STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Application of Northwestern Medical Center, Renovation of Emergency Department and Front Entrance	)	GMCB-003-19con

STATEMENT OF DECISION AND ORDER

Introduction

In this Decision and Order, we review the application of Northwestern Medical Center (NMC or "the applicant") for a certificate of need (CON) to update its emergency department (ED). The project involves renovating 9,267 square feet of existing space and adding 2,392 square feet of new space to the current ED footprint, for a total cost of $7,616,215.

For the reasons set forth below, we approve the application and issue the applicant a certificate of need, subject to the conditions set forth therein.

Procedural Background

On June 27, 2019, NMC filed a CON application and request for expedited review. The Board granted NMC's request for expedited review on July 15, 2019. Through several rounds of questions, the Board sought additional information from NMC, which NMC provided. On January 8, 2020, Disability Rights Vermont (DRVT) petitioned to intervene in the proceedings as an interested party or amicus curiae. The Office of the Health Care Advocate (HCA) exercised its statutory right to intervene as an interested party on January 17, 2020. On January 23, 2020, the Board granted amicus curiae status to DRVT. The Board closed the application on March 6, 2020.

The Board held a scheduling conference on March 20, 2020 with representatives of DRVT, the HCA, and NMC. At the scheduling conference, the parties and DRVT agreed to submit written arguments in lieu of a hearing given the ongoing public health emergency due to COVID-19. Following the scheduling conference, the HCA submitted a written waiver of its right to a hearing pursuant to 18 V.S.A. § 9440(c)(5)(C)(i). NMC, the HCA, and DRVT submitted their briefs on April 13, 2020. On April 20, 2020, NMC submitted a responsive brief. On May 8, 2020, the Board asked NMC to answer two additional questions. NMC responded to the Board's questions on May 13, 2020.

At several points in the proceedings the Board received helpful comments from Anne Donahue, Ward Nial, Dan Towle, and leaders of peer and advocacy organizations; the Vermont Department of Mental Health (DMH); Northwestern Counseling and Support Services (NCSS); and the National Alliance on Mental Illness (NAMI).

Jurisdiction

The Board has jurisdiction over this matter pursuant to 18 V.S.A. § 9375(b)(8) and 18 V.S.A. § 9434(b)(1).

Findings of Fact

1. NMC provides services to a population of over 56,000 in northwestern Vermont. This area could not be adequately served without an emergency department. Application (App.), 1, 18.

2. The design of NMC's ED dates back 30 years to its original construction in 1990. The ED originally had nine beds. Approximately 20 years ago, bed capacity was increased to 14 with the absorption of the adjacent endoscopy area. The internal patient care space of the ED has had little more than cosmetic upkeep in the three decades since it was constructed. App., 1.

3. The project involves renovating/constructing a total of 11,659 square feet (sq./ft.) of space. Specifically, the project involves 9,267 sq./ft. of renovation – essentially all the existing ED except the parking portion of the attached ambulance bays – and construction of a 2,392 sq./ft. addition to the existing footprint of the ED for relocation of a mechanical room. App., 8.

4. NMC determined that renovating "in place" while emergency services continued would result in negative financial impacts because it would lengthen the project and reduce overall ED capacity. To avoid this, NMC plans to temporarily relocate the ED to the former Intensive Care Unit and Step-Down Unit, which is in proximity to the existing ED. App., 8.

5. No diagnostic imaging equipment is being purchased as part of this project. App., 9.

6. NMC has made meaningful efforts to reduce avoidable ED visits, including by working with NCSS on strategies to reduce avoidable mental health visits to the ED and embedding a crisis worker within the ED to collaborate with NMC's case managers and its Screening, Brief Intervention and Referral to Treatment (SBIRT) personnel for substance use disorder. NMC's ED visits decreased from 27,998 in 2012 to 24,536 in 2018. App., 13-14.

7. While the number of ED visits has declined over the past few years, NMC's ED lacks appropriate capacity for current and projected volumes. In the twelve months prior to the application, NMC treated 25,227 patients in the 14 existing treatment rooms within the ED. This translates to 1,801 visits per room, which is higher than the national benchmark of 1,400 - 1,500 visits per bed specified in Strauss and Mayer's "Emergency Department Management" publication;[1] it is also higher than comparable Vermont hospitals. App., 4. In approximately 1,200

[1] NMC also reviewed benchmark information from the Emergency Department Benchmarking Alliance and Health Environments Research & Design Journal. The Emergency Department Benchmarking Alliance's analysis for 2015 was that most EDs are designed to see 1,300 to 1,700 visits per patient care space per year. The Health Environments Research & Design Journal's analysis in 2012 was that 1,500 patients a year can be treated in each patient care space. Resp. (Oct. 7, 2019), 1.

(or 5%) of these visits, care was provided in hallway beds due to an inadequate number of treatment rooms in the ED. App., 6.

8. Based on a 2018 report from the Vermont Department of Labor, Franklin County, which comprises the majority of NMC's service area, is one of the few Vermont communities experiencing population growth of approximately 2.4%, compared with 0.2% reduction in population for Vermont as a whole. Additionally, Franklin County aligns with the State trends of an aging population, with the number of Franklin County residents over age 60 projected to more than double between 2010 and 2030. Data from the Centers for Disease control and Prevention shows that the rate of ED visits steadily increases as the population progresses from ages 65-74, 75-84 and 85 and over. App., 3.

9. The project will increase the total number of ED beds from 14 to 20, as shown below.

Type of Treatment Area	**Current**	**Planned**
Trauma Room Beds (unchanged – now reserved for trauma)	2	1
Cardiac Room Beds (unchanged – now reserved for cardiac)	1	1
Traditional Treatment Beds (becoming private rooms)	10	12
Airborne Infectious Isolation Rooms (will be used for others)	0	2
Dedicated Safe Holding Rooms for Mental Health	1	2
Convertible Safe Holding Rooms (can be used for mental health or others)	0	2

App., 7.

10. The project will enhance NMC's ability to handle surges in patient volumes while better preserving its most advanced treatment rooms (the trauma room and the cardiac room) for the specific life-threatening emergencies they are designed to address. App., 7.

11. While the project results in 7 additional beds, NMC does not anticipate that the project will increase the number of ED visits. Resp. (Aug. 22, 2019), 1. NMC projects 24,000 visits annually to the ED for 2020, 2021, and 2022, which would equate to 1,200 visits/bed. NMC Response to Questions (Resp.) (Oct. 7, 2019), 1, and Revised Narrative, 5. This would be within a national benchmark range of 1,400 to 1,500 visits per bed. App., 4-5; Resp. (Oct. 7, 2019), 1-2; NMC Brief (April 13, 2020), 3.

12. The following table shows NMC's current and planned ED visits per bed in relation to other Vermont hospitals:

	NMC	NMC Planned	RRMC	SVMC	BMH	North Country Hospital
Patient Volume	25,000	24,000	36,000	24,400	13,000	16,000
ED Beds (Medical)	13	16	26	16	10	7
ED Beds (Safe and Convertible)	1	4	7	3	2	3
Total ED Beds	14	20	33	19	12	10
Visits Per Beds	1,786	1,200	1,091	1,284	1,083	1,600

Resp. (Oct. 7, 2019), 5.

13. NMC's ED fails to provide patients with privacy, which is important for candid medical discussions. The core treatment areas within the ED are separated only by curtains, allowing patients and visitors to overhear clinical and personal conversations in the neighboring bays. This causes disruptions in patient and visitor attentiveness during instruction; negatively impacts restfulness during patients' stays in the ED; and creates safety concerns for patients, visitors, and staff as physical disruptions can easily move from one curtained treatment bay to another. The lack of adequate capacity within NMC's current ED also creates privacy issues. As noted above, NMC was required to treat patients in non-private hallway beds 1,200 times in the twelve months prior to the application. App., 6.

14. The project will convert the main ED treatment area from curtained treatment bays to private treatment rooms, which will enhance patient privacy and patient care. App., 6.

15. The registration area of NMC's ED is currently located next to the public entrance and outside the secure perimeter of the patient care area. In the event of a "lock down" due to an active shooter or other serious threat, the doors to NMC's ED seal for protection, leaving the registration staff at risk. The project will move the registration area into the new secure ED patient care space. App., 5.

16. NMC's existing ED also lacks dedicated, airborne infectious isolation rooms for treatment of individuals suffering from diseases such as tuberculous, measles, chicken pox, or rarer conditions such as SARS, Ebola, and now COVID-19, putting patients and staff at risk for infection. Temporary portable measures to approximate a true airborne infectious isolation room within the ED have been used, but even with the best of intentions, these approaches carry a level of set-up delay and operational risk that can be avoided or minimized through properly designed, permanently constructed rooms. Two such rooms are included in the project. App., 5-6.

17. The Centers for Medicare and Medicaid Services (CMS) surveyed NMC in the fall of 2018 in response to a complaint relating to the hospital's use of law enforcement officers to deal with instances of severe aggression, mental health concerns, or suicidal ideations. App., 1. The surveyors expressed concern about the design and physical environment of NMC's ED. At the time, NMC did not have any "Safe Holding Rooms." As part of its plan of correction, NMC modified its ED to create an acceptable temporary solution. Subsequently, NMC created a single secure holding room in its ED for patients with serious mental health issues. App., 1, 4.

18. The project involves creating two ligature-free, dedicated "Safe Holding Rooms" that NMC stated it will use for patients who are "at risk for harming themselves or others." App., 7; Resp. (Dec. 23, 2019), 4. These rooms are labeled "Mental Health 1" and "Mental Health 2" in the figure below. The project also involves creating two convertible patient rooms that can quickly be transformed into ligature-resistant "Safe Holding Rooms" with hard ceilings and sliding panels that can be used to cover wall-mounted equipment. App., 7; Resp. (Feb. 27, 2020), 6. These rooms are labeled "Exam 15" and "Exam 16" in the figure below.

Resp. (Aug. 22, 2019), Proposed Floor Plans (as modified in HCA Brief (April 13, 2020), 2).

19. NMC does not plan to use the two designated ligature-free safe holding rooms for patients with routine medical concerns, although it may do so in rare times of patient surge within the ED. NMC does plan use the two convertible ligature resistant patient rooms for patients with routine medical concerns depending on departmental capacity. Resp. (Dec. 23, 2019), 4. All four rooms in this "unit"[2] will have natural light and are situated to avoid most ED traffic and provide a more private and calming space than other treatment areas in the ED. NMC Brief (April 20, 2020), 1.

20. NMC will be able to lock all four rooms, as well as the double doors in the hallway that connects Mental Health 1 and Mental Health 2 to Exam 15 and Exam 16 (Secure Hallway 1) and the double doors in the hallway outside Exam 15 and Exam 16 that connects the area to the rest of the ED (Secure Hallway 2). Resp. (Feb. 27, 2020), 5; Resp. (Nov. 5, 2019), 1. The default setting on these doors is to be unlocked. NMC Brief (April 13, 2020), 5. NMC states that it will utilize the locks "as needed based on patient specific behaviors and risks." For example, NMC states that if it has a patient in one of the dedicated Safe Holding Rooms who is not a "high risk patient" and it has a low enough census in the ED, it can lock the outer door and provide a safe space for the patient to walk in the hallway. Resp. (Nov. 5, 2019), 1.

21. Most patients who seek mental health care do so voluntarily. Memo from Commissioner Squirrel (Nov. 14, 2019), 2 (stating that 95% of patient seeking help for mental health care in an ED are voluntary). This is true at NMC as well. In FY2019, NMC saw 25,681 visits to its ED. Of these 25,681 visits, 613 or 2.4% involved patients with a chief complaint of anxiety, depression, psychiatric evaluation, suicide ideation, or overdose. Of these 613 "mental health" visits to NMC's ED, only 17 or 2.6% were identified as being "involuntary." Resp. (Feb. 27, 2020), 1.

22. NMC states that its determination of how many treatment spaces in its ED should be ligature-free patient treatment rooms and how many should be ligature-resistant patient treatment rooms has some relation to, but was not driven by, the numbers of voluntary and involuntary patients it sees. NMC cautions that these numbers do not account for length of stay or the fact that patients are not evenly spread out across the hours of a day or the days of a year and asserts that while the numbers "might inaccurately suggest that a single room would suffice, we know from a day-to-day basis that we can frequently have two patients, occasionally four, and even six on rare occasions needing this type of resource at any given time." Resp. (Feb. 27, 2020), 2.

23. While the typical ED patient at NMC has an in-department length of stay of approximately 164 minutes, it is not unusual for a patient awaiting placement for mental health concerns to have a length of stay of 48 to 72 hours – the equivalent "bed time" of 17.5 to 26.3 typical ED visits. App., 1.

[2] NMC objects to the HCA's characterization of the space as a "mental health unit," noting that all patient treatment rooms in the new ED may be used for any patient if there is a surge in volume. By using the term "unit," we simply seek to connote the secure space represented in the figure above.

24. NMC considered an alternate version of the project estimated at approximately $4 million that would have created two safe holding rooms, but not in an area that could be separated from the rest of the ED. This option lacked the flexibility of expanding to four beds through convertible Safe Holding Rooms and NMC determined that maintaining those rooms in the general ED treatment area would have led to continued disruption of care and reduced safety for patients with severe mental health concerns or suicidal ideations. NMC also determined that this option would not address the safety concerns for registration staff. Finally, NMC determined that the alternate version of the project would not provide adequate space for clinical personnel (including embedded Care Management and SBIRT – Screening, Brief Intervention, and Referral to Treatment – personnel) or equipment storage and would create an inefficient workflow for staff and patient movement to diagnostic imaging and inpatient units. The alternate design was brought to the Planning Committee of the NMC Board and discussed in detail. It was found to not address enough of the fundamental concerns to be worth the still-significant investment. App., 17-18.

25. The design and floor plan of the new ED was discussed with the local Designated Agency, NCSS, and individuals identified to NMC as having lived experience with mental health issues. Resp. (Nov. 5, 2019), 1. A request for a common space outside the ED rooms did not arise from those discussions and the review of the floor plans. Resp. (Dec. 23, 2019), 5. NMC told the Board that NCSS has been and will be consulted in the ED renovation design and operational policy development, which will focus on providing the most suitable therapeutic environment for all patients including to promote care in the least restrictive environment. NMC's Opposition to Disability Rights Vermont Request for Intervener Status (Jan. 17, 2020), 2.

26. During the CON application review process, concerns regarding the new mental health unit of the ED were raised by the HCA, DRVT, DMH, NAMI, Anne Donahue, and other peer and advocacy organizations. The concerns primarily related to two subjects:1) when and under what circumstances the rooms or areas within the unit will be locked and the potential that patients who are voluntarily seeking mental health services will be confined against their will; and 2) the lack of a lounge or other "common space" in or near the ED where patients can socialize, engage in activities, and interact with peer supports, legal advocates, and family members. *See, e.g.,* Memo from Commissioner Squirrel (Nov. 14, 2019), 1-3; Memo from Commissioner Squirrel (Jan. 7, 2020), 1; HCA Brief (April 13, 2020), 2-5; DRVT Letter (Jan. 3, 2020), 1-2; DRVT Letter (Mar. 5, 2020), 1-2; DRVT Brief (April 13, 2020), 1-4; Letter from Anne Donahue et al. (Nov. 11, 2019); Letter from Anne Donahue (April 17, 2020).

27. With respect to the issue of seclusion, DMH stated that while there will be a small number of patients in EDs that are involuntarily under the care and custody of the Commissioner of DMH and may need a secure, locked area, 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. Memo from Commissioner Squirrel (Nov. 14, 2019), 2.

28. According to DMH data, the 16 involuntary patients[3] waiting in NMC's ED in FY19 had a mean wait time of 58.34 hours, a median wait time of 47.21 hours, a minimum wait time of 1.5 hours, and a maximum wait time of 148.5 hours, and the number of involuntary patients that were waiting in NMC's ED in a given month ranged from one to five. Memo from Commissioner Squirrel (Nov. 14, 2019), 2.

29. While NMC agrees with DMH that the majority of patients seeking mental health care do so voluntarily, it asserts that "the designations of 'voluntary' versus 'involuntary' or the designation of custody do not necessarily align with the reality of a patient's potential to or intent to harm themselves or others." Resp. (Dec. 23, 2019), 4. NMC states that "[a] patient may come to the NMC Emergency Department on a fully voluntary basis and still be suicidal/homicidal or dangerously violent to the point of being a danger to themselves or others. Appropriate safety precautions still have to be used in this clinical instance, despite the fact that the patient is there voluntarily." *Id.* at 3. NMC emphasizes that the design of its facility must provide for a "least restrictive environment" with the flexibility for the space to support the medical team's judgment as situations unfold. *Id.*

30. Due to what it characterizes as NMC's failure to clarify how it intends to use the locking capabilities of the new mental health unit without violating the rights of voluntary patients to leave the unit, DRVT recommends that the CON for the project be "conditioned upon NMC providing an acceptable policy on how they will utilize the locking unit-entry doors, including assurances that no voluntary patient is locked in the unit unless they have provided informed consent or a clinician has documented an imminent risk of serious harm to self or others that could not be reasonably addressed with less coercive means, such as assigning a one on one staff person to observe and intervene in case of dangerous behavior." DRVT Brief (April 13, 2020), 2-3. The HCA similarly recommends that the Board include "a condition in the CON requiring NMC to configure the ED [Mental Health Unit] or adopt policies regarding when the doors can and cannot be locked such that mental health patients who are voluntary and not temporarily secluded can be treated without abridging their right to leave the ED [Mental Health Unit]." HCA Brief (April 13, 2020), 4-5.

31. NMC initially stated that it had not formalized written guidance as to when the rooms/areas within the unit will be locked and/or monitored. Resp. (Dec. 23, 2019), 5. Later, NMC clarified that the rooms/areas would only be locked as ordered by a physician under NMC's restraint and seclusion procedures, which were last updated 12/2018. Resp. (Feb. 27, 2020), 3-4; *see also,* NMC Brief (April 13, 2020), 5.

32. NMC had hoped to host a meeting in its current ED to talk further with advocates from DRVT, the HCA, and others who have filed public comment regarding the project. However, it

[3] There was a slight discrepancy between the number of involuntary patients identified by NMC for FY19 (17) and the number of involuntary patients identified by DMH for FY19 (16). We assume this discrepancy is due to the use of different fiscal years (i.e., the hospital fiscal year in the case of the data provided by NMC and the state fiscal year in the case of the data provided by DMH). Regardless, the discrepancy is not material.

decided to postpone this meeting to a time after the COVID-19 emergency. NMC Response Brief, (April 20, 2020), 2. Despite the delay in meeting with advocates, NMC states that it is committed "to working with DRVT and others to reach a community of understanding with all who provide support to patients awaiting inpatient mental health treatment on NMC's ED policies and its philosophy of maintaining an unrestricted environment or as least restricted as possible." *Id.*

33. The HCA and DRVT assert that the project's failure to include a common space denies patients access to the quality of care afforded to other ED patients and assert that the Board should condition the CON on the creation of a common space in the mental health unit. HCA Brief (April 13, 2020), 3; DRVT Brief (April 13, 2020), 3-4. This was echoed by comments submitted by Anne Donahue and others.

34. DMH noted that the design lacks a space for patients outside their rooms and stated that patients in need of an admission to a psychiatric unit tend to have longer stays in EDs than those there for solely medical issues and 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. Memo from Commissioner Squirrel (Nov. 14, 2019), 2-3.

35. In response to the Board's final set of questions regarding the application, NMC stated that space within the mental health unit could be temporarily flexed for use as a common space if conditions allow. The convertible patient rooms are an option for the creation of such a space because the stretcher in those rooms could be removed and replaced with chairs. The hospital chapel, which is located 150 feet from the ED, could also be used for meeting space if conditions allow. Resp. (May 13, 2020), 1.

36. The project cost is $7,616,215, which equates to approximately $650 per square foot. This cost is in line with other ED construction/expansion projects that have been undertaken by Vermont hospitals. App., Exhibit 3. The project cost will be financed with $500,000 in fundraising and cash reserves of approximately $7.1 million, which is estimated to reduce the hospital's days cash on hand by 23 days. App., 10; Resp. (July 9, 2020) 1.

37. NMC has lost money from operations in FY 2017-FY 2019. NMC hopes to close the gap in operating losses in FY 2019 and FY 2020 by reducing operating expenses. App., 16; Resp. (July 9, 2019), 1-2. NMC states that if it is not successful in reversing operating losses in 2020-2022 and/or is not successful in achieving its $500,000 fundraising goal for the project, other future capital projects may be deferred or reevaluated to maintain a financially prudent number of days cash on hand. Resp. (Aug. 22, 2019), 2.

38. As of the end of February 2020, NMC had approximately 235 days cash on hand. GMCB Staff Presentation on NMC's Budget Modification Request (April 29, 2020), 6. NMC acknowledges that COVID-19 has and will continue to have a negative impact on its financial health, although it believes some portion of the losses will be recovered. With COVID-19 and the uncertainty it has introduced, it is not clear how many days cash on hand NMC will have when the

project starts. NMC states that the project will not commence until its leadership and Board of Directors have confidence that the hospital will have sufficient cash reserves, certainly no less than 130 days cash on hand, to commence the project. NMC Brief (April 13, 2020), 1-2.

39. NMC planned to start construction in spring of 2020 with completion in spring of 2021. App., 11. However, with COVID-19, the timetable for the project and financial resources that will be available in the coming months is unclear. NMC Brief (April 13, 2020), 1-2.

40. The project is designed to meet or exceed energy efficiency requirements. NMC is consulting with Efficiency Vermont in the identification, adoption, and refinement of appropriate energy efficiency strategies for the project. App., 18, Exhibit 6. The architect for the project is E4H Architects, which has extensive expertise in the design of health care facilities. App., 23. The project meets all FGI Guidelines and mechanical, electrical, plumbing and fire protection requirements. Resp. (Oct. 28, 2019), 1-5.

41. The project is not expected to result in any increase in the cost of medical care, will not raise charges for ED services, and will not require changes in staffing. App., Table 8; Resp. (July 9, 2019), 2.

42. There is no impact on transportation that will result from the project as the ED is remaining in the existing location. App., 20.

43. The project does not have a health information technology component. App., 20.

44. NMC has a well-established set of quality metric and clinical indicators that it collects and monitors. NMC will continue to track measures such as volumes, hallway bed usage, length of stay, "left without being seen" occurrences, crisis utilization and other pertinent quality and efficacy metrics. App., 21-22.

45. Converting non-private curtained treatment bays to private rooms will allow for better physical separation of patients which supports improved infection control. NMC's ability to care for patients with infectious disease will also be advanced through the creation of the two private airborne infectious isolation rooms. App., 22.

46. Estimated costs relating to the project were included in NMC's annual budget submissions to the Board in FY 2019 and FY 2020. App., 24.

47. NMC has well-established relationships with NCSS, including contractual relationships for on-call emergency psychiatry consultations. NMC has a mental health crisis clinician and SBIRT clinicians within its ED. The proposed project will provide these clinicians space they need to confidentially collaborate with one another and make sensitive phone calls with their community partners to facilitate transitions of care. App., 24.

Standard of Review

Vermont's CON process is governed by 18 V.S.A. §§ 9431-9446 and Green Mountain Care Board Rule 4.000 (Certificate of Need). An applicant bears the burden of demonstrating that each of the criteria set forth in 18 V.S.A. § 9437 is met. Rule 4.000, § 4.302(3).

Conclusions of Law

I.

Under the first statutory criterion, an applicant must show that the proposed project aligns with statewide health care reform goals and principles because the project takes into consideration health care payment and delivery system reform initiatives; addresses current and future community needs in a manner that balances statewide needs (if applicable); and is consistent with appropriate allocation of health care resources, including appropriate utilization of services, as identified in the Health Resource Allocation Plan (HRAP). 18 V.S.A. § 9437(1).

NMC has shown that the proposed project aligns with statewide health care reform goals and principles. Even before transitioning to new value-based payment programs, a transition NMC has embraced, NMC was working to shift care from its ED to more appropriate clinical settings, including primary care, pediatrics, and urgent care, which is consistent with health care reform goals and principles. Insomuch as it can, the proposed project supports these efforts. The project will not expand services and is not expected to increase ED volumes. *See* Findings, ¶¶ 6, 11-12. Rather, the project will increase capacity to meet existing patient volumes, bringing NMC's ED visits per bed in line with other hospitals in Vermont and with national benchmarks. *See* Findings, ¶¶ 7, 11. The improvements that will be made to the physical space of the ED can be expected to better facilitate work NMC is already doing to deliver the right care, at the right time, and in the right setting, in support of health care reform goals and principles.

The proposed project also addresses current and future community needs; it will modernize an outdated ED that serves as a critical community resource and safety net to the 56,000+ people of northwestern Vermont by creating private rooms (as opposed to curtained treatment areas), dedicated isolation rooms for treatment of patients with airborne infectious diseases, and a flexible space complete with a dedicated ligature-free shower, bathroom, and nurses' station for treatment of patients experiencing serious mental health issues. *See* Findings, ¶¶ 1, 13-18.

The project is also consistent with the HRAP,[4] which identifies needs in Vermont's health care system, resources to address those needs, and priorities for addressing them on a statewide basis. *See* HRAP Standards 1.6 (applicant will collect and monitor data relating to health care quality and outcomes); 1.7 (project is consistent with evidence-based practice); 1.8 (applicant has a comprehensive evidence-based system for controlling infectious disease); 1.9, 1.10, and 1.12 (project is cost-effective, energy efficient and conforms with applicable FGI Guidelines); 3.4 (project has been included in hospital budget submissions); 3.18 (applicant shall explain what

[4] The Vermont legislature in Act 167 (2018) made several changes to the State's CON law. *See* https://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT167/ACT167%20As%20Enacted.pdf. As amended by Act 167, 18 V.S.A. § 9437(1)(C) continues to reference the HRAP, which is in the process of being updated. In the interim, we consider the current HRAP standards.

measures are also being taken to address primary care infrastructure limitations that may be increasing pressure on emergency departments); 4.3 (applicant shall address how it plans to provide access to on-call emergency psychiatry consultations and how the expansion of ED will enhance current or emerging mental health and substance abuse needs in the applicant's service area); and 4.5 (applicant shall ensure that project supports further integration of mental health, substance abuse and other health care).

Based on the above, we conclude that the applicant has met the first criterion.

II.

Under the second statutory CON criterion, an applicant must demonstrate that the cost of the project is reasonable because the applicant's financial condition will sustain any financial burden likely to result from completion of the project and because 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. The Board must consider and weigh relevant factors, such as "the financial implications of the project on hospitals and other clinical settings, including the impact on their services, expenditures and charges [and whether such impact] is outweighed by the benefit of the project to the public." Under the second statutory criterion, the applicant must also demonstrate that less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate; and if applicable, that the project has incorporated appropriate energy efficiency measures. 18 V.S.A. § 9437(2).

We conclude that the project's total cost of $7,616,215 is reasonable. The cost equates to approximately $650 per square foot, which is in line with other ED construction/expansion projects that have been undertaken by Vermont hospitals. Findings, ¶ 36. Despite the financial difficulties NMC has experienced in recent years, we believe the hospital can sustain the financial burden that is likely to result from completion of the project. The cost of the project cost will be financed with $500,000 in fundraising and cash reserves equaling approximately 23 days cash on hand. Findings, ¶ 36. As of the end of February 2020, NMC had approximately 235 days cash on hand. Although it is unclear how many days cash on hand NMC will have when the project starts, NMC has stated that it will not commence the project until its leadership and Board of Directors have confidence that the hospital will have sufficient cash reserves, certainly no less than 130 days cash on hand. Findings, ¶ 38.

We further find that the project will not unduly increase the costs of care, will not unduly impact the affordability of care for consumers, and any fiscal impact is outweighed by the benefit of the project to the public. The applicant will not increase its rates or its charges for ED services as a direct result of the project. Findings, ¶ 41. We do not anticipate that the project will impact other providers' services, expenditures, or charges. Finally, the benefits of the project to the public are meaningful. The project will bring NMC's ED capacity in line with current and projected utilization, thereby reducing the likelihood that patients will need to be cared for in hallways. *See* Findings, ¶¶ 7, 9-13. The project will create private airborne infectious isolation rooms for safe treatment of diseases such as tuberculosis, measles, chicken pox, and rarer conditions such as SARS, Ebola, and now COVID-19. Findings, ¶ 16. The project will also create private rooms, a substantial improvement over the existing ED's curtained treatment areas that will enable more

candid discussions with patients and their family members and more effective instruction. *See* Findings, ¶¶ 13-14. Finally, the project will create a more calming treatment area that will allow NMC to care for patients experiencing serious mental health issues. Findings, ¶¶ 17-19.

The project has incorporated appropriate energy efficiency measures. Findings, ¶ 40.

Finally, the applicant has demonstrated that less expensive alternatives would be unsatisfactory. NMC considered an alternate version of the project estimated at approximately $4 million that would have created two safe holding rooms, but not in an area that could be separated from the rest of the ED. This option lacked the flexibility of expanding to four beds through convertible safe holding rooms and NMC determined that maintaining those rooms in the general ED treatment area would have led to continued disruption of care and reduced safety for patients with severe mental health concerns or suicidal ideations. NMC also determined that this option would not address the safety concerns for registration staff. Finally, NMC determined that the alternate version of the project would not have provided adequate space for clinical personnel (including embedded Care Management and SBIRT – Screening, Brief Intervention, and Referral to Treatment – personnel) or equipment storage and would have created unsatisfactorily inefficient workflow for staff and patient movement to diagnostic imaging and inpatient units. Findings, ¶ 24.

We conclude that the applicant has satisfied the second criterion.

III.

Under the third criterion, an applicant must show that "there is an identifiable, existing, or reasonably anticipated need for the proposed project that is appropriate for the applicant to provide." 18 V.S.A. § 9437(3).

NMC has demonstrated that, for multiple reasons, it needs to renovate its ED, the design of which is 30-years old. More specifically, there is a need to expand capacity within the ED to bring it more in line with other hospitals in Vermont and nationally in terms of the number of visits per bed; there is a need to improve patient privacy given that patients are currently cared for in curtained treatment areas; there is a need to create airborne infectious isolation rooms for safe treatment of diseases such as tuberculosis, measles, chicken pox, and rarer conditions such as SARS, Ebola, and now COVID-19; and there is a need improve staff safety by bringing the registration area within the secure perimeter of the ED patient care area. The proposed project meets all these needs. *See* Findings, ¶¶ 7, 11-16.

NMC has also demonstrated a need to modernize the physical environment within its ED used to care for and hold patients who are experiencing a mental health crisis. *See* Findings, ¶ 17. However, we questioned NMC's plans to meet this need by constructing four lockable rooms in a lockable section of the ED.

Statewide, 95% of mental health patients are voluntary. Findings, ¶ 21. The numbers at NMC are not significantly different. For example, in FY2019, NMC saw 25,681 visits to its ED. Of these 25,681 visits, 613 or 2.4% involved patients with a chief complaint of anxiety, depression, psychiatric evaluation, suicide ideation, or overdose. Of these 613 "mental health" visits to NMC's

ED, only 17 or 2.6% were identified as being "involuntary." Findings, ¶ 21. These numbers do not tell the whole story though.

While the typical ED patient at NMC has an in-department length of stay of around 164 minutes, it is not unusual for a patient awaiting placement for mental health concerns to have a length of stay of 48 to 72 hours – the equivalent "bed time" of 17.5 to 26.3 typical ED visits. Findings, ¶ 23. The data provided by DMH shows that the 16 involuntary patients that waited in NMC's ED in FY19 had a mean wait time of 58.34 hours, a median wait time of 47.21 hours, a minimum wait time of 1.5 hours, and a maximum wait time of 148.5 hours; the data also shows that the number of involuntary patients waiting in NMC's ED in a given month ranged from one to five. Findings, ¶ 28. Given these data, we find NMC's claim that it can frequently have two patients, occasionally four, and even six on rare occasions needing this type of resource at any given time credible. *See* Findings, ¶ 22.

The flexible nature of the space NMC plans to create to care for mental health patients is critical for us. The two convertible patient rooms can be quickly modified to meet the needs of different patients, and all four rooms in the area can be used to treat patients with routine medical concerns if there is a surge in ED patient volumes. Findings, ¶¶ 18-19. While the doors in the area can be locked, the default will be that they remain unlocked. Findings, ¶¶ 20, 31. Based on these facts and on the inclusive process NMC used to develop its plans, we find NMC's decision to construct two dedicated Safe Holding Rooms and two convertible patient treatment rooms to be reasonable. *See* Findings, ¶ 25.

For the reasons stated above, we conclude that applicant has satisfied the third criterion.

IV.

The fourth criterion requires that an applicant demonstrate that the proposed project will improve the quality of health care in Vermont, provide greater access to health care for Vermonters, or both. 18 V.S.A. § 9437(4).

The project will improve the quality of health care in Vermont by increasing the number of beds in NMC's ED, which will reduce the need to care for patients in hallways (in the year prior to the application, 5% or 1,200 ED visits at NMC involved caring for patients in hallway beds). *See* Findings, ¶¶ 7, 11, 13.

The project will also improve quality by creating private treatment rooms. The lack of true private treatment rooms allows patients and visitors to overhear clinical and personal conversations in neighboring bays. This is no longer acceptable in healthcare as a standard practice and has negative impacts on interactions between health care providers and patients and their families. *See* Findings, ¶¶ 13-14.

The project will improve quality by creating two airborne infections isolations rooms (which are flexible and can be used for the care of other patients) for proper and safe care of patients whose conditions necessitate airborne isolation. While portable measures can be taken now to approximate a true airborne infections isolation room, quality can be improved by avoiding

set-up delays and risks through the use of a properly designed, permanently constructed, space. *See* Findings, ¶ 16.

Finally, while we have concerns regarding the potential misuse of these rooms, quality will be improved with the creation of ligature-free and ligature-resistant rooms for patients in need of this type of space. Findings, ¶¶ 18-19.

We find that the applicant has met this criterion.

V.

The fifth criterion requires that an applicant demonstrate that the project will not have an undue adverse impact on any other services it offers. 18 V.S.A. § 9437(5). The project does not create new or expand services and primarily provides needed and required upgrades to the ED so that NMC can continue to provide such services to patients in its service area. Findings, ¶¶ 2-3. As the project simply improves an existing service and does not adversely impact any other services offered by NMC, we find that the criterion has been satisfied.

VI.

The sixth criterion was repealed, effective July 1, 2018. *See* 18 V.S.A. § 9437(6) (repealed).

VII.

The seventh statutory criterion requires that an applicant adequately consider the availability of affordable, accessible transportation services to the facility, if applicable. 18 V.S.A. § 9437(7). As the project does not relocate, add or expand any patient services, we find that this criterion is not applicable. Findings, ¶ 42.

VIII.

Next, if the application is for the purchase or lease of new Health Care Information Technology, it must conform to the Health Information Technology Plan. 18 V.S.A. § 9437(8). The criterion is not applicable to this project. *See* Findings, ¶ 43.

IX.

Finally, an applicant must show that the proposed project will 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, as appropriate. 18 V.S.A. § 9437(9). We find that NMC has satisfied this criterion. The project's design was reached in consultation with NCSS, the local designated agency, and was reviewed by a group which included individuals who have lived experience with mental health issues. Findings, ¶ 25. The modernized ED was designed to be a more private and calming area for the treatment of all patients, including those with significant mental health issues, and it will be a significant improvement over NMC's current ED in terms of its ability to provide appropriate mental health care. *See* Findings, ¶¶ 13-14, 17-19. While we have concerns regarding their misuse, the safe

patient holding rooms will help better ensure patients needing such a space are not harmed during their stay at NMC.

Locking

While there are positive aspects to the flexible design of the new mental health unit that NMC has proposed creating, this design also gives NMC the ability to lock doors and areas within the unit and this has raised difficult questions as to whether, and under what circumstances, these capabilities will be used. *See* Findings, ¶¶ 20, 26-27.

First, we agree with DRVT, the HCA, DMH, and Anne Donahue that there is no legal basis to detain persons against their will if they are not in the custody of the State, including the care and custody of Commissioner of DMH pursuant to the procedures outlined in Title 18 of the Vermont Statutes Annotated. *See, e.g.,* Comment of Anne Donahue et al. (Nov. 11, 2019), 2; DRVT Brief (April 13, 2); Memo from Commissioner Squirrel (Jan. 7, 2020). We are also concerned with statements NMC has made that suggest it may employ the new locking capabilities of the unit to seclude patients experiencing mental health issues without appropriate legal process. *See* Finding, ¶ 29. Even when NMC is legally justified in locking a patient in a room or an area of the unit, as the HCA noted in its brief, the flexible design of the space raises questions as to how NMC can ensure other patients are not improperly restricted in their ability to leave. *See* HCA Brief (April 13, 2019), 4-5.

If the new locking capabilities of the unit are used to illegally detain patients in need of mental health services, the project will not support equal access to appropriate mental health care that meets standards of quality equivalent to other components of health care. At the same time, we do not believe it is appropriate for us to review and approve NMC's policies governing use of restraint and seclusion, as DRVT and the HCA have suggested we do; we are not experts in this area and the questions are quite nuanced. We will, however, ensure that NMC makes good on its commitment to meet with advocacy organizations, including DRVT, the HCA, and Anne Donahue, to discuss its restraint and seclusion policy and its philosophy of maintaining an environment that is as unrestricted as possible. *See* Findings, ¶ 32. Furthermore, we will require that, prior to construction, NMC seek input from DMH on its restraint and seclusion policy and give serious consideration to any recommendations DMH provides. We believe this consultation is appropriate because DMH is responsible for establishing the general policy of the State concerning mental health and for ensuring equal access to appropriate mental health care in a manner equivalent to other aspects of health care as part of an integrated, holistic system of care—a responsibility that mirrors the CON criteria at issue here. 18 V.S.A. § 7201. DMH is therefore uniquely situated to review the policy that will govern how the new locking capabilities of the unit are used.

Common Space

We appreciate the comments and arguments that we received on the issue of a common space, which was a difficult one for us. Patients seeking care in the ED for mental health care typically have longer lengths of stay than other patients and can occasionally stay in the ED for several days. It would be beneficial to some of these patients to have a common space outside of their rooms where they could interact with family members, peer supports, mental health professionals, legal advocates, and others. As DMH stated in its letter to the Board, [h]aving 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." Findings, ¶ 34. However, on this record, we are not prepared to require that NMC create such a space in its remodeled ED.

First, there does not appear to be any legal requirement that NMC have a common space in its ED. The FGI Guidelines for the Design and Construction of Hospitals do not require a separate meeting or multi-purpose room outside of a patient's ED room. *See* Findings, ¶ 40. DRVT and others noted that individuals in the care and custody of the Commissioner of DMH have a legal right to access a support person and to meet with legal advocates. *See* DRVT Brief (April 13, 2020), 3. Specifically, 18 V.S.A. § 7509(b) states that "[a]ll persons admitted or held for admission shall be given the opportunity, subject to reasonable limitations, to communicate with others, including visits by a peer or other support person designated by the person [and] presence of the support person at all treatment team meetings the person is entitled to attend . . . ." However, the law does not appear to require that NMC facilitate this access by creating a separate common space within its ED.

Second, we do not feel it is appropriate, at least not on this record, to impose a requirement through the certificate of need process that hospitals include such a space in their EDs because we are not persuaded that an ED without such a space denies patients equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care. The Intervenors and commenters have not pointed to any quality standards that are not being met because the ED lacks a common space.

While we will not require that NMC create a common space as part of this project, we strongly encourage NMC to explore opportunities to use existing spaces for this purpose. NMC stated that space within the mental health unit could be temporarily flexed for use as a common space if conditions allow and noted that the convertible patient rooms are an option for creating such a space because the stretcher in those rooms can be removed and replaced with chairs. NMC also stated that the hospital chapel could be used for meeting space if conditions allow, noting that the chapel is located 150 feet from the ED. Findings, ¶ 35. NMC should seek to utilize these spaces where appropriate to provide patients with the option of interacting with peer supports, legal advocates, family members and others in a less imposing and more comfortable setting.

Conclusion

Based on the above, we conclude that the applicant has demonstrated that it has met each of the required statutory criterion under 18 V.S.A. § 9437. We therefore approve the application and issue a certificate of need, subject to the conditions outlined therein.

SO ORDERED.

Dated: June 11, 2020 at Montpelier, Vermont.

s/ Kevin Mullin, Chair	)	
	)	GREEN MOUNTAIN
s/ Jessica Holmes	)	CARE BOARD
	)	OF VERMONT
s/ Robin Lunge*	)	
	)	
s/ Tom Pelham	)	
	)	
s/ Maureen Usifer	)	

*Board Member Robin Lunge filed a separate opinion concurring in part and dissenting in part.

Lunge, concurring in part and dissenting in part.

Overall, I concur with the majority opinion approving this important project and the conditions imposed upon it. I, however, would go further than the majority in one aspect. I would add a condition to the Certificate of Need that requires that a convertible room in the new space or another common area in the hospital be used for mental health treatment, where appropriate to the person's clinical condition and safe to do so.

Providing mental health treatment, not simply safe holding, for patients should be the standard of care that we strive for in Vermont. While I agree that creating a common area in the ED does not seem cost-effective or feasible for the proposed project, a designated treatment space should be required in order to meet the requirement 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. 18 V.S.A. § 9437(9).

As noted in the majority opinion, patients seeking care in the ED for mental health care typically have longer lengths of stay than other patients and can occasionally stay in the ED for several days. It would be more than beneficial to some of these patients to have a common space outside of their rooms where they could interact with visitors, peer advocates, mental health professionals, legal advocates, and others – it is necessary for appropriate mental health treatment on par with physical health treatment. As DMH stated in its letter to the Board, [h]aving 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." Findings, ¶ 34.

Also, as DRVT and others noted, individuals in the care and custody of the Commissioner of DMH have a legal right to access a support person and to meet with legal advocates. *See* DRVT Brief (April 13, 2020), 3. Specifically, 18 V.S.A. § 7509(b) states that "[a]ll persons admitted or held for admission shall be given the opportunity, subject to reasonable limitations, to communicate with others, including visits by a peer or other support person designated by the person [and] presence of the support person at all treatment team meetings the person is entitled to attend . . . ." While the law does not appear to require that NMC facilitate this access by creating a separate common space within its ED, the use of a space is necessary to meet this requirement and there should be a space designated for that purpose.

For these reason, I do not agree that NMC has meet the requirement that the proposed project provides equal access to mental health care and would therefore require that they designate a space for mental health treatment as a condition of the CON.

Dated: June 11, 2020 at Montpelier, Vermont.

s/ Robin Lunge
Member, Green Mountain Care Board

Filed: June 11, 2020
Attest: Jean Stetter, Administrative Services Director