residential school** specializing in care for children with disabilities, including a re-tooling of clinical staff to match the lower level of care of that sector. This proposal does not include a major infrastructure project, but moderate investment is necessary to ensure life safety, quality, and regulatory standards on an annual basis.

Alignment to need		Waiting lists exist within sector
Equitable access		Unclear how to set admissions criteria with equity in mind given size of demand
Quality of life		Maintains therapeutic and recreational options
Quality of care		Decreased tools to address medical acuity. Care would be good for admitted.
Operating costs		~$35 M (further analysis needed to compare staffing levels), significant loss of federal reimbursement
Per-bed cost		~$777, likely inefficient relative to the private sector given size of campus
Capital required		~$5-7 M per year for life safety and quality concerns
Timeframe		Ongoing operations, ongoing combination of planned and reactive maintenance
Labor impact		Reduction in force needed. Decrease clinical staff ratios and need for physicians
Other		Would require discharges of patients at hospital level of care Questionable fairness relative to rates established for private sector "competitors"

OPTION: CLOSE CANTON CAMPUS

The "close Canton campus" option involves **ending hospital, school, and vendor operations on site**, including a significant reduction in force. A re-development planning exercise would be launched by the Commonwealth to determine future use. This option would require the identification of appropriate alternative placements for the children currently on campus, which don't currently exist fully without the creation of pediatric services at Western MA Hospital.

Alignment to need		Loss of beds
Equitable access		Loss of access to population in eastern MA.
Quality of life		Loss of services
Quality of care		Loss of services
Operating costs		Approaching $0, costs to maintain site until disposition
Per-bed cost		N/A
Capital required		~$50-60 M for demolition and site remediation given economics of potential development
Timeframe		12-18 months
Labor impact		Initial significant reduction in force to site operations, then full. Loss of talented, hard-working team.
Other		Significant impact to Town of Canton, Tufts Dental Program

COMPARATIVE GRID SUMMARY

Option	Re-imagine	Phased Investment	Status Quo	Lower Level of Care	Close Canton
Alignment to need					
Equitable access					
Quality of life					
Quality of care					
Operating costs	~$60M	~$53M	~$48M	~$35M (+loss of revenue)	$0
Per-patient cost	~950K hospital, ~250K group home	~$950K	$1.1M	~$777K	N/A
Capital required	~$250M	$280M-$300M	~$5-7M	~$5-7M	Demolition
Timeframe	~7-8 years	~10 years	Ongoing	Ongoing	12-18 months
Labor impact	Disruptive but net increase upon completion	Eventual expanded staff	Limited adjustments to volume	Reductions in force to match services	Full reduction
Other	Discharge during construction	Risk during construction; prolongs clinical building separation	Not sustainable	Discharges of hospital level care	Discharges; Town, vendor impacts

Programmatic Options, Continued.

On the second question, the PWG reviewed a proposal from the PHHS leadership to serve children with multiple disabilities and complex medical needs who have been unable to find the medical support they need and deserve in their home or community. The "build Western Massachusetts Hospital (WMH) pediatrics" option envisions **the creation of a 21-bed unit for children with disabilities and complex medical needs at WMH**. These beds would be in addition to the pediatric beds on the Canton campus.

The PHHS team explored options to build pediatric services at the two other hospitals in the system, Lemuel Shattuck Hospital (LSH) and Tewksbury State Hospital (TSH), but both were thought not viable at this time. Both hospitals serve a significant adult population of patients with psychiatric conditions or substance use disorder, and LSH serves a corrections population. The Tewksbury campus is also facing infrastructural challenges like the Canton campus. LSH is moving to a new building in the South End of Boston in 2027, so consideration of potential pediatric services may resume after that move is complete.

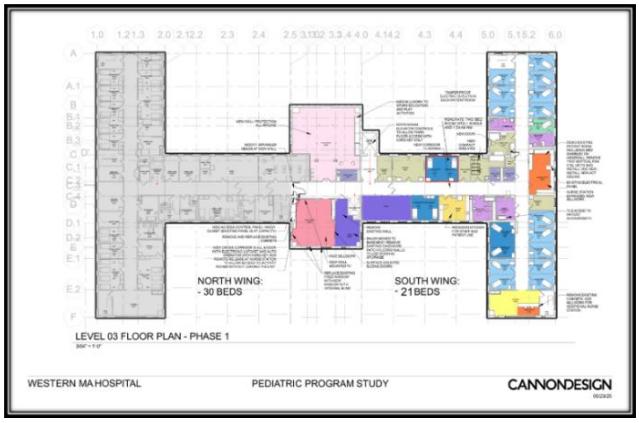
As an already functioning hospital, Western MA Hospital could, with only moderate effort, transition an existing adult unit into a pediatric unit. High-quality pediatric medical, therapeutic, and educational programs would be built, involving the hiring of staff and creation of community partnerships. This initiative would be financially efficient and well supported by campus infrastructure. Since the hospital was modernized with a set of projects over the past 13 years finishing in 2024, the needed infrastructural improvements are minimal.

Challenges include building the needed therapeutic and educational services, as well as recruiting an experienced pediatric clinical team. WMH would need to transfer the adults currently cared for on the unit within the hospital or to other public health hospitals, or discharge to community placements.

Evaluating the option using the same set of criteria yielded the below table:

Alignment to need		21 beds at LTCH level of care, with options to expand 25 behavioral beds
Equitable access		Capable of admitting patients with a wide range of needs
Quality of life		Development of therapeutic and recreational options on campus and surrounding communities
Quality of care		Provides clinicians with the needed tools
Operating costs		Additional $4.8 M to WMH appropriation
Per-patient cost		~$400 K, significant efficiencies building program within existing hospital
Capital required		~$3 M for first 21 bed unit, likely similar amount for second unit
Timeframe		12-18 months

Labor impact		44 additional clinical hires with increase skillsets
Other		Discharge of existing adult patients. Significant travel implications for families living in eastern MA.



[Initial architectural floorplan design and playground rendering of what might be built at WMH.]

Revenue / Financing Options

The PWG further discussed implications of and ideas around potential sources of funding for the Commonwealth's pediatric care programming.

Federal Reimbursement

The Commonwealth receives federal reimbursement from Medicaid at 50% for hospital level care happening at PRHC in the amount of $17.2 M. The option of converting to lower level of care would involve sacrificing a significant portion of this revenue. The federal government only supports residential special education facilities at roughly 15% of a significantly smaller set of allowable expenses. Lowering the level of care would involve reducing the workforce to match lower staff to patient ratios of that sector.

Canton Campus Partial Land Sale

The Town assessed value of the total 160-acre property is only $2,096,000. The strongest market is likely for-sale housing, which is difficult to finance on a ground lease. After acquisition and development costs, net value could be equal to $20-50K per permitted market rate housing unit. The potential revenue from a partial land sale would be orders of magnitude insufficient to offset the sizeable capital costs in the rebuild options. In addition, the Town of Canton has indicated strong opposition to zoning this property for residential housing.

Public/Private Partnership

The PWG believes that a public/private partnership mechanism could have value for achievement of the more ambitious programmatic options for the Canton campus.

- As imagined in the land sale option, there would be value for the developer that could accrue back to the Commonwealth, though housing remains the most likely.
- There is also substantial efficiency to be gained from private construction and financing, which could result in capital cost savings (15-20%). Labor unions have supported public/private partnerships for

construction in the past given sufficient guardrails (prevailing wage, project labor agreements) to protect workers.

- Costs for construction could be in the form of lease payments as opposed to capital borrowing and associated debt service. This mechanism would relieve the Commonwealth's capital budget from this cost, while pressuring the operating budget to funding ongoing lease payments to the developer.
- The Town of Canton would collect property taxes from the private owner/developer.

The PWG also discussed a public/private partnership with a Massachusetts-based health provider/system that may be interested in investing in and operating pediatric programming on the Canton Campus. While private hospital systems are facing their own substantial financial challenges in the current environment, the PWG assessment is to further explore this concept in the coming months. In DPH discussions with the pediatric providers in the Commonwealth prior to the PWG, no interest in taking over the campus was expressed.

Program Revenue

The PWG recognizes there is a lot of human expertise and physical infrastructure on campus that delivers value to the people served. Some of these programs could likely be developed to generate revenue to offset operating expenses, including:

- Rehabilitation / adaptive engineering: statewide wheelchair repair
- Community-based ambulatory / outpatient therapies
- Day school admissions at Brayton School
- Community recreation including daily/vacation and summer programming

While the PWG assessment is that the PRHC leadership team explore these initiatives, these sorts of revenue streams would not materially address the significant capital needs of the campus.

Staffing Implications

As indicated in evaluation grids of the options, impact on staffing for Public Health Hospital System (PHHS) could be significant depending on the policy direction. The chart below describes the current DPH (exclusive of DESE) state employee staffing by bargaining unit at PRHC of 203 FTE.

PRHC Bargaining Units		Current PRHC FTEs	WMH Pediatrics FTE	Canton Campus FTE	PHHS Vacant FTE	At Risk FTE
01	NAGE - Admin	3.00			3.00	-
02	AFSCME - SEIU	105.10	21.80	13.00	53.68	16.62
03	NAGE - Skilled Trade	10.00		5.00	4.00	1.00
06	NAGE - Professionals	16.60			11.67	4.93
07	MNA	58.45	22.72		34.14	1.59
08	SEIU - Social & Rehab	3.00			2.00	1.00
M99	Managers	4.00		1.00	3.00	-
PRT	Post Retirees	2.40				2.40
TOTAL		**202.55**	**44.52**	**19.00**	**111.49**	**27.54**

Acknowledging the significant challenges of relocating a job, options do exist for PRHC employees within the public hospital system. These include the creation of 45 pediatric care positions at WMH, 19 FTE to maintain the Canton campus pending disposition, and over 100 existing vacancies (currently filled with temporary/agency staff) at other public hospitals in the system.

Next Steps

Legislative Action

With the Governor's signature of the FY26 Budget, two relevant provisions became law. Line-item language within 4590-0915 appears as follows:

> *provided further, that not later than August 18, 2025 and monthly thereafter, the department shall submit a report to the joint committee on public health and the house and senate committees on ways and detailing the status of the Pappas Rehabilitation Hospital for Children; provided further, that the report shall include, but not be limited to: (i) a summary of the types of services and programs available through the hospital including, but not limited to, medical, recreational and educational services; (ii) a summary of any reductions or terminations of services for patients and rationales for each change; (iii) the census at the hospital on January 1, 2025; (iv) the number of admittances per month since January 1, 2025; (v) the number of discharges per month since January 1, 2025; and (vi) the total number of staff employed at the facility, delineated by profession including, but not be limited to, teachers, nurses, administrative staff and other professionals; and provided further, that not less than $31,000,000 shall be expended for the continued operation of Pappas Rehabilitation Hospital for Children*

The PWG agrees with this focus on reporting on services and patient census. With full funding for the fiscal year, the PWG encourages PRHC leadership to continue normal hospital operations as described and to broadly communicate its ongoing status to all stakeholders, especially referral sources. PWG looks forward to a prom and graduation in the spring of 2026.

The second relevant provision was the inclusion of outside section 112:

SECTION 112. (a) There shall be established a special legislative commission, pursuant to section 2A of chapter 4 of the General Laws, to conduct a comprehensive investigation and study into the future of the Pappas Rehabilitation Hospital for Children, as designated in chapter 87 of the acts of 2016, formerly known as the Massachusetts hospital school. The investigation and study shall include, but shall not be limited to, a review of the hospital's finances, programs, pediatric services and infrastructure.

(b) The special legislative commission shall be comprised of: the chairs of the joint committee on public health, who shall serve as co-chairs; 1 member appointed by the president of the senate; 1 member appointed by the speaker of the house of representatives; the commissioner of the department of public health, or their designee; the commissioner of the department of elementary and secondary education, or their designee; the commissioner of the division of capital asset management and maintenance, or their designee; and 6 members to be appointed by the governor, 1 of whom shall be recommended by the select board of the town of Canton, 1 of whom shall be the parent of a current patient at the Pappas Rehabilitation Hospital for Children, 1 of whom shall be a member of the Massachusetts Nurses Association currently employed at the Pappas Rehabilitation Hospital for Children, 1 of whom shall be a member of the Service Employees International Union currently employed at the Pappas Rehabilitation Hospital for Children, 1 of whom shall be a pediatrician licensed to practice medicine in the commonwealth and 1 of whom shall be a person with experience in health care finance and management.

(c) Notwithstanding any general or special law to the contrary, services provided to patients of the Pappas Rehabilitation Hospital for Children shall not be reduced or eliminated, nor shall the Pappas Rehabilitation Hospital for Children be closed or consolidated with any other facility until the completion of the report pursuant to subsection (d).

(d) The special legislative commission shall submit a report of its findings and recommendations, if any, to the clerks of the house of representatives and the senate not later than December 31, 2026

The PWG stands ready to conduct a knowledge transfer to the special legislative commission as it begins work.

Canton Campus Fragility

While DPH believes the patients are being safely cared for at the current time, the services at PRHC rest on a fragile infrastructural foundation. Resiliency to potential facility-based critical incidents (HVAC, electrical, plumbing, etc.) is low. In the past 12 months alone, PRHC has experienced:

- Failure of its backup generator plunging the hospital into darkness
- Loss of the HVAC system in the Nelson building, requiring renting portable units and huddling all patients in 9 rooms. This was only possible because the weekend census was low with patients on therapeutic leave.
- Clogging of drains in the basement of the Nelson building, flooding the mechanical room with 2 feet of water
- Multiple failures of the seals in the pool walls, necessitating drainage of water and likely loss of aquatic capacity indefinitely.

While none of these events require patient discharge, PRHC leadership does not trust the situation to remain stable for our patients into the near future.

The Public Health Hospital System has 768 beds, only 45 of which are pediatric, all at Canton. With no pediatric bed alternative available within the public hospital system, the Commonwealth is vulnerable to a significant infrastructure failure at PRHC requiring a disruptive set of unhelpful emergency discharges to the private sector, potentially off hours and under adverse weather conditions. Such an event would be enormously disruptive to the care plans PRHC has painstakingly pursued for its patients and would likely result in sub-optimal placements. The majority of patients at PRHC need wheelchairs and adaptive communication devices, complex G tube feedings, and additional staff attention for dressing change and behavioral needs. When PRHC transfers patients under normal operations, multiple meetings are needed often exceeding two months of planning. The sorts of placements to be found in an emergency situation, such as PHHS adult beds, acute care hospital, or family residences, would not be trained nor equipped to replicate existing services at Canton, jeopardizing clinical care, continuity, and outcomes for these vulnerable patients.

Suggested Actions

With no pediatric bed alternative available to PRHC within the public hospital system, the Commonwealth is vulnerable to a significant infrastructure failure at PRHC that may require a highly disruptive set of emergency discharges, potentially off hours and under adverse weather conditions, to the private sector. The PWG suggests three actions for the near term to address this concern:

- Make targeted facility investments in life safety, quality, and accreditation standards at PRHC to strengthen the environment to deliver at least current level of care.
- Develop a pediatric service at Western Massachusetts Hospital to create additional pediatric beds in the Commonwealth.
- Support the efforts of the legislative commission to conduct its study on the future of the Canton campus.