Project Overview

Acadia Healthcare Company, Inc. (Acadia) is requesting a formal Jurisdictional Determination Review (JDR) from Green Mountain Care Board. Habit Opco, LLC d/b/a Habit Opco-Brattleboro is a wholly owned subsidiary of Acadia and a registered entity in the state of Vermont. As the parent company, we are asking for the JDR on their behalf. We may use the term “Acadia” or “Habit Opco” interchangeably in the application. They are one and the same since Habit Opco, LLC is a wholly owned subsidiary.

Acadia provides behavioral health and addiction services to patients in a variety of settings, including inpatient psychiatric hospitals, specialty treatment facilities, residential treatment centers, and outpatient clinics. At June 30, 2018, Acadia operated a network of 585 behavioral healthcare facilities, with approximately 17,900 beds in 40 states, the United Kingdom, and Puerto Rico. As a publicly traded company (ACHC) with a market capitalization of nearly $3B, Acadia is also the nation’s largest provider of Medically Assisted Treatment (MAT) outpatient services for opioid dependency which the CDC has labeled an epidemic for quite some time now. Approximately 116 facilities treat nearly 60,000 patients a day with this modality.

Acadia provides these services through federal and state licensed facilities around the NE area serving Maine, New Hampshire, Vermont, Massachusetts and Rhode Island. In these states, 23 facilities provide MAT services to roughly 14,000 patients in that region of the country. Both the 116 facilities and nearly 60,000 patients a day also makes Acadia the largest provider of such treatment in America by way of both facilities and patients.

Our facility in Brattleboro has been operating in Vermont from quite some time. It is CARF accredited and maintains all state and federal licensures and has been in good standing with the state throughout its history. It was a former Hub and now operates with a partnership as a spoke to a Hub locally for SA treatment. It came to our attention that an additional site is needed in Bennington, VT. Ms. Cynthia Thomas, Division Director of the Vermont Department of Health has committed $175K towards this project due to dire need in the state and in Bennington specifically. We have located a site and are in lease negotiations. We cordially request an expedited JDR to help the citizens of Vermont and per the state’s request to do so as early as possible.

A brief description of project and service area - Acadia is proposing an OTP be located in the SW corner of Vermont in Bennington. The proposed facility will likely apply for a Hub based on the lack of other treatment and lack of other major medical facilities in the area. The service area would be a 50 mile radius inclusive of all SW Vermont counties that lie within the radial. The facility would provide services typical of an OTP including:

- Screening for Substance Abuse and Opioid Dependence
- TB/HIV testing for admitted patients
- Medication Management
- Individual counseling
- Comprehensive Medical Exam
- Medical referrals for Psych, PCP and OBY/GYN consults as needed

- Group Counseling
- Treatment planning with an assigned treatment team
- Employment and educational referral partners
- Partners for referral out for other medical, mental health and nutritional needs

The services provided would be the same as those at Brattleboro and in common with most all OTPs in Vermont. We offer Methadone, Buprenorphine products and Vivitrol for MAT and are a current Medicaid provider in the state. The proposed facility would be an added site to Habit Opco which is already registered with Vermont as a treatment provider and a Medicaid provider and as a former approved Hub Center of Excellence.

Acadia has assessed a need in Bennington due to the following reasons after consulting with Dr. Nels Kloster. Dr. Kloster is an XDEA Waivered physician and the current Medical Director of Habit's Brattleboro facility. Dr. Kloster has an office based in Bennington which treat opioid dependence in an OBOT model but does not wish to do this any longer. He has ≈200 patients in his practice on BUP. He has signed a MOA and LOI which transfers those patients to our facility once opened. He will also be the Medical Director of the proposed Bennington facility. In addition, the state has roughly 50 patients that they maintain on a contract with another provider which ends on 12/31/18. They will be extending this contract for roughly 6 months but prefer to send them to an OTP with comprehensive services than the OBOT model they are in now. Please contact the VT Department of Health for more information on these patients. In addition, there are few XDEA waivered physicians in this general area who Dr. Kloster has spoken to that state they would transfer patients to so that comprehensive treatment can be provided regardless of which medication is used in their MAT treatment modality. It is anticipated that in the near term after opening, Bennington Comprehensive Treatment Center could be treating over 300 patients. This would make it a rather larger facility in a very short period of time.

A more detailed description of the services provided above are as follows:

Description of Services - The main objective of our services is to provide a therapeutic treatment program in an outpatient setting that offers medical support and medication management coupled with a strong rehabilitation component allowing for treatment phases of sufficient duration to meet the individualized needs of the patients served. We seek to provide the highest quality of professionalized care utilizing highly qualified, trained, disciplined, skillful and caring staff throughout the Division who will provide quality treatment at all levels of care.

Our programs utilize a Medicated Assisted Treatment (MAT) model which is the continual administering and dispensing of medications federally approved for the treatment of opioid dependence at relatively stable dosage levels in conjunction with the provision of appropriate social, clinical, and medical services for an individual who is dependent on opiates, opioids or morphine-like substances.

The MAT model is designed for an unknown and possibly indefinite period, according to the needs of the individual patient. The only appropriate measure of time in treatment is how long it takes the individual to overcome a life of addiction. All programmatic decisions regarding eligibility and admission criteria for the MAT modality will be in conformance with the following regulations:

- Federal Department of Health and Human Services (HHS).
- Substance Abuse and Mental Health Services Administration (SAMHSA).

- Center for Substance Abuse Treatment (CSAT).
- Code of Federal Regulations (CFR) Part 8 and Part 2.

Upon admission of the patient to the facility, the following criteria will be entered in the patient's record:

- Confirmed history of addiction.
- Certification of fitness for program by a licensed physician.
- Evidence of current opioid dependence.

Once an admission has been completed, the patient enters the **Treatment Milieu** described below. The counselor will discuss the rules and regulations of the facility with the patient to help with orienting the patient.

The assigned counselor and patient will complete and addiction severity assessment. The treatment plan will be developed with meaningful objectives and goals agreed to by the patient and their counselor. In counseling sessions, the specific goals of the treatment plan will be discussed to include appropriate ways for the patient to reach their objectives.

The facility atmosphere and staff approach toward the patient will reinforce appropriate behavior and acknowledge the increasing responsibility demonstrated by the patient. Treatment progress may be made slowly as unreasonable treatment demands of a new patient might result in alienation which would reduce the future possibility of meaningful therapeutic interaction.

Treatment Milieu - Acadia's has a variety of comprehensive services designed to help patients at different levels of their disease state. Each service will be provided as appropriate and is designed with a harm minimization approach to outcomes. The main services we will provide to each community are the following;

- Assessment
- Admission (and rules regarding exemptions from admissions)
- Medical evaluations and examinations
- Triage in treatment programs – Medication selection
- Treatment planning – Methods, forms, programs offered, groups available and case management.
- Special considerations – Women's issues, disabled, mental illness, etc.
- Detox programs available
- Discharge planning
- Networking to community based services

The above can be grouped into several sub-categories for the purposes of showing how the comprehensive service array can help each community. Each patient is unique and so are the treatment plans. Acadia recognizes that each treatment plan must be tailored to each individual's specific need and that all available services both internally and externally will be used as appropriate as part of the integrated treatment plan.

Assessment and Admissions – This service will provide for a comprehensive, detailed process to make sure each patient is clinically appropriate for treatment. If treatment is clinically appropriate, the patient will proceed to admissions where intake paperwork will be completed so that the Medical Director can provide for a medical examination of the patient.

Medical Evaluations and Exams – Patients are provided the services of a licensed Medical Director who performs a live physical exam and whose staff will take the clinically appropriate urine, blood, and other tests needed for admittance to the program. If the physical yields other medical conditions, the patient will be informed and encouraged to seek treatment outside of the clinic with the appropriate referrals to community resources/medical offices by the medical staff.

Medication Model – This service provides patients diagnosed with Opioid Dependence an array of medications that are approved for such treatment by the Medical Director. Methadone Maintenance Treatment (MMT) is at the core of our treatment models with options such as Suboxone, Subutex, Buprenorphine, and Vivitrol available as well. These medications will be provided or dispensed by a licensed nurse per the Medical Director's orders at all times as regulated by all applicable state and federal laws.

Psycho-Social Treatment – Each admitted patient will be assigned qualified case manager to engage patients in their treatment and recovery with appropriate state required licensures. Case Managers will use a variety of available services to accomplish their stated treatment goals and will include, but not limited to, the following; individualized counseling, group counseling, family/significant other partners involvement, outside coordination with community services as needed and as appropriate, educational tools designed to help educate patients on the disease of addiction, self-help groups both internally and externally as appropriate. Special needs programs may also be part of the service array. Examples are women's issues and programs for the expecting mother. Patients will be seen by their case manager based on different "Phase Scales" used by states which varies in visitation frequency. Please refer to an attached manual for a full range of services in our treatment planning process.

Detoxification – Acadia has both a program to provide for the supervised medical withdrawal off of methadone (Buprenorphine and Vivitrol) as well as programs to detox patients from other opioids to methadone. In this array, we provide three types of detoxification services that are outlined in the attached manuals. They are; Detoxification Program, Maintenance to Abstinence Program, and Short Term Detox Program.

Staffing BCTC will consist of the following:

Medical Director	A licensed medical doctor or a licensed doctor of osteopathy as described in 26 V.S.A. Ch. 23 § 3	
Clinic Director	No specific requirement per VT regulations for this position	
Clinical Supervisor	4-5 years minimum in the field of Substance Abuse and:	
	(A)	Supervised work experience shall be earned under a supervisor acceptable to the Director who must be:
		(1) an LADC of at least one year full-time professional experience working as such, and who is licensed and in good standing in the state of practice; or
		(2) an independent clinical social worker, psychologist, marriage and family therapist, or clinical mental health counselor, licensed and in good standing in Vermont or a foreign jurisdiction acceptable to the Director, who has completed addiction-counseling training consistent with the requirements of § 5-3 and has accrued at least one year of full-time addiction counseling experience or its part-time equivalent; or

		(3) an allopathic or osteopathic physician certified in addiction medicine by the American Society of Addiction Medicine, the American Osteopathic Association, the American Board of Psychology and Neurology, or an equivalent certifying body approved by the Director.
	(B)	Nature of Work. Supervised work experience means work as a counselor providing clinical counseling services to clients. Direct clinical counseling services, as opposed to indirect services, must compose at least half of any supervised work experience recognized under this Part. Not fewer than half of the required hours must be earned within five years of satisfying other license requirements. Hours accrued in violation of the laws or rules of this or another jurisdiction will not be recognized. Supervised work experience must include:
		(1) screening, assessment and engagement;
		(2) treatment planning, collaboration and referral;
		(3) counseling; and
		(4) Professional and ethical responsibilities.
	(C)	Supervision: Manner and Frequency. A clinical supervisor must be familiar with the nature of the applicant's clinical activities, monitor the quality of the counseling, and contribute to the enhancement of self-knowledge and substance use disorder counseling skills. Supervision shall be conducted in person, face to face, in a formal setting such as an office, clinic, or institution, and may occur by videoconference. One hour of face-to-face supervision must be documented for each 40 hours of supervised practice, such that 50 aggregate hours of supervision occur within each 2,000 total hours. Group supervision of up to six unlicensed individuals is permitted, but at least half of all supervision hours must be individual in nature. The Director may require an enhanced ratio of one-on-one 7 supervision where a supervision schedule is irregular, inconsistent, or infrequent. No more than forty hours of supervision may be earned in any one week.
	(D)	Documentation. Clinical supervision must be documented by the supervisor using forms supplied by the Office, to be filed at the inception and conclusion of the supervisee's work experience, upon a change in supervisors, or at such other intervals as the Director may require. Reports must document at least 10 hours of supervision in each of the four categories set out in subsection (b), above, and must be sufficiently detailed to illustrate compliance with all applicable provisions of these rules. Incomplete reports will not be processed. Reports demonstrating a failure of supervisory

		integrity or inadequate skill mastery may be disallowed or assigned partial credit.
Nurse Supervisor		Licensed LPM or RN in the state of Vermont
Dispensing Nurse		Licensed LPM or RN in the state of Vermont
Counselors	**(Cite as: 26 V.S.A. § 3236) - Licensed alcohol and drug abuse counselor eligibility**	
	(A)	To be eligible for licensure as an alcohol and drug abuse counselor, an applicant shall:
		(1) have received a master's degree or doctorate in a human services field from an accredited educational institution, including a degree in counseling, social work, psychology, or an allied mental health field, or a master's degree or higher in a health care profession regulated under this title or Title 33, after having successfully completed a course of study with course work including theories of human development, diagnostic and counseling techniques, professional ethics, and a supervised clinical practicum;
		(2) (A) Hold or be qualified to hold a current alcohol and drug counselor certification from the Office or:
		(2) (B) hold an International Certification and Reciprocity Consortium certification from another U.S. or Canadian jurisdiction or a U.S. or Canadian national certification organization approved by the Director;
		(3) successfully pass the examination approved by the Director; and
		(4) Complete 2,000 hours of supervised practice as set forth in rule.
	(B)	A person who is engaged in supervised practice toward licensure who is not within the preferred provider network shall be registered on the roster of non-licensed and noncertified psychotherapists. (Added 2013, No. 131 (Adj. Sess.), § 129, eff. May 20, 2014; amended 2015, No. 156 (Adj. Sess.), § 4, eff. Sept. 1, 2016.)
	(Cite as: 26 V.S.A. § 3236a) Certification of apprentice addiction professionals and alcohol and drug abuse counselors	
	(A)	(a) The Director may certify an individual who has met requirements set by the Director by rule as:
		(1) an apprentice addiction professional; or
		(2) an alcohol and drug abuse counselor.
	(B)	(b) The Director may seek cooperation with the International Certification and Reciprocity Consortium or other recognized alcohol and drug abuse provider credentialing organizations as a resource for examinations and rulemaking. (Added 2015, No. 156 (Adj. Sess.), § 4, eff. Sept. 1, 2016.)

- Receptionist/Office Manager – No specific State qualification needs. Only per experience

- No services off=site but referrals are made to:
  - Medicaid office
  - Educational partners
  - Employment partners
  - Mental health
  - Primary care
  - Women's unique needs (OBY/GYN)
  - Nutritionists
  - Community Health Centers

Our HIT/EMR components are currently in use at our Brattleboro facility which submits to the State of Vermont a wait list summary and census reports each month (electronic submission) and quarterly a block grant summary report is written. In addition our current EMR, SMART, collects and maintains all relevant patient treatment data along with ongoing collection of patient outcome data. In addition outside the EMR we track data such as time to first response to patient calls, admission conversion, admission and discharge, average length of stay, and patient satisfaction.

Acadia plans to finance the project with cash reserves held in liquid assets or cash on hand as filed with the SEC for the most recent reporting quarter. Please see SEC filing for Acadia Healthcare Company, Inc. (ACHC) for cash on hand as well as liquid assets and balance sheets per SEC requirements. Acadia is a publicly traded company with market capitalization and net revenue around $3B.

The projects implementation schedule in as follows:

Acadia can complete the process from concept to opening between 10 and 12 months.												
Timeline in Months to open	**6/ 18**	**7/ 18**	**8/ 18**	**9/ 18**	**10/ 18**	**11/ 18**	**12/ 18**	**1/ 19**	**2/ 19**	**3/ 19**	**4/ 19**	**5/ 19**
Start - notification of project - vet agents												
Property survey and search/site visits												
Negotiating lease												
Secure Zoning approval letter												
Finalize floor plan												
Hire Architect to produce test fit												
Submit bids to GC												
Permits approved for project												
Lease finalized												
Project breaks ground on construction												
90 days to complete build out (est.)												
Hire all staff (start 30-60 prior to opening)												
Finished project receives city inspection												
State schedule visit and approval												
State BOP schedule visit and approval												
DEA scheduled visit and approval												
SAMSHA application approved												
Product inventoried & staff trained												

Doors opened for business												
Many items we cannot control time frames include the following but are not limited to:												
Time from LOI agreement to Lease Final Draft. 40+ page leases can take 6 months if attorneys heavily involved												
Time from Zoning Approval request letter to obtaining zoning approval												
Time from Zoning Approval Special or Conditional use process to gaining approval												
Time from BOP informed of inspection to site inspection												
Time from BOP site inspection to issuance of license												
Time from State informed facility is ready for site visit to time of site visit												
Time from State site visit to issuance of provisional licensure												
Time from DEA informed of site inspection to DEA visit												
Time from DEA visit to DEA approval												
Time from DEA approval to issuance of DEA license												
Time from submitting SAMHSA application to time of approval												
City inspections if needed												
County inspections if needed												

Statutory Criteria and HRAP Standards Taken from selected sections for CON applications:

The Proposed project aligns with statewide health care reform goals and principles because the project:

1. Takes into consideration health care payment and delivery system reform initiatives set by the state of VT;
2. Addresses current and future community needs in a manner that balances statewide needs and addresses the opioid epidemic with the standard of care for opioid dependence.
3. It is consistent with appropriate allocation of health care resources, including appropriate utilization of services, as identified in the HRAP pursuant to section 9405 of this title. Vermont's Department of Mental Health has provided block grant funding for the project due to its dire need for this type of facility in this particular location of the state.

CON STANDARD 1.6: Applicants seeking to develop a new health care project shall explain how the applicant will collect and monitor data relating to health care quality and outcomes related to the proposed new health care project. To the extent practicable, such data collection and monitoring shall be aligned with related data collection and monitoring efforts, whether within the applicant's organization, other organizations or the government.

Our CTC currently submits to the State of Vermont a wait list summary and census reports each month (electronic submission) and quarterly a block grant summary report is written. In addition our current EMR, SMART, collects and maintains all relevant patient treatment data along with ongoing collection of patient outcome data. In addition outside the EMR we track data such as

time to first response to patient calls, admission conversion, admission and discharge, average length of stay, and patient satisfaction.

Although the proposed project is in a new area, the project itself is an added site to the parent subsidiary of Habit Opco, Inc. which already provide data collection, monitoring and submissions to the state per Vermont regulations. The proposed operation will operate identically to the current operation thus the systems being proposed will mirror precisely with the system in current operation and in compliance with all applicable Vermont Department of Health guidelines governing such data. Please refer to Brattleboro Treatment Center's state inspection report for compliance to all applicable statutes and administrative code compliance.

CON STANDARD 1.7: Applicants seeking to develop a new health care project shall explain how such project is consistent with evidence-based practice. Such explanation may include a description of how practitioners will be made aware of evidence-based practice guidelines and how such guidelines will be incorporated into ongoing decision making. (2005 State Health Plan, page 48.)

Multiple studies demonstrate that a positive treatment outcome is as much as three times more likely in individuals treated with an MAT OTP modality, along with psychosocial treatment, than among those treated with psychosocial treatment alone. The United States Surgeon General, the Director of the National Institute on Drug Abuse, the Assistant Secretary of the Department of Health and Human Services and numerous other leaders in the field have emphasized the importance of MAT as a standard of care. Recently, the federal Government and the Substance Abuse and Mental Health Services Administration (SMAHSA) approved over $1B in grant money for treatment inclusive of this modality of care.

There are currently three FDA-approved MAT options: Products containing naltrexone, products containing buprenorphine, and methadone. All three options have advantages and disadvantages for specific patients, and all three are demonstrated to improve treatment outcomes. There is no evidence that one form of MAT is more effective than the others. Therefore Acadia offers all three medications pending the Medical Director's decision on which MAT best fits each individual's needs.

For all medical disorders, including opioid use disorders, providers should inform patients of the nature of their disorder and the options for treatment, including the likelihood of success and potential problems associated with each form of treatment, as well as the potential course of the disorder without treatment. For opioid use disorders, these treatments should include all forms of MAT in combination with psychosocial treatment and psychosocial treatment alone. The patient then can use this information to make the best-informed decision and give his/her informed consent for a treatment approach best suited to them.

Many providers cannot offer all forms of MAT, and some do not have the ability to offer MAT at all, but patients should be informed of the different options available and referrals made when needed. MAT MMT in an OTP setting has been considered the gold standard of care for opioid dependence for nearly half a century.

Research and evidence based outcomes on MAT in an OTP modality:

• U.S. Department of Health and Human Services, Office of the Surgeon General. Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf. Washington, DC: HHS; 2016.

• Substance Abuse and Mental Health Services Administration. Medication-assisted treatment for opioid addiction in opioid treatment programs. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. SMA 12-4214. http://adaiclearinghouse.org/downloads/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs-51.pdf. Rockville, MD; 2005.

• Perry AE, Neilson M, Martyn-St James M, et al. Pharmacological interventions for drug-using offenders. Cochrane Database System Rev. 2013;(12).

• Volkow ND, Frieden TR, Hyde PS, Cha SS. Medication-assisted therapies—tackling the opioid-overdose epidemic. New England J Med. 2014;370(22):2063-2066.

• Mattick RP, Breen C, Kimber J, Davoli, M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database System Rev. 2014;2(2).

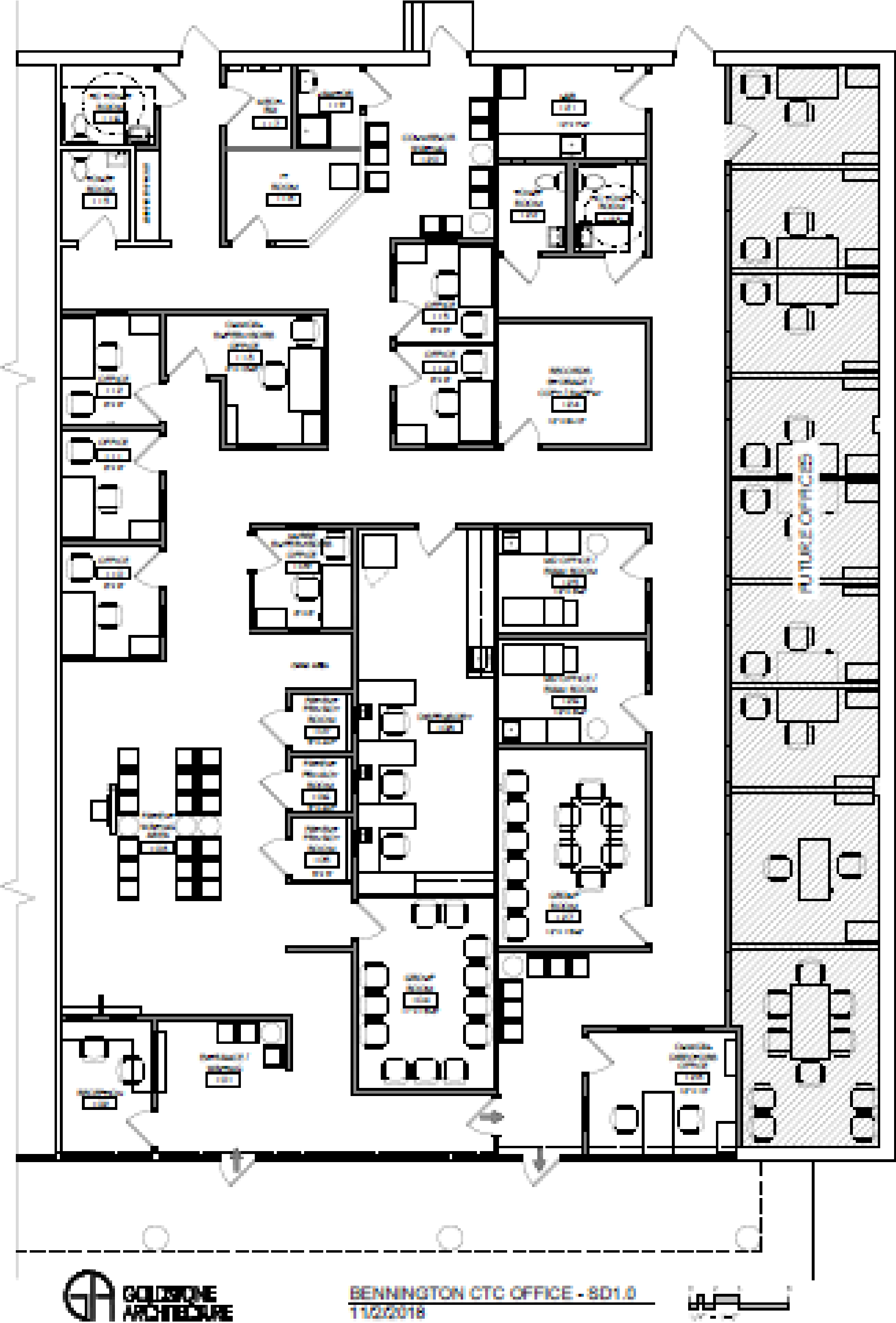
CON STANDARD 1.9: Applicants proposing construction projects shall show that costs and methods of the proposed construction are necessary and reasonable. Applicants shall show that the project is cost-effective and that reasonable energy conservation measures have been taken.

Below is the Capital Expenditures (CapEx) projected costs. All of the specifications are to the highest standards and are needed to complete an OTP and are within reasonable costs. Floor plan is attached for the state to review the layout of the proposed facility. All "green" energy efficient measures are used in the construction which meet or exceed Vermont's code

SF	4,500 Bennington De Novo	Sub Total	TOTAL
Leasehold Improvement (Leases only)			
A&E (All Architect and Engineering costs)		$45,000	
Permits		$2,000	
TI - Sole costs of construction to demise new space		$297,500	
TI change orders estimated at 10% of TI costs		$29,750	
Security System (Installation, hardware, equipment and contracts)		$35,000	
Leasehold Improvement TOTAL			$409,250
Fixed Equipment (PP&E - Safes, signage items left behind if moved)			
Safes - two safes per SOP - 1 for METH and 1 for BUP			$8,000
Signage			$3,000
Major Moveable Equipment (FF&E - total of Staples, Kirkland, Furniture,)			$30,000
IT Total			$160,000
Sub total			$610,250
Contingency 5%			$30,513
Other Charges			$10,000
Other - legal fees, moving costs, misc other project costs			$6,000
Total other costs associated with project			$46,513
TOTAL PROJECT COSTS			$656,763

These costs are within the average cost per square foot for demising space to achieve inspection approvals from all state and federal agencies relative to OTP facilities. The suggested floor plan is also attached to provide construction specifications which are reasonable and necessary.

Habit Opco is leasing a portion of the subject property and renovating it.



Locksets & Keying:

- Exterior Doors – *match to other exterior doors only, mastered.*
- General offices: Counselors, Clinical Supervisor (CS), Nursing Supervisor (NS), Medical Director (MD), Lab, Exam, Group Rooms, Patient Privacy Rooms, Break Room, Chart Room, IT Room, Reception Office – *matching, classroom lockset, mastered.*
- Clinic Director (CD) Office – *not matching, classroom lockset, mastered.*
- Pharmacy Entry Door – *not matching, storeroom lockset + deadbolt,* ***not*** *mastered. Grade I. Key storeroom lever and deadbolt sets separately.*
- Restrooms – *privacy sets.*

Blocking behind sheetrock:

- Pharmacy: Wall-to-wall at nurses' dispensing workstations (pharmacy side), up to the ceiling. At a minimum, start from the counter and extend up, although many GC's find it simpler to block full sheets starting at the floor to avoid having to step the sheetrock at the counter junction.
- Reception office workstation wall – same as above.
- At the Ergotron Kiosk location in reception area, from floor to ceiling, 48" wide.
- Patient waiting area TV location at 6' AFF. 32"x32" blocked area typical.
- Clinic Director's office CCTV monitor/NVR location. 6' AFF. 32"x32" blocked area typical.

High electrical receptacles & data boxes/strings – locations will be noted on CD set:

- Clinic Director office 72" AFF, for CCTV monitor & NVR.
- Patient waiting area, 72" AFF, for TV.
- Inside Reception office, above reception window, 72" AFF, for CCTV monitor.
- Patient waiting area, 84" AFF, for Kiosk.
- Pharmacy, between middle-most patient windows, 84", for CCTV monitor.

General

- Commercial Hollow Metal frames for all interior doors and interior glazing.
- Solid, standard-rated, commercial pre-stained, dark tone wood doors.
- Install a locking cash drawer under the Reception Office workstation counter.
- Install a peephole at 60" AFF in the Pharmacy's nurse entry door, viewed from the inside of the pharmacy.
- Door closures: pharmacy, patient privacy rooms, IT room, any corridor entries, and restrooms.
- Kick plates: patient privacy rooms, any corridor entries.
- Corner Guards placed in all high traffic common areas. Korogard GS35 16g #4 high with 2" wings.
- Chair rails at 33"OC AFF. Install in patient waiting areas, main corridors, and group room(s).
- Acoustical Batt insulation in interior walls + one horizontal batt width above the ceiling along wall perimeters.
- Thermostats either passcode programmable and/or equipped with locking covers.
- Horizontal aluminum mini-blinds, neutral white color, at all perimeter office exterior windows, and any interior observation window(s). *Not* installed on patient dispensing windows.
- Substitute window film in lieu of mini-blinds on large exterior windows where waiting patients would be visible from the outside (e.g. patient waiting area, storefront doors leading to reception window).
- LED light fixtures throughout.
- 20A *dedicated* circuit/receptacle for a multi-function copier, typically located in the chart room.
- Ceiling Tiles: Armstrong Fine Fissured 2nd Look II #1761.

CON STANDARD 1.10: Applicants proposing new health care projects requiring construction shall show such projects are energy efficient. As appropriate, applicants shall show that Efficiency Vermont, or an organization with similar expertise, has been consulted on the proposal.

Please see above Specification package which includes Green Energy conservation installed systems where possible which either meet or exceed those of Efficiency Vermont. A licensed GC in Vermont who would be assigned the project would be made aware of Efficiency Vermont Standards and that they are being met. A licensed Vermont GC would also serve as the same consultant for us since they would be versed in Vermont's Energy codes. We cannot show at this time that the project's constructions specifications met or exceed such standards as the plans are not yet created. An applicant would first have to have a CON approved before they would have invested the money in plans that could show the board such plans meet or exceed such standards. The applicant will comply and the CON 1.10 standard and attest that either EV will be consulted or that our GC has the expertise in the state's energy codes.

CON STANDARD 1.12: New construction health care projects shall comply with the Guidelines for Design and Construction of Health Care Facilities as issued by the Facility Guidelines Institute (FGI), 2014 edition.

Acadia's constructions specifications manual is included in section 1.9 and our designs meet or exceed the guideline of construction of Health Care Facilities issued by FGI. DEA, state, BOP and other inspections have yielded comments which reflect a level of construction not seen in OTP development in terms of construction standards and quality. The applicant attests that it will comply with such standards during the design and construction phase.

CON STANDARD 4.4: Applications involving substance abuse treatment services shall include an explanation of how such proposed project is consistent with the Department of Health's recommendations concerning effective substance abuse treatment or explain why such consistency should not be required.

Below find Vermont's Department of Health recommendations for the 2017-2020 strategies to combat the opioid epidemic the state is experiencing and is directly related to their goal. Due to the location of this facility, it is speculated that the operation will be applying as a Hub since there is very little care in the area of SW Vermont, specifically as it relates to substance abuse treatment of any kind. An OTP by the sheer nature of services they provide is directly consistent with the DOH recommendations concerning effective SUD treatment.

March 2017

Public Health Strategies to Reduce Opioid Use Disorders • 2017-2020

In Vermont, like other states, the use of heroin and misuse of other opioids (e.g. prescription narcotic is a major public health challenge. Such disorders increase pressure on our health care, child protection, and criminal justice systems, and has far-reaching effects on families and communities.

Vermont is taking a multi-faceted approach to addressing opioid addiction that involves multiple community partners. The Health Department has a leading role in the State's comprehensive strategy

Following is a snapshot of interventions for which the Health Department has responsibility, with public information, social marketing and messaging; pain management and prescribing practices; prevention and community mobilization; drug disposal; early intervention; overdose prevention and harm reduction; expanded access to treatment and recovery services; and recent legislation enacted.

Expanded Access to Treatment and Recovery Services --

Care Alliance for Opioid Addiction – Hub & Spoke System
The Care Alliance for Opioid Addiction (also called the Hub & Spoke System) is a statewide partnership of specialty treatment centers and medical practices that provide comprehensive Medication Assisted Treatment (MAT) services to Vermonters who are diagnosed with opioid use disorders.

Regional treatment centers (Hubs) located around the state treat patients with complex needs, while physicians lead a team of nurses and clinicians to treat opioid use disorders in their own medical practice and according to their own medical specialty (Spokes). Spokes include primary care, OB-GYN, or psychiatry practices.

Regional Coordinated Referral System
The state supports multiple initiatives to foster regional collaborations that will result in better service delivery and improved outcomes. The initiatives include: Referrals and information sharing with community providers through the AHS Substance Abuse Treatment Coordination (SATC) Initiative; staff to offer regional services navigation and develop Patient Centered Medical Neighborhoods through the Medication Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) grants; and the Lund Regional Partnership Program, which serves families involved with the DCF.

CON STANDARD 4.5: To the extent possible, an applicant seeking to implement a new health care project shall ensure that such project supports further integration of mental health, substance abuse and other health care.

Case management services are provided by our professional Counselors. Patient-centered and identified, together, the patient and Counselor determine a need for ongoing communication with area resources. Our Counseling staff are trained in, and come from, the communities in which they serve, and as a result, are part of the community care network where our OTPs are located.

These services provide support for, and work closely with, community services and can provide individual care coordination, outreach and ongoing communication with social and economic support services in the community. Counselors frequently refer the patient, as needed, to primary medical care, mental health, and other substance abuse services not offered on-site, dental care, subspecialty medical care, wellness groups, tobacco treatment, and community recovery support. Referrals to services will address the patient's overall needs, which may include shelter and housing, education and job training, partner violence, managing a chronic disease, finding mutual help programs, etc.

Counselors may engage in proactive communication with community treatment providers to monitor patient utilization of services and promote coordination. Our Counselors participate in Multidisciplinary Team Meetings (MDT) where they contribute information on patient progress to team deliberations as well as scheduling meetings for Care Plan reviews/update meetings.

Patients and their Counselors regularly review and revise the Plan of Care according to changes in substance use and physical and mental health status. Patients will be ready for discharge when the patient's apparent risk for further substance abuse is low, coping skills have improved, and physical and mental health are stable.

Activities:

- Provide referrals based on the assessment and member's care plan as appropriate.
- Follow through on referrals to insure that the member is connecting with the services.
- Provide referrals to community, social support and recovery services to members.
- Connect members to community and social service support organizations that offer supports for self-management and healthy living, as well as social service needs such as transportation assistance, housing, literacy, employment, economic and other assistance to meet basic needs, as appropriate.
- Support services promote recovery by supporting participation in treatment, allowing members to maintain independence and improve the quality of their lives. Referrals to corresponding agencies will be made based on the assessment and member's care plan as appropriate.
- Employ approaches which may include but are not limited to peer supports, support groups, and self-care programs.
- Increase member and caregiver knowledge about an individual's chronic condition(s),
- Promote member engagement and self-management capabilities
- Help the member improve adherence to their prescribed treatment.
- Assessment of individual and family strengths and needs
- Provide information about services and education about health conditions,
- Provide assistance with navigating the health and human services systems,
- Provide opioid substance use disorder supports and outreach to key caregivers
- Provide assistance with adhering to treatment plans.

CON STANDARD 4.6: Applicants for mental health care, substance abuse treatment or primary care related certificates of need should demonstrate how integration of mental health, substance abuse and primary care will occur, including whether co-location of services is proposed.

The proposed location will not have a co-location of other services other than OTP services provided on site. See above CON Standard 4.5 as to how referrals will occur and how tertiary integration of mental health and co-occurring poly substance abuse treatment becomes part of a patients treatment and coordinated care supplements that provided by an OTP.

The Institute of Healthcare Improvement (IHI) calls for 3 aims of treatment. These will be addressed by the provider by:

(a) Improving the individual experience of care;

Acadia is proposing to establish an integrated opioid treatment facility in Bennington County to expand countywide access to Medication Assisted Treatment (naltrexone, buprenorphine, and methadone) and reduce unmet need by developing and implementing a comprehensive model or care, treatment and support.

Our model of care—where recovery support and wellness strategies are integrated with behavioral treatment and primary care supported by care coordination—assumes that people with behavioral health challenges can get better through integrated care, by learning to manage their own conditions, making healthy lifestyle choices and through comprehensive support for making those decisions. Integrated treatment principles will be operationalized in the following ways:

Outreach

- Mobilize community providers and stakeholders to help locate hard-to-reach individuals with opioid dependence and encourage them to enroll in treatment.
- Educate Primary Care Physicians (PCPs) in community practices to refer patients with diagnosed or suspected opioid dependence.

Flexible service system

- Create a system for rapid response to inquiries to enhance access to intake.
- Foster a culture for "curbside consultation" where CTC Team members communicate frequently and informally on patient issues.

Integrated, interdisciplinary model of behavioral health care

- Coordinate behavioral services across multiple disciplines and delivery systems.
- Address provision of nutrition, clothing, personal care, housing, and transportation as necessary adjuncts to treatment.
- Ensure that the most necessary screening and referrals are made and completed.

Create greater access to mainstream medical and health care system

- Enhance connections with community health care providers to facilitate specialty and support referrals
- Intensify the care coordination system with a greater level of integration and resources.

Multidisciplinary team

- The team of care providers will build mutual trust with patient.
- Promote patient retention and continuity of care, in the whole range of behavioral care, in primary care and in community support services.
- Use professionals and paraprofessionals with strong engagement skills; listen to patients in a nonjudgmental way; train staff thoroughly in SUD and co-occurring disorders.
- Behavioral health providers will continually support wellness and recovery initiatives for their patients integrated into treatment.
- Care providers will address psychosocial barriers to recovery as well as medical and treatment issues.

Patient and Family involvement

- Plans of Care will be developed with patients as active participants.
- Assist patients and family members to deal with complexities of MAT and help them effectively navigate the behavioral health care system.
- Case conferences may include the patient, family members, peer supports, clinicians both medical and behavioral, community agency staff and the Case Manager.
- Develop a QA system that recognizes and responds to the unique and critical dimensions of MAT integrated health care
- Able to respond to data needs from the state.

Program Management

- Robust capacity for reporting, contract and subcontract management and financial management.
- National structure for clinical leadership, consultation and support.

(b) Improving health of populations;

There is no current OTP in all of SW Vermont leaving citizens of numerous counties without the gold standard of treatment for what the CDC and Vermont claims is an epidemic at hand. MAT for Opioid Dependence is an evidence based modality for nearly half a century and the improvements are not only seen in over health, but one MAT study showed improvements in areas such as somatic morbidity, occupation, alcohol use (a decrease), drug use (a decrease), criminality (a decrease), family situation and psychiatric morbidity.

	Baseline	3 months	6 months	9 months	12 months
Somatic morbidity	0·31 (0·66)	0·14 (0·62)	0·22 (0·66)	0·16 (0·60)	0·22 (0·70)
Occupation*	0·94 (0·34)	0·80 (0·20)	0·80 (0·46)	0·73 (0·56)	0·64 (0·50)
Alcohol use	0·06 (0·44)	0·02 (0·16)	0·01 (0·02)	0·01 (0·02)	0·09 (0·50)
Drug use†	0·29 (0·22)	0·09 (0·18)	0·05 (0·16)	0·06 (0·16)	0·03 (0·12)
Criminality‡	0·19 (0·44)	0·07 (0·30)	0·08 (0·36)	0·01 (0·02)	0·02 (0·18)
Family situation	0·20 (0·40)	0·20 (0·46)	0·17 (0·50)	0·11 (0·26)	0·14 (0·38)
Psychiatric morbidity	0·13 (0·42)	0·12 (0·30)	0·12 (0·34)	0·07 (0·18)	0·06 (0·22)

*p=0·0006 for effect over time. †p<0·0001 for effect over time. ‡p=0·02 for effect over time. Data are mean (SD).

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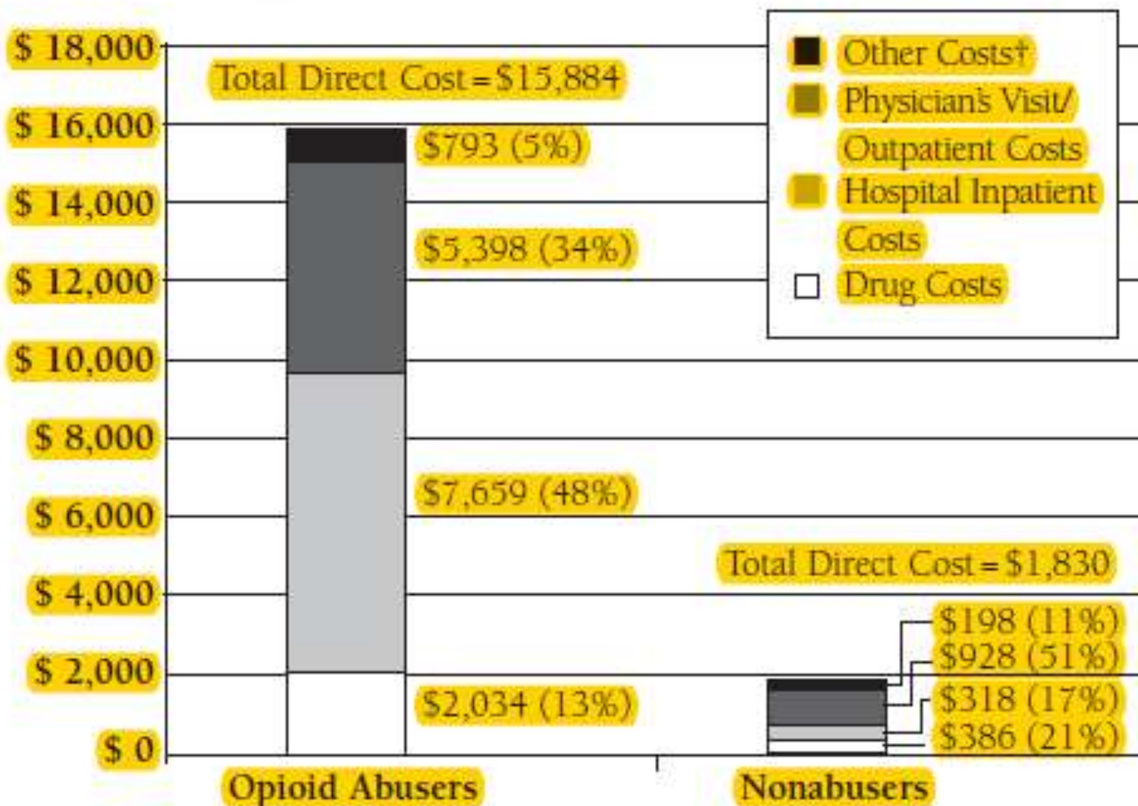
1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomised, placebo-controlled trial

(c) Reducing the per capita costs of care for populations.

The well document cost savings for treating opioid dependence has been extremely well documented over time by many entities including states, Medicaid systems, Drug Courts, Commercial Manage Care plans and many more. The data is best summed up which shows the reductions and savings on a per capita costs are detailed below. One can extrapolate that whatever the cost of care is now per capita for those suffering from opioid dependence and left untreated due to having no MAT OTP option at all, the cost savings would be approximately 7 fold. See below from HHS and a study on health care costs incurred by those suffering from opioid dependence left untreated and those who do not suffer from opioid dependence. Notice

the increased overall healthcare costs associated with untreated opioid dependence vs. another member who does not suffer from a SUD.



* Costs are in 2003 dollars. The differences between all mean annual costs of opioid abusers and nonabusers are statistically significantly different at the 1% level (P<0.01) except for "Other Costs" for which the "Other Place of Service" component is significantly different at the 5% level (P<0.05).

† "Other Costs" include: "Other Place of Service" and "Emergency Room" costs.

Conclusion

Opioid abuse is a costly condition that imposes a large direct cost burden on private payers. Opioid abusers have direct health care costs that are approximately 8 times higher than those of nonabusers. These costs are likely driven by higher prevalence rates of costly comorbidities.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

April 2009

Cost Offset of Treatment Services

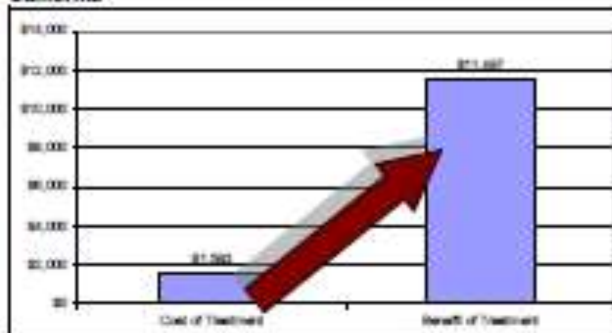
There is a great paucity on nationwide data related to the cost benefit of substance use treatment. However, the limited research in some States suggests that there is a major benefit to substance use treatment. According to recent estimates[1], the total financial cost of drug use disorders to the United States is estimated to be $180 billion annually. The economic costs of alcohol abuse were 184.6 billion in 1998[2]. Accessible and effective community-based alcohol and drug treatment is imperative to reduce society's financial burden from problems associated with drug use. As the U.S. economy faces unsustainable escalations in health care costs, we need to ensure needed substance use disorder treatment and recovery programs help reduce health and societal costs.

The benefits of treatment far outweigh the costs. Even beyond the enormous physical and psychological costs, treatment can save money by diminishing the huge financial consequences imposed on employers and taxpayers.

Cost Savings of Treatment: California, New York, and Washington

Treatment has been shown to have a benefit-cost ratio of 7:1[3]. The largest savings were due to reduced cost of crime and increased employer earnings (see Figure 1).

Figure 1. Cost Offset of Substance Abuse Treatment in California



For every **$100,000 spent on treatment,**

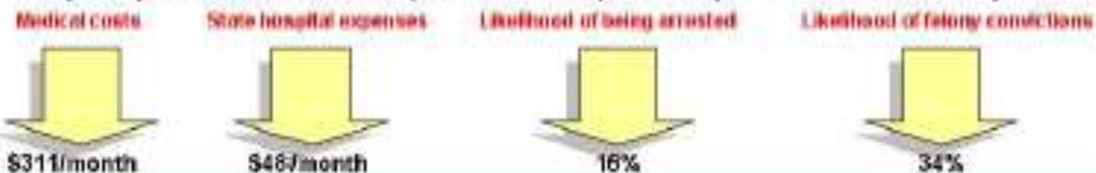
$487,000 of health care costs[4] and $700,000 of crime costs were shown to be avoided[5].

Public Assistance in Washington

A comparison of medical expenses of Medicaid clients[6] who received treatment noted these savings:

Modality	Savings per Medicaid member per month
Inpatient	$170
Outpatient	$215
Methadone	$230

Spending money on treatment has led to important health and public safety cost reductions in Washington[7]:



Health Care Utilization Savings: California

Treated patients have been shown to **reduce**[8]:

ER visits by **39%**

Hospital stays by **35%**

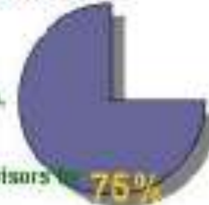
Total medical costs by **26%**

when compared to a control group.

Employers

Employees treated for substance use[9] have:

- reduced absenteeism,
- reduced tardiness,
- lowered on-the-job injuries,
- fewer mistakes, and
- disagreements with supervisors by 75%



Benefit-Cost Comparisons

- A study[10] comparing the direct cost of treatment to monetary benefits to society determined that on average, costs were $1,583 compared to a benefit of $11,487 (a benefit-cost ratio of 7:1).
- In an analysis[11] of methadone detoxification patients (n=102), authors observed that for every dollar spent on treatment, $4.87 of health care costs were offset.
- In comparing cost offsets in Washington State of people in treatment to non-treated, authors noted:[12] lower medical costs ($311/month); lower state hospital expenses ($48/month); lower community psychiatric hospital costs ($16/month); reduced likelihood of arrest by 16%; and reduced likelihood of felony convictions by 34%.

Health Care Utilization

- In a study[13] examining nearly 150,000 Medicaid claims for beneficiaries in six states, authors determined that people with substance abuse disorders had significantly higher expenditures for health problems compared to others.
- In comparison of medical expenses for welfare clients in Washington State[14] (n=3,235 treatment group and n=4,863 control) it was determined that substance abuse treatment was associated with a reduction in expenses of $2,500 per year.
- In reviewing selected beneficiaries in Oregon's Medicaid program,[15] researchers concluded that eliminating the substance abuse benefit led to increased medical expenditures.
- A review[16] of over 1,000 patients in a Sacramento chemical dependency program noted a substantial decline in hospital (35%), emergency room (39%), and total medical costs (26%) when compared to a control group.
- A recent article[17] on medical costs concluded that health care costs are higher for families with a person who has a dependency problem than for other similar families.

Employer Savings

An intake-to-follow-up assessment[18] study of nearly 500 people treated at Kaiser Permanente's Addiction Medicine program demonstrated significant reduction in missed work, conflict with coworkers, and tardiness. It also noted that employers break even on investing in chemical dependency treatment.

Every $1 spent on addiction treatment saves $7 in crime and criminal justice costs. When researchers added savings related to health care, the savings-to-cost ratio was 12:1.[19]

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[1] Office of National Drug Control Policy (2004). "The economic costs of drug abuse in the United States, 1992-2002." Washington, DC: Executive Office of the President (Publication No. 207303).

[2] Harwood, Henrick. (2000). "Updating estimates of the economic costs of alcohol abuse in the United States." Report prepared by the Lewin Group for the National Institute on Alcohol Abuse and Alcoholism.

[3] Ettner, S.L., D. Huang, et al. (2006). "Benefit-cost in the California treatment outcome project: does substance abuse treatment 'pay for itself'?" *Health Services Research*, 41(1): 192-213.

[4] Hartz, D.T., P. Meek, et al. (1999). "A cost-effectiveness and cost-benefit analysis of contingency contracting-enhanced methadone detoxification." *American Journal of Drug and Alcohol Abuse*, 25(2):207-18.

[5] NIDA, Principles of Addiction Treatment, 1999.

[6] Wickizer, T.M., A. Krupski, et al. (2006). "The effect of substance abuse treatment on Medicaid expenditures among GA clients in WA State." *Milbank Quarterly*, 84(3): 555-76.

[7] Estee, S. and D. Norlund (2003). Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report. R.a.D.A. Division and W.S.D.o.S.a.H., Services, Washington State.

[8] Parthasarathy, S., C. Weisner, et al. (2001). "Association of outpatient alcohol and drug treatment utilization and cost: revisiting the offset hypothesis." *Journal of Studies on Alcohol and Drugs*, 62(1): 89-97.

[9] CATOR Connection, Comprehensive Assessment and Treatment Outcome Research, St. Paul, MN, 1990.

[10] Ettner, op cit.

[11] Hartz, D.T., P. Meek, et al. (1999). "A cost-effectiveness and cost-benefit analysis of contingency contracting-enhanced methadone detoxification." *American Journal of Drug and Alcohol Abuse*, 25(2):207-18.

[12] Estee and Norlund, op cit.

[13] Clark, R. E., M. Samnaliev, et al. (2009). "Impact of substance abuse disorders on Medicaid beneficiaries with behavioral health disorders." *Psychiatric Services*, 60(1): 35-42.

[14] Wickizer and Krupski, op cit.

[15] McConnell, K.J., N.T. Wallace, et al. (2008). "Effect of eliminating behavioral health benefits for selected Medicaid enrollees." *Health Services Research*, 43(4): 1348-65.[16].

[16] Parthasarathy and Weisner, op cit.

[17] Ray, G.T., J.R. Mertens, et al. (2007). "The excess medical cost and health problems of family members of persons diagnosed with alcohol or drug problems." *Med Care*, 45(2): 116-22.

[18] Jordan, N., G. Grissom, et al. (2008). "Economic benefit of chemical dependency treatment to employers." *Journal of Substance Abuse Treatment*, 34(30): 311-19.

[19] NIDA, Principles of Addiction Treatment, 1999.

1. **The cost of project is reasonable because each of the following conditions is met:**

2. Habit Opco's parent company Acadia Healthcare Company, Inc.'s (ACHC) financial reports show sound rationale that the project will sustain any financial burden likely to result from completion of the project. See SEC filing for all applicable financial filing. These can be found at http://www.acadiahealthcare.com/investors/sec-filings
3. The project will not result in an undue increase in the costs of medical care or an undue impact on the affordability of medical care for consumers. In fact, it will add to, and complement, services already existing and provide new services not being offered and are unique. Consider:
    a. There is no OTP in a 40 mile radius so patients will not be coming from another service provide offering the same services. The service is unique in the area.
    b. The benefit of having an OTP far outweighs the benefits on not having one accessable from data provided herein and the applicant cannot provide any deleterious effects that would be realized by any other service provider.
4. Less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate. The SW area of Vermont really has little to no alternatives (in-patient, IOP, PHP or other) which are currently treating opioid dependence in an MAT setting.
5. If applicable, Acadia will incorporate appropriate energy efficiency measures to meet or exceed and all VT's EV initiative. Since such plans are much further down the timeline of a project, they cannot be provided at pre-CON approval time. The applicant will attest to complying with or exceeding all EV standards and all other applicable standards for such a building.

6. **There is an identifiable, existing, or reasonably anticipated need for the proposed project that is appropriate for the applicant to provide.**

    There are 200+ patients that are being by one doctor alone who has signed an agreement to turn said patients over to our care. This physicians will also be the facilities Medical Director. The Vermont Department of health has 50 patients with funding and no care facility in which to send them and has requested that Acadia site a facility here to help. The local community physicians as anecdotally reported by the future medical director who treat using their XDEA waiver for Buprenorphine products have suggested that they have dozens of patients they maintain that need a higher structured level of care offered by a comprehensive treatment center.

    The proposed facility upon 1 year after opening is forecasted to be one of Vermont's most attended OTP clinics by merely the patients that are expected from current treatment providers. It does not take into account those needing but not seeking treatment or those needing and seeking treatment but not attending. Two categories tracked by NSDUH. When those statistics are calculated into account, the facility could reach as high as 400-500 by year five making it one of Vermont's top 2-3 attended OTP facilities in the state.

7. **The project will improve the quality of health care in the State or provide greater access to health care for Vermont's residents, or both.**

There are no other OTPs in the near 50 mile radius of the proposed facility and its services stand alone in the area and surrounding counties, even encroaching service areas expected from neighboring states. There are no other state or federally licensed OTPs in SW Vermont. There are very few XDEA waivered physicians and by SAMHSA locator account, less than 5 in a 25 mile radius and less than 10 in a 50 mile radius.

8. **The project will not have an undue adverse impact on any other existing services provided by the applicant.**

   There are no other OTPs in the near 50 mile radius of the proposed facility and its services stand alone in the area and surrounding counties, even encroaching service areas expected from neighboring states. There are no other state or federally licensed OTPs in SW Vermont and thus no adverse impact is expected or anticipated. There actually is a lack of substance abuse counselors in the area and thus the impact of providing a team of professionals properly licensed to do this positively impacts all MH/SA providers in the area.

9. ***REPEALED***

   Not applicable.

10. **The applicant has adequately considered the availability of affordable, accessible transportation services to the facility, if applicable.**

    Not Applicable.

    *Note: The applicant has chosen a location that is on the public transportation route with a stop at the retail center for the ease of available, accessible transportation.

11. **If the application is for the purchase or lease of new Health Care Information Technology, it conforms with the Health Information Technology Plan established under section 9351 of this title.**

    Not applicable.