Green Mountain Care Board
144 State Street
Montpelier, VT 05601
April 17, 2020

Re: Northwestern Medical Center Emergency Department renovation
CON Docket No. GMCB-003-19con

To the Green Mountain Care Board:

We submit this public comment in response to the submissions from Northwestern Medical Center on February 27 and April 13, 2020 which continue to fail to address the objections we have raised in regards to its application for a certificate of need for renovations to its emergency department specific to the area it has designed for psychiatric patients. Although we speak as individuals with lived experience of mental health conditions who have used emergency departments in Vermont and who have been engaged in assisting in emergency room designs at three other hospitals, we remind the board that our letter of November 11, 2019 first outlining these concerns was endorsed by eight Vermont peer and advocacy organizations and five additional individuals.

We sincerely regret that the coronavirus pandemic resulted in the need for NMC to cancel a meeting with advocates scheduled for March, because we truly believe these issues are easily resolvable. NMC has clearly made efforts towards meeting patient needs, and we believe that it desires to meet quality care standards for psychiatry that are equivalent to what they seek for all patients. We see many opportunities within the existing plans to make adjustments that would meet those standards. Indeed, it was through such a dialogue that there were successful design changes both at the University of Vermont Medical Center and Central Vermont Medical Center. In fact, the same architectural firm that we worked with in the CVMC planning designed the NMC ED. Addressing these issues need not derail, nor even slow down, the NMC efforts.

Nonetheless, NMC has failed thus far to respond in ways that engage in or correct the crucial deficiencies that have been on the table since November, choosing instead to attempt to rebut the clear failure to meet CON criteria 9 that requires that the project "support equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care." This was affirmed by the Commissioner of the Department of Mental Health, Sarah Squirrell in her letters of November 14 and January 7. Because of the failure to meet criteria, a CON should not be issued unless it includes mandatory conditions that require proof of resolution.

To re-iterate:

1. The plans fail to "support equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care" because **the standard of care in Vermont for a psychiatric emergency room area requires access to a multi-use common room for patients**, and the plan fails to include this essential space, making it not equivalent to the health care provided in other parts of the emergency room which do meet the standards of care for those conditions;

2. The plans fail to support that same criteria of equity because the physical design itself, as proposed, makes it likely that some patients will be locked into a treatment unit area when they are not in state custody and are not in a status of imminent danger, and have not provided informed consent, which is **not an appropriate or legal option** for the care of any patient and which patients with other conditions are not subjected to, and because **access will be denied for those patients in a psychiatric crisis who will be deterred by fear of the trauma and violation of rights and dignity that result**. The new statements in the NMC response of April 13 specific to restraint do not change the failure to meet Criterion 9.

We have attached an example of brainstorming on various design opportunities for NMC to address these failures to meet CON criteria. Although without collaboration with an architect it cannot be demonstrated that these are specifically viable options, they present the same kind of ideas that led to resolutions in addressing some similar issues that arose with development of designs at CVMC and UVMMC. It does appear that the project delays engendered by the pandemic will offer additional time to work on such discussions.

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1. Standard of Care for Environmental Design

NMC asserts that its *"ED modernization meets all standards known to us for ED design,"* (response of April 13) and suggests that a common area is only required for inpatient psychiatric units, stating, *"The modernization of the NMC Emergency Department does not include certain aspects that may be required of a full inpatient psychiatric facility, such as an activity room or dedicated socialization space."*

In fact, there is ample evidence that the standards for a psychiatric emergency department care area require a physical environment that includes a lounge/common area that can also function as a meeting area for families and outpatient support teams, separate from the individual patient exam rooms. We provide the additional support, below, that demonstrates that NMC is inaccurate in its assessment that this is not the current standard of care in emergency rooms.

In 2014, this was still an emerging standard. The journal, *Emergency Physicians International*, noted, *"There is limited evidence-based design research supporting the appropriate design characteristics of behavioral health environments in the emergency department. Much of what has been gathered has occurred through anecdotal evidence and trial and error approaches based on the care model in place at the emergency department in question."* Nonetheless it noted that, *"careful planning and design can enable best-in-class models of care that promote greater collaboration between emergency medicine and psychiatry while reducing the overall length of stay for behavioral health patients in the emergency department"* and it included **recommendation of a feature it called an internal waiting area** within a separated care environment: ***"Features of the internal waiting area include psychiatric-safe interior furniture, a de-escalating design, and visual distractions such as video and reading materials."*** https://www.cannondesign.com/assets/EPI-New-Psych-ED_Spring-2014.pdf

By 2018, Johns Hopkins observed that, *"As more hospitals divide psychiatric emergency units from the rest of their emergency departments, they are fine-tuning the art and science of* ***creating therapeutic and safe spaces for patients."*** In an article entitled, *Design Features Set Psychiatric Emergency Areas Apart*, it described an affiliate's new emergency room suite as *"including a cozy-looking lounge where patients can eat, socialize and watch television…. 'The*

new space is much larger, much more private and more humane,' says Susan Webb, the hospital's director of behavioral health emergency and outpatient services. *'People don't feel like they are locked in their rooms. They can get a meal together at a table. They are treated with kindness and care and compassion. All that makes them feel better.'"*
https://www.hopkinsmedicine.org/news/articles/the-design-features-that-set-psychiatric-emergency-areas-apart

In 2017, **Rutland Regional Medical Center opened its new psychiatric emergency room suite** and the VT Digger coverage of the event observed, *"The $6 million ER expansion includes **a shared common room with a TV and a cart stocked with checkers, chess and coloring books."*** The Green Mountain Care Board order granting the amendment to its certificate of need for its new emergency department noted, *"CEO Thomas Huebner … explained that RRMC's initial ED design would not accomplish some of the hospital's objectives; in particular, the new design more keenly focuses on needs of psychiatric patients that enter the hospital through the ED."* Order Amending Original Certificate of Need, January 15, 2016
https://gmcboard.vermont.gov/content/2015-con-decisions-issued-0

NMC has stated repeatedly that its design meets standards of care because it "mimics" and is modeled on the RRMC design (responses of November 5 and December 23), yet in fact it fails to provide this essential element of this standard of appropriate care.

This is also evidence-based care. The Commissioner of Mental Health noted in her November 14 letter that, *"**Having a comfortable area outside of their individual patient room they can freely access has been shown to reduce stress and acuity of individuals trying to manage a psychiatric crisis."***

Currently, three other Vermont hospitals are in various design phases for new psychiatric emergency room spaces, and all three include patient lounge/common area spaces as part of the design. This includes the CON application for an emergency room renovation project submitted on March 10, 2020 by Southwestern Vermont Medical Center, which notes, *"Specific features of the mental health crisis care area, such as windows and **a group room for peer-to-peer support**, are designed to improve mental healing, decrease length of stay, and increase access."* (Docket No. GMCB-019-19con)

Beyond being more therapeutic and calming, a common area within a psychiatric emergency room area is required for collaborative network team meetings with patients that are crucial to the emerging best practice treatment model based upon the "Open Dialogue" intervention pioneered in Finland in the 1990's. The Vermont Collaborative Practice Institute administered initial funding from the Department of Mental Health to pilot the application of Open Dialogue in the state and is currently expanding training to implement it throughout the system of care. The model has been incorporated as the Collaborative Networks Approach at the Howard Center in Burlington and at Counseling Services of Addison County, spearheaded by Dr. Sandra Steingard, the Medical Director at the Howard Center for the past 21 years and a clinical Associate Professor of Psychiatry at the College of Medicine of the University of Vermont. It has already been introduced into the Vermont Psychiatric Care Hospital and other community and hospital settings in the state.

The core of the approach is the involvement of the patient's family and social network. At all meetings, clinical discussions occur with all participants in the room. It includes mobile, responsive outreach and continuous support in both inpatient and outpatient settings. The provision of an immediate response in a crisis aims to prevent hospitalization in as many cases as

possible, including avoidance of involuntary admissions. When that is not possible, the enhanced team continuity and support extends through hospitalization.

The Substance Abuse and Mental Health Administration (SAMHSA) has endorsed Open Dialogue as an emerging model and hosted a webinar in 2016 on *"Recovery-oriented Crisis Services: Applying Principles of Open Dialogue and Peer Support."* The presenters discussed the application of the approach when a patient has arrived in an emergency department and needs immediate intervention. *"And of course a very common one to which we can all relate is when any of us go to the ER, pretty much the first thing that happens is even if we were brought there by friends and family we get ushered into the bowels of the ER while our support system waits in the waiting room. So separating people from their critical supports."* With the Open Dialogue approach, *"If we have someone in the ER is having a lot of difficulty…If it is possible to take a couple of hours and get some sleep and look at the situation the next day, it often looks radically better."* The presenters noted that at the meetings *"the clinicians follow the lead of the family and network as the problem is explored. It really conveys this idea that* ***people at the center of concern should have as much control as possible and should not be isolated from family, from their friends …"***

This need was recognized by SWMC in its emergency department application, noting a design that ***"enhances opportunities for support from peers with lived experience and enhances collaboration by caregivers to ensure trauma-informed care,"*** which it observes, ***"aligns with the Vermont Department of Mental Health's Vision 2030."***

It is essential to the Collaborative Networks Approach to have adequate space to gather these key clinical and support person team members when the immediate intervention needs to occur in the emergency room. Such meetings would not be possible within the confines of a patient room. To design a brand-new psychiatric emergency room area without addressing known emerging treatment practices would be terribly short-sighted.
See, https://www.sevendaysvt.com/vermont/burlingtons-howardcenter-tries-a-new-approach-to-treating-mental-illness-more-talking-fewer-meds/Content?oid=2242671;
https://vermontcarepartners.org/journeying-back-to-myself-restoring-trust-in-vermonts-mental-healthcare-system/;
https://www.samhsa.gov/sites/default/files/programs_campaigns/recovery_to_practice/crisis-open-dialogue-transcript-20160126.pdf

In conclusion, in order to meet Criterion 9, the new psychiatric care unit in the emergency department must meet the standard of care for psychiatric emergency room units, and **that standard clearly includes access to a common area as a patient support space.** Such a space is also necessary to enable meetings with patients and support teams under the emerging evidence-based practice of "Open Dialogue"/Collaborative Networks Approach.

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2. Standard of Care Regarding Locked Capacities

Our previous letters have discussed both the legal issues under Vermont law and the significant negative impact on quality of care as a result of the trauma that is experienced by patients who are locked into treatment areas without consent. We note that trauma-informed care is, in and of itself, an established standard for appropriate patient care. As the Commissioner of Mental Health noted in her November 14 letter, *"voluntary patients do not need, and should not*

be, locked in a room or separate area simply because they are presenting with a mental health concern."

The NMC response of April 13 continues to conflate the question of whether its policies meet regulatory requirements for the rare need for patient seclusion with the question of providing a legal basis addressing the structural design allowing for the locking double security doors at the exit of a 4-patient area into the main corridor, and for a locking security door at the exit from the inner two patient rooms. Both of the inner halls are explicitly marked *"secure hallways."*

Its responses have largely referenced regulatory standards that relate to emergency seclusion of patients individually when they present an imminent threat of serious bodily injury. They have provided no legal justification at all for detaining more than one patient in a patient care area outside of a single room. Despite the assurance in its April 13 response that the hallway doors will only be locked when *"clinically indicated"* under its restraint policy, NMC has clearly indicated in prior responses an intent to lock patients up in the psychiatric treatment area of the emergency room at a significantly lower threshold than that required under CMS for emergency use of seclusion, and its new statements do not align with the minimal actual capacity that would be needed for legitimate use of only emergency restraint or seclusion.

NMC provided very explicit responses in its November 5 response, when it described the outer, double doors that access the main corridor and how they *"would be locked as needed in certain circumstances,"* stating, *"An example would be when we have a behavioral health patient* ***who is not a high risk patient*** *and we have a low enough census in the Emergency Department, we can lock that outer door and thus provide a safe space for the behavioral health patient to walk in that hallway if desired. We would also lock if we had more than two behavioral health patients in the department and were utilizing one or both 'flex' rooms."* [Emphasis added.] The statement specifically distinguished between *"extreme*" situations in which an individual patient might be locked in a room (seclusion) from the other situations when either or both of the sets of doors to the inner or outer two-room suites might be locked.

In its January 3 questions, the Board asked NMC to confirm that the hallway doors do not automatically lock, and asked whether its policy was finalized yet regarding when *"the doors into this area from the main hallway and door between the two sets of rooms and this area will be locked or unlocked to be compliant with CMS and state requirements and statutes"* and directed it to submit *"the policy NMC will follow regarding locked areas that is compliant with all CMS requirements and state statute."* NMC did not ever respond as to how its policies were compliant with the applicable state law, 18 V.S.A. § 1852.

The February 27 NMC response did include that, *"Having the capacity to lock a space in a busy Emergency Department is an important security measure for patient and staff safety. These rooms can be utilized for patients who pose any sort of a security risk in order to keep the entire department safe."* It then went on to say – as repeated in the April 13 response -- that the specific steps to lock the doors is covered by its 'Restraint Use' policy which it asserted addresses seclusion in compliance with CMS regulations, and said that the term seclusion was inclusive of locking a hallway door. NMC is undoubtedly aware that CMS does not interpret seclusion to include areas that care for more than one patient or when there is a nursing unit incorporated as part of the area (as the NMC design includes), and that Licensing and Protection in Vermont has specifically found that the use of such a configuration is not within the definition of seclusion, as NMC disingenuously describes it. In fact, the definition that NMC attributes for "seclusion" – the locking of doors for an area that includes more than one room, not restricted to a single person, and inclusive of a nursing station – would mean that the entirety of any locked inpatient

unit would be seclusion under CMS regulations. (As an aside, note that if the inner hallway door is locked, patients in the outer section would not have access to a bathroom – something we did not recognize until reviewing a close-up of the design. The second bathroom serves the on-call physician room, not the potentially locked outer suite.)

If NMC actually intended to only lock the hallway doors under the exigent circumstances that met CMS criteria for seclusion, it would mean the that NMC **intends to provide care for most involuntary patients, as with voluntary patients, in a completely open setting**. That seems improbable, at best, as well as contrary to general practice; we have never questioned the need at times to have a secure setting for involuntary patients who do not require individual restraint. It is inconceivable, however, that there would be the need at the level of emergency restraint to hold four patients at the same time. The design itself, therefore, would impair the capacity for the overwhelming majority of patients who would not meet the criteria for seclusion – or, as ably demonstrated in the comments submitted by Vermont Legal Aid, which detailed the locations and flow of the doors – those patients would end up being themselves illegally restrained by virtue of co-location. Indeed, in its November 5 response, NMC stated that the ability to lock rooms *"it is not a capability we would currently anticipate using except in certain extreme circumstances."* In the new response of April 13, NMC again states that the doors *"will be used in locked format only when clinically indicated and ordered by a physician. This is in keeping with NMC's existing patient restraint policy."* However, despite assertions about the data-driven nature of its presentation for the renovation project, NMC has never offered the most basic of information to demonstrate it would require the proposed level of capacity for patients in need of such emergency restraint. Data from past years is easily accessible, since the use of emergency involuntary procedures is information that is required to be maintained by the hospital. If NMC believed it needed this level of capacity for the extreme circumstance of use of seclusion, it should have presented it.

Even as it was claiming it would restrict use of locked areas to the legal standard for seclusion in its February 27 response, NMC was making its clear statement about the purpose for having *"the capacity to lock a space"* when it said that such locked areas in an emergency department can be utilized for ***"patients who pose any sort of a security risk."*** Obviously, *"any sort of a security risk"* does not remotely comport with the state and federal regulations later cited by NMC for the use of locked-room seclusion, which underscores our concern about the inconsistencies in how NMC has discussed the locked or unlocked use of the hallway doors.

It is important to remember that NMC's own data in its reply on February 27 shows that only 2.6 percent (17 patients) in 2019 were involuntary, part of a trend of a reduction in the percentage of involuntary patients in the ED over four years (4.1% in 2016; 3.4 % in 2017; 3.4 % in 2018). NMC asserted in that reply that the lengths of stay for those patients are "*strikingly different"* and as a result *"we know"* the conclusions on capacity needs for secure care are correct. This was a dramatic but wholly unsubstantiated assertion. NMC presented absolutely no data in support of this "knowledge." In contrast, DMH data for 2019 show a higher percentage of involuntary patients as a statewide average than at NMC, although still very low at five percent, and its recognition of the longer length of stay for those patients has actual data behind it. Total bed days in emergency rooms for all involuntary patients represent approximately 20 percent of the psychiatric patient emergency room utilization in the state. Applied to the NMC psychiatric patient data, roughly 10 percent of the average actual utilization in the ED would have been by involuntary patients in 2019.

However, because NMC is equating the locking of the entire psychiatric care area to emergency seclusion, even that 10 percent utilization does not indicate an actual capacity need for locked rooms. The statements in its April 13 submission indicate that involuntary patients will not be held in *any* level of secure setting, unless they meet the "*extreme circumstances"* that justify seclusion, thus representing only a very much smaller subset of those patients.

The physical design as proposed will make it likely that in reality, voluntary patients will at times be locked up when seeking care, which does not represent equal access to care that is required by CON criterion 9 because it **is not an appropriate or legal option**, and because **access will be denied for those in a psychiatric crisis who will be deterred by fear of the trauma and violation of rights and dignity that result.**

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We therefore urge the Green Mountain Care Board to require full resolution of these two deficiencies as a condition of a CON for renovations of the emergency department at Northwestern Medical Center.

Sincerely,

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Attachment

Sample design opportunities to resolve CON criteria deficiencies.

We note that without dialogue with the architects it is not possible to identify definitive solutions, and an initiative to discuss options was not offered by NMC until February. Unfortunately, the coronavirus pandemic forced the cancellation of that meeting. However, these examples present the same kind of concepts that led to resolutions in addressing some similar issues that arose with development of designs at CVMC and UVMMC.

1. **Options for creation of a patient common area within the psychiatric emergency room exam area:**
    a. The room labeled "mental health 1" could become the common room, thus directly facing the team station for observation, and the room labeled "exam room 14" could have a door accessing the interior secure hallway. This would allow exam room 14 to be fitted as a ligature resistant room that could either have the inner door secure and access from the outer hall (as a regular medical exam room or a psychiatric exam room for a voluntary patient) or with the outer door secure and access to the interior hallway (for use if there is a second involuntary patient, or if a voluntary patient provides informed consent to be within the locked suite in order to access the common space and shower amenities). This dual-door option and flexible functioning was integrated into the CVMC plan for two of its ED rooms.
    b. The room labeled "exam room 14" which currently faces the exterior hallway could be reversed to face the interior hallway with an open side to become the common space area. This would also allow a window from the team station to direct observe the space.
    c. Exam room 16 could become the common area room, opened up and directly facing the team station. Exam room 7 (not visible; across the main corridor) could then become the second ligature resistant "swing room" to accommodate either medical or psychiatric use. A major advantage of this change would be the creation of an unlocked patient room facing an open hallway but still directly across from the psychiatry team station for the use of patients who did not want to choose to utilize the 3-room psychiatric suite when it might be locked. [See discussion of secure area, below. A similar solution worked exceptionally well in revisions that were made in late stages of design in the UVMMC ED.]
    d. As with (c), exam room 16 would become the common area room, opened up and directly facing the team station. The room labelled "on call bedroom" would then become the second ligature resistant "swing room" with [as in option (a)] an access door either within the secure suite or to the outer hallway. An advantage of this plan would be creating access within the second psychiatric suite to a bathroom. In the current design, if there are patients locked within the area served by secure hallway 1, and other patients are locked within the area served by secure hallway 2, those patients no access to a bathroom.
    e. The area behind the current toilet/shower room is "mechanical space." Moving that diving wall would add the space needed to add revisions to the psychiatric suite without having to relocate the on-call bedroom or to lose exam room 14. This would increase opportunities for redesign, but would increase the extent of the redesign.

We recognize these solutions might require finding replacement space for other existing uses, but none require major redesign.

2. **Options for elimination of design features that would result in locked areas being used for voluntary patients who have not provided informed consent:**
    a. Removal of the doors between the main corridor and first suite so that hallway 2 could not be used as a locked area. This would require a combined solution with 1a or 1b, above, because it is individuals in a locked suite who have greater need for access to a larger ambulatory space and common area. The disadvantage would be that it would put limitations on access to the common area for voluntary patients if hallway 1 needed to be locked.
    b. Ensure an adequate number of rooms in unlocked areas to protect the right of a voluntary patient to choose between remaining in a single, unlocked room, or to opt voluntarily to stay in the locked suite in order to access its amenities. This could be achieved with several of the options above, since they allow for at least one patient room to be within an unlocked section, even if the psychiatric suite needs to be locked because of the presence of an involuntary patient (which is limited to an average of 20% of overall patient use.) The listed design options vary in the degree of flexibility they offer for the number of patients who could choose to be in an unlocked or locked area when there is a patient in the emergency department at the time who requires a locked area because of involuntary status.

We note that these are very much compromise solutions. As Legal Aid pointed out in its comments of April 13, it is discrimination to require patients with a psychiatric disability to have to surrender their right to freely leave in order to access equivalent facilities. These solutions, however, would at least improve the ability to a patient to have a choice, albeit by forfeiting the access to a common area and bathroom with shower.