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**State of Vermont**

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*Agency of Human Services*

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Docket No. GMCB-002-21con

Certificate of Need Application

A Physically Secure Residential  
Treatment Program

Vermont Department of Mental Health

May 2021

Documents prepared by:

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## Contents

RE: Docket No. GMCB-002-21con.....	5
Verification Under Oath.....	7
<b>Certificate of Need Cover Sheet and Application Form .....</b>	<b>9</b>
PROJECT OVERVIEW.....	10
Legislative Requirements Leading to this CON Application.....	10
Operation of MTCR and Ongoing Need .....	12
Proposed Location and Design.....	13
<b>Statutory Criteria and HRAP Standards.....</b>	<b>14</b>
1. Proposed project aligns with statewide health care reform goals and principles because the project:	14
A. takes into consideration health care payment and delivery system reform initiatives; .....	14
B. addresses current and future community needs in a manner that balances statewide needs (if applicable);.....	16
C. 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.....	17
Intensive Recovery Residences Capacity .....	17
Community Health Needs Assessments .....	19
1.2: Applicants seeking to expand or introduce a specific health care services shall show that such services have been shown to improve health. <b>To the extent such services have been the subject of comparative effectiveness research, an applicant shall show that the results of this research support the proposed project.</b> .....	20
1.3: To the extent neighboring health care facilities provide the services proposed by a new health care project, an applicant shall demonstrate that a collaborative approach to delivering the service has been taken or is not feasible or appropriate.....	22
<b>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.</b> .....	<b>23</b>
1.7: Applicants seeking to develop a new health care project shall explain how such project is consistent with evidence-based practice. ....	24
1.8: Applicants seeking to develop a new health care project shall demonstrate, as appropriate, that the applicant has a comprehensive evidence-based system for controlling infectious disease.....	26
1.9: Applicants proposing construction projects shall show that costs and methods of the proposed construction are necessary and reasonable. ....	27
1.10: Applicants proposing new health care projects requiring construction shall show such projects are energy efficient.....	27
1.11: Applicants proposing new health care projects requiring new construction shall demonstrate that new construction is the more appropriate alternative when compared to renovation.....	28

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), current edition. ....	28
3.3: Applicants seeking to add inpatient capacity shall demonstrate that such capacity is needed by the service area population and that services are not available at neighboring hospitals. ....	29
4.1: Applicants for inpatient mental health service related certificates of need shall include specific information about how the proposal relates to the VSH Futures Project (or subsequent plan). ....	30
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.....	31
Triple Aims: Institute of Healthcare Improvement (IHI), Triple Aims: Explain how your project is: .....	32
(a) improving the individual experience of care; .....	32
(b) improving health of populations; .....	33
(c) reducing the per capita costs of care for populations. ....	33
1. The cost of project is reasonable because each of the following conditions is met: .....	35
A. The applicant’s financial condition will sustain any financial burden likely to result from completion of the project; .....	35
B. 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 making a finding, the Board shall consider and weigh relevant factors, including:.....	35
(i) The financial implications of the project on hospitals and other clinical settings, including the impact on their services, expenditures and charges; .....	35
(ii) Whether the impact on services, expenditures, and charges is outweighed by the benefit of the project to the public;.....	35
C. Less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate. ....	36
D. If applicable, the applicant has incorporated appropriate energy efficiency measures.....	36
3. There is an identifiable, existing, or reasonably anticipated need for the proposed project that is appropriate for the applicant to provide. ....	36
4. 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. ....	37
5. The project will not have an undue adverse impact on any other existing services provided by the applicant. ....	37
7. The applicant has adequately considered the availability of affordable, accessible transportation services to the facility, if applicable. ....	37
8. 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.....	38

9. The applicant must show the project will support equal access to appropriate mental health care that meets the Institute of Medicine’s triple aims. 18 V.S.A. § 9437(9). .....	39
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May 1, 2021

Donna Jerry, Health Care Administrator  
Green Mountain Care Board  
144 State Street  
Montpelier, VT 05602

RE: Docket No. GMCB-002-21con

CON Application for a physically secure residential treatment project.

Dear Ms. Jerry,

This application is pursuant to the Certificate of Need (CON) statute, 18 V.S.A. §9440(c)(2)(A). The Department of Mental Health (DMH) and the Department of Buildings and Grounds (BGS) are submitting this CON application to build a permanent physically secure residential treatment facility (DMH Recovery Residence) to replace to the current seven-bed DMH operated Middlesex Therapeutic Community Residence (MTCR). First built as part of the emergency response after Tropical Storm Irene forced the closure of the Vermont State Hospital, MTCR fulfills a critical step-down residential treatment need in Vermont's mental health care system. This new facility and resulting CON are the result of years of legislative initiatives, studies, plans, and requirements to meet the needs of Vermonters and build a permanent facility, all of which included extensive stakeholder engagement surrounding need, siting, design, and programming.

DMH and BGS are seeking to build a state-of-the-art 16-bed secure residential facility that will meet the critical needs of Vermonters ready to transition from inpatient hospital level of care to a lower level of residential care but due to clinical needs require a high-intensity, secure program. The DMH Recovery Residence's program will improve quality of treatment and outcomes across the system as well as increasing critical capacity and relieving pressure on emergency departments and inpatient units, all while reducing overall cost of care.

While originally meant to be a two-year temporary solution, MTCR continues to serve Vermonters and demonstrate positive treatment outcomes eight year after opening. Staff have worked hard to make MTCR as therapeutic as possible, but the facility was always meant to be temporary, and it poses multiple challenges to residents and staff as well as needing constant maintenance and repair.

A secure recovery residence was an identified need in the mental health system of care well before Tropical Storm Irene forced its creation, and data continues to support this need despite

several additional investments in community-based care, prevention, and intervention programming. This level of care targets a small but very vulnerable population – those individuals whose clinical presentations and safety risks present such a challenge that designated agencies or other programs are unable to safely and therapeutically care for them in the community. A secure residence is the only option for these individuals to step down to lower level of care and as such it is a critical resource to promote in our mental health system.

DMH believes a secure, state-of-the-art therapeutic residence and use of best practices are key tools that will allow an individual to transition from the most restrictive level of care at the earliest time possible while still receiving intensive residential support services. Adding this capacity through the DMH Recovery Residence will greatly improve the movement of patients through our system, improve outcomes, and ensure the right care is delivered at the right time and in the right place.

DMH's goal is to move the current residents of MTCR into the new facility as soon as possible. The current facility, hastily erected after Tropical Storm Irene when flooding forced the closure of the Vermont State Hospital, is not an ideal treatment facility due to its quick construction (two FEMA trailers) and temporary nature. While staff have done an admirable job providing the best possible treatment, our residents will be much better served in the new, state-of-the-art facility. DMH anticipates the final appropriation needed from the legislature for the funding of the DMH Recovery Residence in the coming days.

The expedited need of this project and moving forward with construction in a timely way should be underscored. Due to seasonal building constraints, if this CON is not approved until after August, Buildings and General Services (BGS) has indicated that construction may be delayed to the Spring of 2022. Not only would this greatly delay our ability to move residents to a more appropriate and therapeutic facility, BGS also believes there will be inflationary cost increases between \$240,000 and \$650,000.<sup>1</sup>

Attached with this letter is the signed and notarized Verification of Oath form.

We thank the Green Mountain Care Board for their consideration of this very important project for Vermont's mental health care system.

Shayla Livingston,  
802-241-0090  
[Shayla.livingston@vermont.gov](mailto:Shayla.livingston@vermont.gov)

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<sup>1</sup> See more detailed information in "Proposed Location and Design" starting on page 8.

## Verification Under Oath

### STATE OF VERMONT GREEN MOUNTAIN CARE BOARD

In re: Submission of Certificate )  
Of Need Application for ) Docket No. GMCB-002-21con  
Physically Secure Residential )  
Treatment Center )

Verification Under Oath to File with the Certificate of Need Application, correspondence and additional information subsequent to filing an Application.

Sarah Squirrell, being duly sworn, states on oath as follows:

1. My name is Sarah Squirrell. I am the Commissioner of the Vermont Department of Mental Health. I have reviewed the certificate of need application to build a physically secure residential treatment facility.
2. Based on my personal knowledge and after diligent inquiry, I attest that the information contained in the certificate of need application to build a physically secure residential treatment facility is true, accurate and complete, and does not contain any untrue statement of material fact and does not omit to state a material fact.
3. My personal knowledge of the trust, accuracy and completeness of the information contained in the certificate of need application to build a physically secure residential treatment facility is based upon either my actual knowledge of the subject information or upon information reasonably believed by me to be true and reliable and provided to me by the information they have provided is true, accurate and complete, does not contain any untrue statement of a material fact and does not omit to state a material fact.
4. The following individuals have provided information or documents to me in connection with the certificate of need application to build a physically secure residential treatment facility and each individual has certified, based either upon their actual knowledge on the subject information or, where specifically identified in such certification, based on information reasonably believed by the individuals to be reliable, that the information or documents provided are true, accurate and complete, do not contain any untrue statement of material fact, and do not omit to state a material fact:

Karen Barber, General Counsel, Department of Mental Health  
Mourning Fox, Deputy Commissioner, Department of Mental Health  
Kathy Hentcy, Mental Health & Health Care Integration Coordinator, Department of Mental Health  
Tabrena Karish, Project Manager, Department of Buildings and General Services  
Shayla Livingston, Policy Director, Department of Mental Health

Frank Reed, Past Director of Mental Health Services, Department of Mental Health

Anna Strong, Financial Director 1, Department of Mental Health

Samantha Sweet, Operations & Care Management Director, Department of Mental Health

Shannon Thompson, Financial Director, Department of Mental Health

5. In the event that the information contained in this certificate of need application to build a physically secure residential treatment facility becomes untrue, inaccurate or incomplete in any material respect, I acknowledge my obligation to notify the Green Mountain Care Board and to supplement the certificate of need application to build a physically secure residential care facility as soon as I know, or reasonable should know, that information or document has become untrue, inaccurate or incomplete in any material respect.



Sarah Squirrell, Commissioner, Department of Mental Health

On 4/30/2021, Sarah Squirrell appeared before me and swore the truth, accuracy and completeness of the foregoing.



Notary Public

My commission expires 1/31/2023



## Certificate of Need Cover Sheet and Application Form

Name of Applicant: Vermont Department of Mental Health

Date of Application: May 1, 2021

Project Title: Physically Secure Residential Treatment Program

Contact Person: Shayla Livingston

Mailing Address:

280 State Drive  
Waterbury, VT 05671

Email: [shayla.livingston@vermont.gov](mailto:shayla.livingston@vermont.gov)

Phone Number: 802-241-0090

Proposed Total Project Cost: \$16,072,200.00

## PROJECT OVERVIEW

The need for an intensive, secure level of care was first identified as part of the ongoing planning process to replace the Vermont State Hospital in the 2005 document, “*Vermont State Hospital Futures Plan*.” When Tropical Storm Irene flooded and closed the Vermont State Hospital in 2013, devastating Vermont’s state-run involuntary psychiatric inpatient care capacity, the state implemented this new level of care. Passage of [Act 160 \(2012\)](#) and [Act 79 \(2012\)](#) codified the statutory basis of a secure residential recovery facility, the resident population it would serve, and its state-run operations role within a “*diverse system and continuum of mental health care throughout the state*.”<sup>2</sup>

### Legislative Requirements Leading to this CON Application

During the eight years MTCR has been operating, its replacement has been the subject of, or a component of, several different legislative acts. Following the legislative codification of the statutory basis for a secure residential facility in 2012, Act 178 of 2014<sup>3</sup> first proposed the creation of a 14-bed permanent secure residential replacement facility. At a projected capital cost of approximately \$12 million and an ongoing annual operating cost of approximately \$5 million, the size and cost of the replacement facility then became the subject of Act 26 of 2015.

Act 26 directed DMH, along with BGS, to further explore siting and design considerations for such a facility, as well as consideration of the “broadest options for management and ownership” of the replacement with a proposed timeline for closure of MTCR in 2018. In the fall of 2015, DMH issued a Request for Information (RFI) seeking interest in either design or operation of a replacement capacity served by the Middlesex facility. The RFI process culminated in seven submissions of interest. Release of a final Request for Proposal (RFP) for a secure residential replacement program followed a prolonged period of development through much of 2016.

Consistent with the requirements of Act 26, DMH submitted a Facilities Report<sup>4</sup> to the legislative committees of jurisdiction in January 2017. The report reviewed the various RFI responses, the various populations to be served, a broad RFP process, the siting issues of potential properties, and considerations of funding mechanisms for the project and ongoing operations. In early 2017 four proposals emerged that aligned with the earlier RFI interests.

During the 2017 -2018 legislative session, Act 84 authorized BGS under Sec. 30 “*to purchase an option on land or purchase land for a permanent, secure residential facility; provided, however, that the size and location of the land shall be consistent with the siting and design examination conducted by the Agency of Human Services, as required by 2015 Acts and Resolves No. 26, Sec. 30.*” In January 2018, the Secretary of Agency of Human Services (AHS) provided an overall AHS Facilities Report of capacities needed for populations served by DOC, DMH, and DCF.

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<sup>2</sup> Act 79, §7255 (8).

<sup>3</sup> <https://legislature.vermont.gov/Documents/2014/Docs/ACTS/ACT178/ACT178%20As%20Enacted.pdf>

<sup>4</sup> <https://legislature.vermont.gov/Documents/2018/WorkGroups/House%20Corrections%20and%20Institutions/Dept.%20of%20Corrections/W~Frank%20Reed~Secure%20Residential%20Facility%20Overview~1-20-2017.pdf>

Also, during the 2017-2018 session, the legislature passed Act 82 (2017) and Act 200 (2018) seeking further examination of mental health care delivery and coordination across service settings. Included was consideration of unrealized elements of Act 79 (including an additional eight residential recovery beds), discussion of ongoing emergency department wait times for psychiatric inpatient care services, unmet mental health needs for individuals in correctional facilities, and evaluation of reimbursement structures for community mental health services.

DMH provided a report of its evaluation of key components in for Act 82 in September 2017, including a recommendation to build up to a 16-bed adult secure residential program. Around the same time, DMH submitted its annual Act 79 report with the same recommendations regarding the ongoing utilization of and need for an expanded and permanent secure residential program.

Act 200, passed in May 2018, included a specific intent to “*replace the temporary Middlesex Secure Residential Recovery Facility with a permanent facility that has a 16-bed capacity and which may be state operated.*” In addition, a report due by January 2019 required that the Secretary of AHS “*submit a comprehensive evaluation of the overarching structure for the delivery of mental health services within a sustainable, holistic health care system in Vermont*” and include that “*the evaluation process provides for input from persons who identify as psychiatric survivors, consumers, or peers; family members of such persons; providers of mental health services; and providers of services within the broader health care system. The evaluation process shall include such stakeholder involvement in working toward an articulation of a common, long-term vision of full integration of mental health services within a comprehensive and holistic health care system.*”

In January 2019, DMH presented the legislature a comprehensive report, per the requirements of Act 200, Sec. 9, and subsequently, in January 2020, a 10-year plan [“\*Vision 2030, A 10-Year Plan for an Integrated and Holistic System of Care.\*”](#) These provided an overview of the evaluation process, engagement with key stakeholders, and next steps to maintain an active feedback loop, as well as making recommendations that emerged through a broad stakeholder input process and intensive “Think Tank” sessions.

Concurrently, pursuant to Act 26 Section 2, in December 2019 DMH submitted a report that outlined “*the mental health bed needs for residential programs across the State by geographic area and provider type, including long-term residences (group homes), intensive residential recovery facilities, and secure residential recovery facilities. This evaluation shall include a review of needs in rural locations, current and historic occupancy rates, an analysis of admission and referral data, and an assessment of barriers to access for individuals requiring residential services. The evaluation shall include consultation with providers and with past or present program participants or individuals in need of residential programs, or both.*” Specific to the MTCR replacement, the report outlined the population served, justification for ongoing need, and the funding request in the FY 20 capital bill as highlighting that this project continued to be a priority for AHS and DMH.

Also demonstrating the legislature’s increased commitment, in the 2019-2020 legislative session, Act 42 (the capital bill) made available to BGS \$3 million for land acquisition, design, permitting, and construction documents for the new secure residential in FY 2020 and \$1.5 million in FY 2021.

As required by Act 42, DMH and BGS worked together with a contracted architectural firm to design a state-of-the-art therapeutic yet secure facility as well as to site a location for the facility. Building design schematics included the involvement of key stakeholders during the summer and fall of 2020.

Originally the design included the use of seclusion and restraints (EIPs). However, during the 2021 legislative session, DMH received feedback against their use. Taking that into consideration, as well as consultation with national experts, DMH decided not to use EIPs and amended the design and programming accordingly. DMH does not believe this change in programming impacts the number of beds needed as the proposed enhanced staffing model as well as the significantly improved design and environment will allow it to provide services to residents who would not otherwise be accepted or prioritized for admission into non-secure community residential programs.

### Operation of MTCR and Ongoing Need

Since the opening of the temporary MTCR secure residential program in 2013, DMH has served fifty-two residents who otherwise might have remained hospitalized in higher, more restricted levels of care. Over nearly seven years of operation, the seven-bed, temporary, secure residential program in Middlesex has successfully transitioned many individuals with complex needs from inpatient care back to local communities or less intensive support programs and services. Over 64% of residents have successfully transitioned from MTCR to other community-based services with an average length of stay of 10.4 months. As indicated earlier, DMH seeks to increase program bed capacity from seven to up to 16 beds to serve a similar population who would otherwise have difficulty being admitted to community-based treatment programs. The current seven-bed program has operated at nearly full capacity since its opening. The Analysis of Residential Bed Needs Report<sup>5</sup> found that point in time data surveying inpatient facilities indicate that at any given time 7 – 10 individuals could step down to a physically secure recovery residence if capacity were available. The proposal for a 16-bed program will address both current need, unmet demand, and future need as illustrated by the data.

Since planning began in earnest in 2014, DMH has continued to see comparable numbers of individuals eligible for this level of care even though there has been expansion of bed capacity, design improvements, and staffing supports in community programs. Recent data indicates that over the past two years nearly 100% of referrals to MTCR are from Level 1 units unable to identify adequate discharge options for individuals requiring more than residential or intensive residential programs can provide. Level 1 is the highest level of clinical acuity within Vermont's inpatient system, thus indicating the individuals served by the physically secure recovery residence have higher treatment needs and risk factors that impact public safety and exceed the capacity of community providers.

Having a secure facility with expanded capacity is crucial to the flow of the system, assuring that individuals in need of this level of treatment can access it and in turn, individuals in need of hospitalization presenting in emergency rooms can access that level of care while seeing fewer

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<sup>5</sup> [https://legislature.vermont.gov/assets/Legislative-Reports/Act-26-Section-2-Report\\_Analysis-of-Need\\_FINAL\\_01152020.pdf](https://legislature.vermont.gov/assets/Legislative-Reports/Act-26-Section-2-Report_Analysis-of-Need_FINAL_01152020.pdf)

unnecessary delays and lengthy wait times as the new facility allows movement out of inpatient beds.

### Proposed Location and Design

The proposed site for construction is 26 Woodside Drive located off Route 15 in Essex, the site of the former state-run Woodside Youth Rehabilitation Facility, recently closed by the legislature. The state-owned site includes 10.2 acres, 5.4 acres of which are developed. The site is naturally shielded from Route 15 by a steep slope to the north and west. The Winooski River drops away on the east and south, giving the site privacy and natural vistas. The existing 13,800 square foot Woodside program building will be demolished to make way for the new residence. The site also features an existing gymnasium which will be renovated to meet new program use needs. The site features an access drive and plans approximately 40 parking spaces. Site work and land preparation for new construction will be extensive given the proposed design. A rough estimate of an area of disturbance for the project is approximately 135,000 square feet, or just over 3 acres.

New building construction that meets the needs of the program, in the final design stages, is anticipated to be a three-wing, single story residential-looking building with full attic access for mechanical equipment and maintenance. The new residence will offer locked-secure program services within an approximately 17,000 square feet footprint. The secure residential program will operate as a state-wide resource for those adults meeting assessed need and eligibility for the residential treatment program services. Anticipated length of stay is projected to be an average of 6-18 months of treatment before transition to other community-based residential and mental health support services.

Design plans include typical residential dining, living, and relaxation spaces, and single occupancy bedrooms with private bathrooms. Additionally, service space will include necessary offices, treatment and wellness service space, and meeting spaces for staff, residents, and visitors. Augmenting the existing gym use will be outdoor and recreation spaces sufficient for the program size. The residence grounds will afford accessible areas from two access points from the building. Both outside spaces have been enlarged for resident uses since the submission of the original letter of intent for this project. A large area occupying 6,439 square feet and a smaller 4,342 square foot area will be surrounded by a modern, privacy enhanced, no-climb security fence.

Ideally, due to the construction timeline and some anticipated construction challenges brought about by the unique soils at the property, DMH and BGS would like to begin this project in, or in best case scenario before, August 2021. The soil is a mix of sand and clay which is “very loose” and subject to excessive settlement. The soil under the new building foundation will need to be preloaded to allow the building to be placed on compressed soils to prevent settling of the building after construction. This work must be complete before the ground freezes to allow sequential construction activities to continue during the winter months. If the CON is not approved until after August, there will not be enough time to complete the necessary work before we expect the ground to freeze and thus construction would be unable to commence until the ground thaws in the Spring of 2022.

Thus far, the legislature has authorized \$4.5 million in funding for this project in the FY21 legislative session. Additional funding of \$11,572,200.00 for this project is currently in the Capital Bill request for the FY22 session. If allowed to proceed on the ideal timeline, the project will use Capital Funding of approximately \$16,072,200.00 and be completed in FY23. We are concerned that delaying the project until Spring 2022 would increase costs due to inflation by as much as \$240,000 and \$650,000 due to remarkable volatility in the market.

## Statutory Criteria and HRAP Standards

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

A. takes into consideration health care payment and delivery system reform initiatives;

A primary goal of DMH is to work with community partners and other stakeholders to provide person-led care that strives to achieve the quadruple aim of healthcare reform of improving outcomes, reducing costs, improving quality, and the experience of providing care. DMH adopted healthcare payment and delivery system reform in 2019, beginning a shift in community-based reimbursements in our work with the Designated Agencies (DAs).

In further support of systems change work, DMH embarked upon an ambitious project to engage Vermont's mental health system stakeholders to develop a 10-year vision to achieve a comprehensive, coordinated, and integrated mental health system for all Vermonters. The result was [\*"Vision 2030, A 10-Year Plan for an Integrated and Holistic System of Care."\*](#) *Vision 2030* aims to provide Vermonters timely access to whole health, person-led care that achieves the Quadruple Aim of healthcare: 1) increasing the quality of care and patient experience, 2) improving population health, wellness, and equity, 3) lowering per-capita costs, and 4) creating a better environment for Vermont's providers. By fully embracing an integrated system that works collectively to address population health, wellness, and equity, Vermonters will have improved access to care, be healthier and happier, and the state, as a whole, will realize significant economic benefits.

The concept behind the DMH Recovery Residence was developed to align with the goals laid out in *Vision 2030*. For example, *Vision 2030* is built on eight "action areas". Action Area 2, "Influencing Social Contributors to Health," states that we must "ensure that all Vermonters' most basic needs are met, including, but not limited to, food stability; housing; transportation; affordable, accessible childcare; employment; a community responsive to their needs; a medical home; access to mental health services." The lack of a secure step-down residence for those on an order of non-hospitalization (ONH) means that such individuals might otherwise remain hospitalized due to lack of appropriate community residential support and service programs. MTCR currently fulfills that critical need, and the DMH Recovery Residence will expand the capacity to service this critical need.

MTCR has operated at over 90% capacity on average for the last six years. It provides a necessary and crucial level of care for individuals who might otherwise remain hospitalized. In effect, the lack of additional capacity at MTCR for the population of Vermonters needing this specialized level of care could leave them without access to the mental health services they need. Lack of bed capacity at MTCR regularly leaves Vermonters needing inpatient services without access to hospital beds and facing unnecessary wait times in emergency departments. Thus, this project is a critical keystone in the mental health system of care continuum to ensure that all Vermonters can access the care they need, when they need it, where they need it.

In addition, as discussed in *Vision 2030*, DMH is committed to “build, empower and sustain a strong peer network throughout Vermont.” Peers will be key members of every resident’s treatment team, and the programs and services at the DMH Recovery Residence will support residents in building their functional living skills, including establishing food and housing stability, employment, and connection to community. A strong relationship and coordination with primary care will also be fundamental to every treatment plan.

*Vision 2030*’s Action Area 5, “Enhancing Intervention and Discharge Planning Services to Support Vermonters in Crisis,” calls for clear, consistent information and support for people in crisis; implementation of practices that improve an individual’s experience while in a crisis; strengthening prevention, care coordination, and hospital diversion programs; development of alternative options to utilization of emergency departments.

As noted above, this project will provide an appropriate and available residential option for Vermonters experiencing ongoing mental health needs and requiring a secure setting but not a hospital level of care. The DMH Recovery Residence will directly contribute to reduced emergency department waits and access for people needing hospital beds by freeing up beds that may be currently occupied by those who would be able to “step down” to this residence.

Action Area 6 in *Vision 2030* is “Peer Services are Accessible at All Levels of Care.” As noted, peers will be key members of every treatment team at the DMH Recovery Residence, helping to prepare residents to transition successfully back to their community, with peer connections and necessary supports for quality of life in community.

A critically important area for improving client experience in our system is building a culture of care that not only treats individuals with respect and dignity but supports them in leading the development of their own treatment plan and recovery goals. This project will not only provide the necessary beds at the appropriate level of care and security for those on an ONH, but also greatly improve respect and dignity in treatment.

Finally, the strategies in Action Area 7 of *Vision 2030* require holding the person’s individual needs, values, and interests as the guiding beacon of care. Some of the steps outlined in this section include reshaping practices to include advance directives so that individuals can take the lead in their care from a position of wellness, rather than at the point of a mental health crisis and incorporating outcome measures and a clear system of feedback to support continual improvement of person-led service delivery. These are



fundamental to the culture envisioned for the DMH Recovery Residence.

B. addresses current and future community needs in a manner that balances statewide needs (if applicable);

This project is a keystone in the mental health system of care continuum, critical to ensuring that all Vermonters can access the care they need, when they need it, where they need it. MTCR operates consistently at or near capacity and while the overall number of people needing this level of care is relatively low, these individuals account for much longer lengths of stay in hospital beds due to inadequate aftercare support options other than the current seven MTCR beds. The need for expanded capacity in this critical area, first recognized in the 2005 *Vermont State Hospital Futures Plan* work, has continued as the subject of numerous legislative acts over the years.

To be an effective part of the system, the DMH Recovery Residence will be coordinated and integrated into the continuum of care, working in partnership with inpatient units and community providers to assure a seamless transition of care. Below are three examples – based on clinical presentations we have seen over the years – of the types of individuals DMH seeks to serve at the new, state of the art, therapeutic recovery residence. As these examples illustrate, the individuals who need this level of care are quite complex and are otherwise unable to be served in the community, at least at the time of their readiness to discharge from inpatient care. Please note these have been anonymized and the clinical presentation slightly changed to assure the privacy of those we serve.

1. Greg is a 40-year-old man with a history of numerous psychiatric hospitalizations as well as placements at various group living settings. His length of stays at the group living situations range from a matter of days to a few months with the transition resulting in re-hospitalization. His hospitalization history includes need for non-emergent involuntary medications, and he traditionally stops taking medications in the community. He has resided at several of the Intensive Recovery Residences where he has either eloped or has assaulted others. While he stabilizes in an inpatient setting with medications, none of the community providers (DAs, SSAs, and Peer run programs) feel they can safely manage his ongoing risk of violence due to his history.

2. Randy is a 45-year-old man who has been charged with murder and has been found Incompetent to Stand Trial due to his mental illness. He has refused medications and due to his stable presentation while at the hospital, petitions for non-emergent involuntary medications have been denied. Because of that he remains delusional and psychiatrically under-treated. Due to public safety concerns and his history of extreme violence when untreated, no community providers feel comfortable that they could safely treat him in the community.

3. Gretchen is a 38-year-old woman with history of long inpatient stays. Her hospitalizations include a history of court ordered non-emergent involuntary medications. Her response to medications is seen as marginal and she remains psychotic at baseline. During her hospitalizations, she regularly has dysregulated moments where she will destroy property or assault others at a frequency of about once every 4 to 6 weeks. Other



than these episodes, even though she remains psychotic, she is behaviorally stable. Due to the ongoing episodic nature of her behavioral dysregulation, none of the community providers feel that she is appropriate for their programs as they cannot guarantee the safety of the other residents under their care.

C. 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.

Because the last HRAP was completed in 2009, it does not address current need. We understand it is in the process of being updated, but in the interim DMH conducted a bed study to determine need for mental health care resources and has consulted the most recent [Community Health Needs Assessment](#) conducted by the hospitals. Social/Environmental challenges and Health challenges identified have been drawn from this assessment to inform this CON application.

DMH's [Analysis of Need: Residential Mental Health Beds](#), Act 26 (2019), Section 2 report to the legislature highlights opportunities to better understand current needs. Data shows that the occupancy rate for group homes is extremely high and turnover lower for the cohort of individuals who may be unable to live independently without the level of support services the DMH Recovery Residence would provide. The population proposed for this project requires support and supervision that would exceed staff-secure community care (as opposed to the physically secure DMH Recovery Residence) and such community care rarely is a viable option for the population this project will serve. The data consistently shows that within inpatient psychiatric hospitals there are seven to ten individuals at any one time that need a physically secure residential setting.

Residential treatment programs can be effective for people diagnosed with mental illness and can allow them to reside in their community. While varying in resources available and program focus, residential psychiatric facilities share some core characteristics: individualized therapeutic treatment goals, supportive structures and routines, personal responsibility, contribution to the community, peer support, and higher quality of life. A variety of residential settings are critical to and needed to address the needs of people served by our system of care. The DMH Recovery Residence would fill a crucial need in this care mix.

Even though further areas of research were identified in the Act 26 report, it is clear that the creation of a physically secure residence is indicated, as is some expansion of other community capacities. It also is becoming clear that further investment in group home capacity and other independent living options are indicated for allocation of additional resources as well.

#### Intensive Recovery Residences Capacity

Analysis performed by the DMH Research and Statistics Unit based on utilization data collected by the six community-based non-state-run intensive recovery residences (IRRs) for 2013 – 2020, indicates that four of the six IRRs ran between mid-80% to low 90% occupancy rates. Since introduction of Maplewood in Rutland in 2014, this IRR has consistently been well over 90% occupancy. The introduction of the Soteria Program in 2015 likewise saw in the most recent four-year period occupancy rate of between 86%-92%. Please note the occupancy rates for all

IRRs were skewed in CY 2020 and are therefore an unreliable indicator of trends given the COVID-19 pandemic as evidenced in the following chart.

#### Percent Occupancy for Adult IRR Beds CY13-20

	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	CY2019	CY2020
	% Occ	% Occ	% Occ	% Occ	% Occ	% Occ	% Occ	% Occ
Hilltop Recovery Residence	85%	97%	94%	88%	85%	77%	84%	70%
MapleWood Recovery Residence		94%	94%	94%	96%	95%	92%	88%
Meadow view Recovery	91%	97%	98%	89%	97%	88%	96%	88%
Pathways Vermont - Soteria			73%	92%	86%	89%	90%	87%
Second Spring North	85%	94%	87%	83%	95%	98%	87%	76%
Second Spring South	96%	95%	82%	79%	84%	95%	87%	75%
<b>Total</b>	<b>92%</b>	<b>96%</b>	<b>88%</b>	<b>85%</b>	<b>89%</b>	<b>91%</b>	<b>88%</b>	<b>78%</b>

Analysis performed by DMH Research and Statistics Unit.  
 Analysis based on data collected by the Electronic Bed Board based on data entered by IRR staff for beds - capacity, occupied, and closed. Percent Occupancy is based on Occupied beds divided by Capacity. Percent Available Occupancy subtracts Closed beds from Capacity before using that value as the denominator.

Nationally recognized standards for efficient residential program operations set occupancy rates between 85-90% which is consistent for community-based IRRs in Vermont. The annual vacancy rates of less than one unfilled bed at any point in time in most of these programs clearly supports increased bed capacity need in the community for “staff secure” IRR’s. This IRR level of care, however, even with increased bed capacity, is not comparable or adequate for the unmet secure residential bed needs for individuals who otherwise might continue to be placed on acute inpatient hospital beds because they cannot be safely discharged to the community. The DMH Recovery Residence will provide the necessary level of supervision and residential support for this population.

Calendar Year	Individuals admitted to an IRR from an Involuntary Hospitalization stay
<b>2016</b>	6.1%
<b>2017</b>	7.1%
<b>2018</b>	5.9%

**2019** 3.9%  
**(6 months)**

The table at left illustrates the percentage of individuals who are admitted to IRRs from involuntary hospitalization stays. DMH sought to determine the percentage of clients that went to an IRR from an involuntary hospitalization compared to how many

individuals were hospitalized involuntarily. These figures also show a decline in both actual number of admissions as well as a decrease in the percentage of admissions from involuntary hospitalizations, while occupancy rates remained high. As mentioned above, these figures indicate that this level of care either requires more capacity, or individuals are unable to transition to the next lower level of care, such as residential group-home living, independent living with supports, or other independent living arrangements.

Admissions to Intensive Recovery Residences by Year				
	CY 2016	CY 2017	CY 2018	CY 2019 (6-mo)
<b>Maplewood</b>	2	8	0	2
<b>Meadowview</b>	4	4	7	2
<b>Hilltop</b>	3	3	5	1
<b>Second Spring (N&amp;S)</b>	16	20	13	5
<b>MTCR</b>	8	5	7	1
<b>Total</b>	<b>33</b>	<b>40</b>	<b>32</b>	<b>11</b>

The table above details the relatively small number of admissions across all IRR beds between 2016-2019. Both physically secure residential and Intensive Recovery Residences are consistently needed as timely discharge options.

#### Community Health Needs Assessments

In the 2018-2019 Community Health Needs Assessments (CHNA), “access to mental health services” or “eliminating barriers to mental health services,” was noted by 11 of Vermont’s 12 hospitals. The 12<sup>th</sup> hospital simply noted that mental health needs are significant.

The DMH Recovery Residence will greatly reduce the “bottleneck” that occurs as hospitalized individuals on an ONH are ready to transition to a lower level of care, but frequently wait to be accepted at a program that can provide a secure residence, leaving those currently needing inpatient treatment to wait in emergency rooms for a hospital bed to open.

In this way, as noted above, the DMH Recovery Residence is a keystone in the mental health system of care continuum, critical to ensuring that all Vermonters can access the care they need when they need it.

1.2: Applicants seeking to expand or introduce a specific health care services shall show that such services have been shown to improve health. **To the extent such services have been the subject of comparative effectiveness research, an applicant shall show that the results of this research support the proposed project.**

The health and well-being of Vermonters with serious mental illness is dependent on timely access to the proper level of treatment. Without such access, Vermonters suffering a mental health crisis may wait in an emergency room for many days, and in some cases, up to two weeks, until a bed becomes available.

Long wait times in Emergency Rooms is symptomatic of inadequate system “flow.” “Flow” refers to the ability of the system to manage patients effectively with minimal delays as they move through stages of care. Expanding the clinical and bed capacity of the secure residential program is critical to improve flow in the mental health system of care, which will also improve outcomes as the appropriate care will be available as needed. The expanded capacity the DMH Recovery Residence provides will allow individuals ready for discharge to step down from hospital beds and as a result, increase access to beds for people needing hospitalization.

A large and growing body of research focuses on the lack of transitional or “step-down” treatment capacity for those with serious mental illness. Without such capacity, according to La, et al., in *Increasing Access to State Psychiatric Hospital Beds: Exploring Supply-Side Solutions* (*Psychiatric Services* 67:5, May 2016), “major increases in state psychiatric hospital inpatient capacity are necessary to ensure timely admission of people in crisis.” While this statement may seem focused on bed type needs, “timely admission of people in crisis” is critical to ensure the best outcomes. Similar to how a person experiencing even a minor cardiac event who has to wait for care will likely have a poorer outcome than another person who gets immediate appropriate care, timely access to treatment for mental health crises predicts the best outcomes.

For example, Veteran’s Affairs, in its study of VA mental health services<sup>6</sup>, concluded that “studies of wait times for veterans have found that long wait times can compromise health because of delayed use and can lead to poorer health outcomes and decreased user satisfaction.” Further, they noted that the poorer outcomes included increased mortality.

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<sup>6</sup> Evaluation of the Department of Veterans Affairs Mental Health Services. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee to Evaluate the Department of Veterans Affairs Mental Health Services. Washington (DC): National Academies Press (US); 2018 Jan 31. <https://www.ncbi.nlm.nih.gov/books/NBK499495/>

In Transforming Mental Health Care in the United States<sup>7</sup>, a RAND research brief, McBain et al. found that “it is the responsibility of the health system to make sure that patients are receiving care that meets their level of need...” The RAND study called on states to “define and institutionalize a continuum of care...Individuals with mental health needs often fall through the cracks because of a lack of clarity regarding who should provide care, at what level of intensity, and in what settings over time.” The Rand brief goes on to specify that care should follow clinical guidelines, which the DMH Recovery Residence would allow Vermont to do more consistently.

In addition, *Crossing the Quality Chasm, A New Health System for the 21<sup>st</sup> Century*<sup>8</sup>, from the Institute of Medicine, highlighted six aims towards quality improvement – safe, effective, patient-centered, timely, efficient, and equitable care.

Additional beds and increased clinical capacity are central tenets of the proposed 16-bed, state run DMH Recovery Residence. The Residence will continue to serve individuals who no longer require acute inpatient care, but who remain in need of treatment within a secure (locked) setting for an extended period. To achieve the desired outcome of improving flow in the mental health system of care, and to provide patients step-down treatment from Level 1 inpatient beds, the clinical attributes and programming that will be available in the Residence are critical and essential to Vermont’s system of care.

According to Thomas, et al<sup>9</sup>, patients who receive acute residential services experience “treatment outcomes equivalent to those of inpatient units, with users reporting high satisfaction.” Such residential services help to prepare the resident for discharge, by developing domestic and vocational skills, relating to others, finding, and maintaining suitable housing and more. The DMH Recovery Residence will provide just these services.

Scanlan, et al<sup>10</sup>. noted that “The time following discharge from psychiatric hospitalization is a high-risk period. Rates of hospital readmission are high and there is increased risk for homelessness and suicide. Transitional and post-discharge support programs have demonstrated positive results in terms of enhanced wellbeing, improved connection with community-based services and, in some cases, reductions in hospital re-admission.”

The DMH Recovery Residence will allow safe transitions from hospitalization to this next level of care for those who are no longer acutely symptomatic but would rapidly decompensate if discharged without ongoing supports and intensive treatment services. The program will be more home-like and structured to support individuals who remain likely to intermittently experience

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<sup>7</sup> McBain, Ryan K., Nicole K. Eberhart, Joshua Breslau, Lori Frank, M. Audrey Burnam, Vishnupriya Kareddy, and Molly M. Simmons, Transforming Mental Health Care in the United States. Santa Monica, CA: RAND Corporation, 2021. [https://www.rand.org/pubs/research\\_briefs/RBA889-1.html](https://www.rand.org/pubs/research_briefs/RBA889-1.html).

<sup>8</sup> <https://www.ncbi.nlm.nih.gov/books/NBK222274/>

<sup>9</sup> Clinical and Cost-Effectiveness of Acute and Subacute Residential Mental Health Services: A Systematic Review Kerry A. Thomas, B.Sc.(Psych.), B.Soc.Sc.(Psych.) Debra Rickwood, Ph.D., B.A. *Psychiatric Services* November 2013 Vol. 64 No. 11 <https://ps.psychiatryonline.org/>

<sup>10</sup> (Scanlan et al. BMC Psychiatry (2017) 17:307) Evaluation of a peer-delivered, transitional and post-discharge support program following psychiatric hospitalisation. Justin Newton Scanlan, Nicola Hancock and Anne Honey DOI 10.1186/s12888-017-1469-x

behavioral dysregulation that compromises safety for themselves or others but does not warrant immediate removal from the home.

The program capacity will allow people with challenging mental illness to continue their path to recovery in the community. This will greatly improve the movement of patients through the systems as they are ready, improve their outcomes, and ensure the right care is delivered at the right time and in the right place.

This approach is supported by studies of residential step-down models. For example, Zarzar et al.<sup>11</sup> found that “the majority of patients who no longer need an inpatient psychiatric level of care, but who cannot be discharged due to either lack of appropriate housing or inadequate community supports, or both, can be stepped down to a lower level of care,” and that “this model may offer an alternative, less costly approach to increasing acute psychiatric bed capacity for the seriously mentally ill, and may reduce emergency department overcrowding.”

1.3: To the extent neighboring health care facilities provide the services proposed by a new health care project, an applicant shall demonstrate that a collaborative approach to delivering the service has been taken or is not feasible or appropriate.

The Vermont mental health system of care currently includes seven IRR programs that are geographically distributed throughout the state, including the seven-bed MTCR. Five IRRs are independently operated by DA's or a consortium of DA's, called Collaborative Solutions, to provide “staff secure” enhanced residential services for individuals requiring this level of treatment services. Staff secure programs provide close supervision and supports but are not locked residential programs that prevent an individual's leaving the residence. All these IRRs operate as part of state-wide referral programs for these services. One IRR, Soteria House, is a peer-run program offering an alternative level of support to individuals seeking services other than traditional pharmacological supports as part of the program. This program, too, is staff secure for individuals who are willing to participate within the scopes of residential support services. The MTCR is the only state-wide IRR that operates as a receiving program for individuals who are required to be on an ONH and provides locked residential services. As such, there is no comparable IRR that provides the same types of residential services for persons referred to the program.

The DMH care management team, working closely with Level 1 hospitals and the other state-wide IRR programs, is a point of triage for facilitating step-down placement for individuals discharging from inpatient care services. Referrals are made statewide to IRRs closest to an individual's home community whenever possible, by a person's preference for step-down when possible, or state-wide if the individual's needs cannot be readily met by a closer or preferred discharge destination. Inpatients who are nearing readiness for discharge but lack adequate community services or decline recommended supports placing them at high risk for decompensation and readmission without services, may remain in hospital for extended periods

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<sup>11</sup> Reducing Length of Acute Inpatient Hospitalization Using a Residential Step-Down Model for Patients with Serious Mental Illness. Theodore Zarzar, Brian Sheitman, Alan Cook and Brian Robbins Community Mental Health J (2018) 54:180–183 DOI 10.1007/s10597-017-0111-1

of time. With current MTCR capacity, there are frequent delays in admission acceptance for individuals needing locked, secure residential services.

DMH has demonstrated its collaboration with existing IRRs to serve the higher acuity population ready to leave hospitalization but still in need of secure residential services that exceed that offered by staff-secure features alone. In 2015, through an RFI process, DMH sought to determine interest in programs for an expanded scope of care and secure features to serve a population that otherwise remains hospitalized for potentially longer than is clinically recommended if adequate residential support services existed. While there would be benefit to additional staff-secure IRR programs in the state, lack of available and timely secure residential capacity leaves hospitals unable to free up inpatient bed capacity for persons needing hospital admission from hospital emergency departments. Additional locked residential capacity will allow timely discharge for individuals on ONH's who could otherwise be discharged if beds were available to meet the residential support services of the patient and an ONH condition of release by the court.

**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.**

While not a new health care project, the MTCR program does track data elements similar to DA- and peer-operated IRR's. Annually, DMH tracks the following standard operating and quality metrics: length of stay, discharge disposition, number of admissions overall and by year, referral sources, staff training, client or staff event reporting, and bed occupancy rates. MTCR also regularly utilizes the Broset Violence Checklist (BVC) with residents which assists in reviewing indicators of violent or dysregulated behavior when planning activities, groups participation, and appointment transport. Medication side-effect monitoring tools, such as the Abnormal Involuntary Movement Scale (AIMS), are used if certain psychotropic medications are part of the treatment plan. Wellness Recovery Action Plan (WRAP) are utilized when residents have completed such plans. MTCR staff have attended WRAP training to engage residents and support them in the initiation and development of these self-help and supporter-help tools if a resident wants to develop their plan during residency.

DA- and peer-operated IRRs, per contract, also track reasons for not admitting referrals, resident level of care (LOCUS) scores, employment outcomes, and consumer, family member, and community partner survey outcomes.

DMH sees the new DHM Recovery Residence as an opportunity to both continue tracking the above metrics and more regularly look at satisfaction rates and measures of engagement with residents and their significant others and family. While screening for co-occurring treatment needs per resident is part of admission screening and part of ongoing assessment and individualized treatment plan development, tool tracking and scoring for the subset of the current population has not been consistently collected, so DMH plans to include additional quality metrics.



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.**

The DMH Recovery Residence has been designed and will operate consistent with evidence-based practices. This new facility will rely on 1) evidence demonstrating the need for a step-down option, 2) improved therapeutic techniques for aiding recovery, and 3) intentional design of the build environment.

As referenced earlier, in CON Standard 1.2, the research literature notes that transitional step-down programs have demonstrated success in transitioning individuals back to the community while also freeing up inpatient beds. In *Transforming Mental Health Care in the United States*<sup>12</sup>, a RAND research brief, McBain et al. found that “it is the responsibility of the health system to make sure that patients are receiving care that meets their level of need...” The RAND study called on states to “define and institutionalize a continuum of care... Individuals with mental health needs often fall through the cracks because of a lack of clarity regarding who should provide care, at what level of intensity, and in what settings over time.” The RAND brief goes on to specify that care should follow clinical guidelines, which the DMH Recovery Residence would allow Vermont to do more consistently.

This proposed approach with the DMH Recovery Residence, building on the MTCR program, is supported by studies of residential step-down models. For example, Zarzar et al.<sup>13</sup> found that “the majority of patients who no longer need an inpatient psychiatric level of care, but who cannot be discharged due to either lack of appropriate housing or inadequate community supports, or both, can be stepped down to a lower level of care,” and that “this model may offer an alternative, less costly approach to increasing acute psychiatric bed capacity for the seriously mentally ill, and may reduce emergency department overcrowding.”

The DMH Recovery Residence offers programming and clinical staffing to treat a higher level of acuity and psychiatric needs than the currently available system of non-physically secure IRRs. Certain high acuity individuals who step down from inpatient treatment to a secure residential program need a higher level of oversight and support services than an unlocked residential program. Because of their unique needs, these individuals many have been denied by other IRRs or have previously been at another IRR and the residence will not consider re-admission at the time of discharge from hospitalization.

MTCR’s capacity, and the additional capacity of the DMH Recovery Residence, to transition individuals out of Level 1 inpatient units who are no longer acutely in need of that level of care permits patient access to those same acute inpatient beds and improves the flow within the

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<sup>12</sup> McBain, Ryan K., Nicole K. Eberhart, Joshua Breslau, Lori Frank, M. Audrey Burnam, Vishnupriya Kareddy, and Molly M. Simmons, *Transforming Mental Health Care in the United States*. Santa Monica, CA: RAND Corporation, 2021. [https://www.rand.org/pubs/research\\_briefs/RBA889-1.html](https://www.rand.org/pubs/research_briefs/RBA889-1.html).

<sup>13</sup> Reducing Length of Acute Inpatient Hospitalization Using a Residential Step-Down Model for Patients with Serious Mental Illness. Theodore Zarzar, Brian Sheitman, Alan Cook and Brian Robbins *Community Mental Health J* (2018) 54:180–183 DOI 10.1007/s10597-017-0111-1



mental health system. This flow also ensures individuals are supported in the least restrictive level of care so they can make successful progress in their overall health and recovery goals.

The treating team of the Recovery Residence also represent providers and treatment team staff who are actively engaged in ongoing evidence-based practices development and skills training to enhance their engagement strategies and tools with the population served by the secure residential program. Current staff have been active participant is the Beck Institute's Recovery-Oriented Therapy (CR-T) cognitive therapy treatment model embodying the principles and spirit of the recovery movement using a treatment approach designed to promote empowerment, recovery, and resiliency in individuals with serious mental health conditions.

Staff also actively participate in Open Dialogue which is a model of mental health care that emphasizes listening and understanding and engages the social network from the very beginning with the participation of the resident served – rather than relying solely on medication or hospitalization as treatment. It comprises both a way of organizing a treatment system and a form of therapeutic conversation, or Dialogic Practice, within that system.

Additionally, clinical staff are familiar with Dialectical Behavioral Therapy treatment which is a type of psychotherapy that emphasizes the psychosocial aspects of treatment. DBT teaches skills for coping with sudden, extreme mood swings and behavioral dysregulation that may interfere with treatment gains. Motivational Interviewing is also in the residential staff toolbox. This technique is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.

Ongoing consultation is also available and will continue in the new residential program by national experts knowledgeable in the Substance Abuse and Mental Health Services Administration (SAMHSA) Six Core Strategies for Reducing Seclusion and Restraint Use. This best practice, in conjunction with resident engagement and empowerment approaches, enlists leadership and direct services staff to inform practice changes. Emphasis is focused on review and use of data, ongoing development of staff skills and training, de-escalation skills and decision-making strategies, and de-briefing with resident involvement and choice options whenever possible as fundamental program and communication components.

DMH believes a secure, state-of-the-art therapeutic residence and use of best practices are key tools that will allow an individual to transition from the most restrictive level of care at the earliest time possible while still receiving intensive residential support services. Adding this capacity through the DMH Recovery Residence will greatly improve the movement of patients through our system, improve outcomes, and ensure the right care is delivered at the right time and in the right place.

Consistent with environmental features known to improve outcomes, the new residence is being designed according to the latest research regarding the profound effects the built environment has on physical and mental health. An environmental design that feels more like a home than an institution, that allows easy access to nature, and helps residents to feel safe, is an important component of recovery. Large windows that allow as much natural lighting as possible, and soft,

neutral colors through-out the residence help create a calming environment.<sup>14</sup> The DMH Recovery Residence will incorporate all these therapeutic features.

Finally, the design and implementation of treatment and recovery services as envisioned for the DMH Recovery Residence aligns with DMH's *Vision 2030*. These tenets contained in *Vision 2030* are the driving force behind the vision of DMH Recovery Residence: to be the pre-eminent provider of person-led, trauma informed care in Vermont.

1.8: Applicants seeking to develop a new health care project shall demonstrate, as appropriate, that the applicant has a comprehensive evidence-based system for controlling infectious disease.

The DMH Recovery Residence will have a detailed Infection Control Plan that follows best practices laid out by the Association for Professionals in the Infection Control and Epidemiology (APIC), the Center for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA), the Vermont Department of Health (VDH), as well as other evidence-based systems. This plan will include such things as interventions to prevent the spread of infections and to prevent unprotected exposure to pathogens, such as blood borne pathogen control. The plan will include standard precautions and hand washing, transmission base precautions, use of Personal Protective Equipment (PPE), workplace measures to reduce spread of infection, and protocols for the disposal of waste that may be hazardous or facilitate the spread

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<sup>14</sup> Healthcare Environmental Terms and Outcome Measures: An Evidence-based Design Glossary [https://www.healthdesign.org/sites/default/files/chd408\\_researchreportglossary\\_v6\\_final\\_0\\_0.pdf](https://www.healthdesign.org/sites/default/files/chd408_researchreportglossary_v6_final_0_0.pdf). (n.d.). [Brochure]. Author.

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of infection. The Infection Control Plan will be reviewed and updated yearly or as needed if infectious outbreaks happen.

The DMH Recovery Residence will also have a Respirator Protection Program Policy following the guidance of OSHA. This policy will detail when respirators are needed to keep staff safe and to prevent the spread of infection in the program. This policy will be reviewed yearly, and staff will be fit tested yearly to N95 respirators in case of an infectious outbreak.

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.**

The DMH Recovery Residence will reuse an existing state property, utilize state-of-the-art efficiency measures, and use sustainable heating sources. The project will be located on a State-owned site that currently houses the unused Woodside Juvenile Rehabilitation Facility. Selecting this brownfield site in a population center conserves an existing greenfield location elsewhere in Vermont and allows for proportionally reduced travel distance by many staff and visitors when compared with the existing temporary facility in Middlesex, reducing the overall carbon footprint. The proposed facility will also have access to the municipal utility infrastructure which represents lower cost maintenance compared with options requiring onsite water supply and wastewater management.

The project has undergone an energy model analysis to determine the performance of the thermal envelope and to aid in the evaluation of several HVAC system options. The design team, working in concert with BGS mechanical engineer experts and with Efficiency Vermont staff, determined the most efficient and cost-effective solution based on the requirements of this facility. The project achieves a balance of initial cost affordability with lifecycle cost reduction, while attaining the smallest carbon footprint of the options analyzed.

The DMH Recovery Residence has specific requirements related to maintaining a physically secure program that mandate certain aspects of construction. For example, exterior window options are limited to those that pass the required impact resistance criteria for a mental health facility. This limited selection dictates the energy efficiency the project can achieve in relation to window thermal performance, while at the same time requiring additional cost in comparison to standard windows. To mitigate this type of inherent added cost, the entire project team has analyzed over one hundred cost saving concepts ranging from \$2,800 to \$158,000. Some of these concepts have required the State to rethink its standards that would have otherwise mandated more durable construction materials.

The State has been committed to eliminating fossil fuels in its projects to the extent feasible, and for this project a geothermal heating and cooling system with associated electric heat pumps has been selected.

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.**

The DMH Recovery Residence design team along with BGS MEP staff have had multiple meetings with Efficiency Vermont to discuss the design of the facility. The design process utilized an energy model created by the design team to inform the selection of construction materials and mechanical systems. Efficiency Vermont staff were key participants analyzing the energy model data and in the decision-making process when selecting the type of heating and cooling system to be used.

1.11: Applicants proposing new health care projects requiring new construction shall demonstrate that new construction is the more appropriate alternative when compared to renovation.

Given the demonstrated needs of the mental health system of care and the temporary nature of the current transition program, construction of the new DMH Recovery Residence is the only appropriate solution. MTCR consists of two interconnected modular structures, each 88 by 32 feet in size. When established after Tropical Storm Irene, the modular structures were intended to be a temporary solution with a life expectancy of two years. The structures have been in use for ten years and, though still functional and safe, are well past their useful life. A renovation and addition of the existing facility is not feasible.

BGS conducted two land searches for suitable sites for purchase with renovation of an existing building being an option. No existing building renovations were proposed. The proposed Essex site features a building of approximately 16,500 square feet however the structural CMU walls and two-story layout made renovation unfeasible as costs would be similar to a new facility, and layout limitation would raise staffing costs.

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), current edition. See **Bulletin 001 for CON on GMCB website**.

The proposed project will meet the applicable 2018 Facility Guidelines Institute (FGI) as outlined in Bulletin 001. Each of the 16 private bedrooms will be provided with private bathrooms with showers. Each bedroom will be provided with windows that meet the guidelines requirement for impact resistance and all components therein are designed to meet anti-ligature requirements. The rooms are designed to be residential in nature with residents' having controls over lighting, temperature controls and access to fresh air.

The spaces are designed to meet the functional intent of clinical program and be flexible in use. In addition to the required quiet rooms, group activity rooms, and dining spaces that are required as a minimum, the facility includes spaces that offer added choice for activities such as a green house, exercise room, and shared living room. The secured outside garden space is accessible from the dining area, the greenhouse, and a secured corridor. The garden space offers locations for raised bed plantings, walking paths and green space for activities and dining.

The household residential kitchen will double as a life-skills training kitchen and is equipped with residential type appliances, including refrigerator, two-bay sink, and stovetop with oven. A breakfast bar for snacks and beverages is available for all residents. Immediately adjacent to the

household residential kitchen is a secured commercial style kitchen before staff use in preparing the meals. There is a dining room sized to seat all residents for meals, a group room for noisy activities, and a living room for smaller gatherings and quieter functions. The art/music/sanctuary room provides a space for more self-expression and reflection. The sensory room is set up with relaxing furniture, dimmable lighting, and music.

There are spaces allocated for staff including offices for administration, clinical and activities staff, multipurpose conference spaces for training and shift rounds, a breakroom, a lactation room, and respite space. There are areas for environmental services and BGS staff as required to maintain the building's operations.

3.3: Applicants seeking to add inpatient capacity shall demonstrate that such capacity is needed by the service area population and that services are not available at neighboring hospitals.

As discussed above, the DMH Recovery Residence is a necessary and needed component in the state's mental health system of care. This project, like MTCR, will continue to be a licensed as Therapeutic Community Residence (TCR). The Residence, for up to 16 individuals, will continue to meet the definition of a "secure residential recovery facility" as that term is defined in 33 V.S.A. § 7102(11) for an individual who no longer requires acute inpatient care but who does remain in need of treatment within a secure setting for an extended period. The statute is clear that "a secure residential facility shall not be used for any purpose other than the purposes permitted by this section." When describing the secure residential recovery facility, the statutory term "secure" means that the residents can be physically prevented from leaving the facility by means of locking devices or other mechanical or physical mechanisms. The challenge of this program, and an existing service gap in the current continuum of care, is the provision of services that meet both the security and therapeutic treatment needs for this target population.

This project will address the needs of persons for whom the Commissioner of Mental Health seeks continued treatment in a secure setting other than in a hospital, pursuant to an Application for Continued Treatment filed in Family Court. Though a court ultimately determines the need for an ONH with conditions for residency at the secure residential recovery program, the demonstrated lack of sufficient capacity at this level of care requires construction of this additional resource.

As outlined earlier in this application, the lack of a secure step-down residence for those on an ONH means that such individuals might otherwise remain hospitalized for lack of a community residential program adequate to meet their needs. Individuals can sometimes be nearly ready to discharge from an inpatient setting but are either not accepted or prioritized for admission into community residential programs. The average current occupancy of the MTCR exceeds 90% capacity at this necessary level of care and support.

In effect, this lack of additional capacity could leave this population of Vermonters without access to the mental health services they need when they are ready to step down from hospitalization. The DMH Recovery Residence, therefore, is a critical keystone in the mental health system of care continuum to ensuring that all Vermonters can access to the care they need when they need it.

After 2019's Act 26, Section 2 "Analysis of Residential Mental Health Bed Needs" report to the Legislature, DMH continues to see individuals who cannot safely be discharged to other IRRs and continue to wait, often in hospital emergency departments, for secure, locked residential services. Planning for this project includes expansion of bed capacity and residential design and space improvements for more individualized and calming spaces to better meet the needs of this population. Ongoing availability of such a residential resource will help to ensure that individuals in need for hospitalization presenting to emergency rooms for inpatient beds will be able to access that level of care and not see delays or lengthy periods of wait times in emergency departments.

4.1: Applicants for inpatient mental health service related certificates of need shall include specific information about how the proposal relates to the VSH Futures Project (or subsequent plan). **Applicants shall not receive a certificate of need without showing how the proposal is consistent with the most current planning objectives identified by the Vermont Department of Mental Health.**

As earlier outlined in the Project Overview of this application, the existing, temporary MTCR opened in 2013 following the abrupt closure of the former Vermont State Hospital and an emergency Certification of Need application. The need for an intensive, secure level of care was first identified as part of the ongoing planning process to replace the Vermont State Hospital in the 2005 document, "*Vermont State Hospital Futures Plan*." When Tropical Storm Irene flooded and closed the Vermont State Hospital in 2013, devastating Vermont's state-run involuntary psychiatric inpatient care capacity, the State implemented this new level of care. Passage of [Act 160 \(2012\)](#) and [Act 79 \(2012\)](#) codified the statutory basis for a secure residential recovery facility, the resident population it would serve, and its state-run operations role within a "*diverse system and continuum of mental health care throughout the state*." (Act 79 §7255 (8)).

Following nearly eight years of operations in this temporary facility, the MTCR replacement has been the subject of, or referenced in, several acts as outlined earlier in this application.

The mental health system transformation that emerged through Act 79 included planning objectives, timelines, and funding allocations to fulfill the vision in a comprehensive manner has substantially materialized over this period. Act 79 made clear that a component of that vision was secure residential beds to meet clinical and judicial treatment requirements. The efforts to address the ongoing needs for this level of care and secure the necessary funding for a permanent replacement of the secure facility over several years remains consistent. It has also been articulated in this application that the concept behind the DMH Recovery Residence was developed to align with the goals laid out in *Vision 2030* and several of the action areas detailed in that plan put forward by DMH.<sup>15</sup>

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<sup>15</sup> See 1(a), starting on page 9.

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.

This project will utilize an integrated and holistic treatment approach including mental health treatment, substance abuse treatment, and physical health. The program will have trained Mental Health Specialists staffing the everyday functions of the program. There will be available psychiatrists, psychologists and licensed social workers/licensed mental health counselors providing ongoing assessments, treatment plans and discharge planning. These services will integrate assessments for mental health wellness as well as substance use assessments. Treatment plans will incorporate goals based on a holistic approach to wellness including mental and physical health and substance treatment needs. In-house licensed professionals will be able to support residents with counseling, group therapy and wellness activities. The proposed program will also work with community partners in the area to help residents meet their treatment and discharge goals.

All residents of the program will be supported in applying for and undergoing eligibility determinations for all levels of financial benefits that might be available to them.

The project will have 24/7 on-site nursing to address any healthcare concerns that residents have. The program will work collaboratively with community partners at the local community health center as well as individual primary care providers to make sure that all health concerns of residents are addressed, and appropriate follow-up occurs. All residents will be scheduled for a yearly physical with their primary care physician. Additional health services, such as dental and vision care, will be available and residents provided with support to address any concerns/needs in a timely manner.

Group work will address holistic issues like nutrition, sleep, hygiene, mindfulness, stretching, fitness, exercise, gardening, stress management, and Wellness Recovery Action Plans (WRAP) to name just a few.

Mental Health coordination with community partners and DAs will be central to the proposed program. This is a vital piece to a successful discharge for residents back to their communities. An assigned DA case manager for residents enrolled in a DA program will be part of the treatment team to help with a smooth transition of services from the residential program to the community.

The DMH Recovery Residence will work with community providers to access any substance use programming that will be beneficial to the treatment and success of the residents above and beyond the counseling and group services provided at the residence.



## Triple Aims: Institute of Healthcare Improvement (IHI), Triple Aims: Explain how your project is:

### (a) improving the individual experience of care;

As mentioned earlier in the application,<sup>16</sup> in 2019 DMH embarked upon an ambitious project to engage Vermont's mental health system stakeholders in a process to develop a 10-year vision to achieve a comprehensive, coordinated, and integrated mental health system for Vermonters. The result is *Vision 2030, A 10-Year Plan for an Integrated and Holistic System of Care*. Vision 2030 aims to provide Vermonters timely access to whole health, person-led care that achieves the Quadruple Aim of healthcare: 1) increasing the quality of care and patient experience, 2) improving population health, wellness, and equity, 3) lowering per-capita costs, and 4) creating a better environment for Vermont's providers. By fully embracing an integrated system that works collectively to address population health, wellness and equity, Vermonters will have improved access to care, be healthier and happier, and the state as a whole will realize significant economic benefits.

The DMH Residential Recovery program appreciates the importance of improving client experience and is focused on building a culture of care that not only treats those seeking care with respect and dignity, but also supports them to lead the development of their treatment plan and recovery goals. Strategies holding the person's individual needs, values, and interests as a guide for treatment services will be reflected in their services plan. Some of the steps outlined in *Vision 2030* (Action Area 7) include reshaping practices to include advance directives so that individuals can lead to the extent possible in their care from a position of wellness and incorporate outcome measures and a clear system of feedback to support continual improvement of person-led service delivery.

As a key component of the program, DMH has committed to "build, empower and sustain a strong peer network throughout Vermont." Peers will be key members of every resident's treatment team, and the programs and services will support residents in building their functional living skills, including establishing food and housing stability, employment, and connection to community. A strong relationship and coordination with their primary care physician will be fundamental to every treatment plan.

As noted above, this project will provide an appropriate and available residential option for Vermonters experiencing ongoing mental health needs and requiring a secure setting but not a hospital level of care. The Residence will directly contribute to reduced emergency department waits and access for people needing hospital beds by freeing up beds occupied by those who would be able to "step down" to this residence.

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<sup>16</sup> See Project Overview, starting on page 6 and 1(a), starting on page 9.



#### (b) improving health of populations;

The DMH Recovery Residence will play a key role in helping to improve population health in Vermont. Population health depends on a fully articulated system of care that provides ready access to appropriate care.

A recent paper<sup>17</sup> in the Annual Review of Public Health defined population-based approaches to mental health “as nonclinical interventions and activities intended to improve mental health outcomes, and the determinants of these outcomes, among a group of individuals that are defined by shared geography, sociodemographic characteristics, or source of clinical services utilization.” While the DMH Recovery Residence will be a clinical treatment residence, it will also focus heavily on providing such non-clinical interventions and activities, such as functional skill building, practice in seeking and sustaining employment and housing, as well as in building inter-personal and self-care and wellness skills.

DMH will also implement systems-level strategies to improve the effectiveness of clinical mental health services and evaluate outcomes. The DMH Recovery Residence will use quality improvement initiatives such as training and coaching on the implementation of evidence-based practices and measurement-based care to help providers evaluate resident progress and update treatment plans accordingly.

Every resident will be encouraged to enroll in their local Community Rehabilitation & Treatment (CRT) program through their local DA, and if they do, their CRT program manager will be a member of their treatment team. Engagement in community-based settings to promote sustained engagement with care and initiate intensive services for complex needs are important pieces in an overall population health approach. Peer support specialists—people who have successfully lived with mental illness and who work to support individuals toward their own recovery—will assist with care navigation, both within the residence and after discharge to the community.

DMH will continue its role supporting consultation and training to community-based partners to extend the impact of clinical interventions and supports once a resident transitions back to the community. Community partners will provide clinical and nonclinical mental health interventions (e.g., psychoeducation or stress management training). In addition, DMH-supported programs such as evidence-based, supported employment will help former residents access and maintain employment.

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

The DMH Recovery Residence will reduce per capita costs by providing a cost-effective and clinically appropriate alternative to use of inpatient units for a subacute population. DMH has identified numerous studies showing that receiving the appropriate care at the appropriate time and sustaining appropriate care for as long as needed reduces cost and provides better clinical care. Roos, et al<sup>18</sup>, for example, noted that “transferring patients ready for discharge from mental

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<sup>17</sup> Population-Based Approaches to Mental Health: History, Strategies, and Evidence Annual Review of Public Health Vol. 41:201-221 (Volume publication date April 2020) <https://doi.org/10.1146/annurev-publhealth-040119-094247>

<sup>18</sup> Health care utilization and cost after discharge from a mental health hospital; an RCT comparing community residential aftercare and treatment as usual. Eirik Roos, Ottar Bjerkeset and Aslak Steinsbekk

hospital to community residential aftercare can have the potential to reduce total consumption of health services and costs without increased hospital admissions.”

According to Thomas, et al.<sup>19</sup> acute residential services are a “cost-effective alternative to inpatient psychiatric units that can alleviate pressure on inpatient beds for clients whose symptoms do not require the specialized services of inpatient units.”

The authors went on to note that acute and subacute residential services have been shown to help avoid re-hospitalization due to an escalation of symptoms. This not only improves outcomes for the individual and avoids the stigma associated with an inpatient admission, but it also saves on hospitalization costs. Thus, the DMH Recovery Residence will provide evidence-based clinically appropriate care to those who need it in a secure setting, relieve pressure on hospital emergency departments, and reduce costs through timely transition to the appropriate level of care outside of hospitalization.

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<sup>19</sup> Clinical and Cost-Effectiveness of Acute and Subacute Residential Mental Health Services: A Systematic Review  
Kerry A. Thomas, B.Sc.(Psych.), B.Soc.Sc.(Psych.) Debra Rickwood, Ph.D., B.A. *Psychiatric Services* November 2013 Vol. 64 No. 11 <https://ps.psychiatryonline.org/>

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

A. The applicant's financial condition will sustain any financial burden likely to result from completion of the project;

The current state Capital Bill appropriates \$4.5 million as an initial investment in the Recovery Residence - \$3 million from Act 42 and \$1.5 million in Act 139. The FY22 capital request for this project, currently pending, is \$11.6 million, which equates to \$16 million for costs related to replacing MTCR with the DMH Recovery Residence. DMH currently has \$3 million annually allocated in the budget for the operations of MTCR. A larger residence allowing additional treatment and service capacity, as well as trained staffing numbers commensurate with the increased residents to be served, will require additional funding to operate the new residential program. Annualized funding to support these operating costs will be requested in the FY23 budget process.

B. 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 making a finding, the Board shall consider and weigh relevant factors, including:

(i) The financial implications of the project on hospitals and other clinical settings, including the impact on their services, expenditures and charges;

This project could reduce the cost of medical care from unnecessary days of continued hospitalization for the population to be served. Access to step-down level of care options for persons who otherwise may not be able to discharge impacts individuals waiting for hospital beds in emergency departments for both the individual waiting for services and availability of emergency care capacity for individuals needing services and freeing staff to focus on other healthcare emergencies. As previously stated in the application, timely transfer of persons to the right level of care when they need it supports the most efficient use of existing healthcare capacities and allows expenditures and charges to accurately reflect the costs of services and care delivered. In short, treating individuals in the DMH Recovery Residence is more efficient in terms of cost and resources than individuals waiting in an emergency department.

(ii) Whether the impact on services, expenditures, and charges is outweighed by the benefit of the project to the public;

The benefits of receiving the right care, at the right time, and in the right place is advantageous to all members of the public. The goal in building the DMH Recovery Residence to replace MTCR, is that no individual should be disadvantaged due to the lack of the right facility, such as step-down locked residential capacity, from accessing their specific healthcare service needs, needs that might otherwise have been compromised or unavailable through suboptimal utilization of other higher level of care in the form of potentially avoidable and longer inpatient care.

Additionally, the benefits to individuals being able to move in a timely manner from higher level inpatient or residential services, that likely include the most restrictive features on personal

autonomy, to less-restrictive residential settings configured to safely meet their immediate risks and needs is a benefit to the public overall. DMH continues its efforts to ensure that individuals who require a specific set of services to meet their needs will be served in appropriate care settings while also ensuring its responsibility to provide continued services and supports to all persons experiencing mental health issues. Providing as full a spectrum of residential support options as possible in its continuum of services is in the interest and benefit of the public.

C. Less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate.

The DMH Recovery Residence, as proposed, is the best fit for replacing the aging MTCR. Specific to the siting of this project, BGS conducted two land searches. In total, BGS received eight submissions. None were determined to be suitable. During the site selection process, the Woodside Drive site became available. The Woodside Drive Site was identified as the most suitable including community location, privacy, and staffing availability. The site was already owned by the state, which saved purchasing cost and allowed an accelerated overall timeline to occupancy.

Programmatically, alternative community-based programs comparable to the MTCR locked, secure program are not available. DMH efforts to solicit interest in developing comparable programs through the private sector have also been met with preferences for only staff-secure residential program development that would be inadequate for the population needing these services.

Individuals requiring locked, secure residential services are persons initially involuntarily hospitalized and then found by a court as requiring an ONH with conditions for residency at a locked program as the only option once discharged from an inpatient unit. The DMH Recovery Residence will provide this needed support.

D. If applicable, the applicant has incorporated appropriate energy efficiency measures.

As discussed above, this project will be implemented with multiple efficiency measures. These include, but are not limited to, low wattage LED lighting and controls; a building automation system to monitor, track and control all mechanical components; energy recovery ventilation; and a geothermal water-to-water heat pumps system which allows the building's heating, air conditioning, and ventilation systems to be provided from a fully electrified source in lieu of fossil fuels.

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

The Vermont legislature and DMH have identified a longstanding need for secure residential treatment since the findings of the original *Futures Project* in 2005. The common theme in the original Emergency CON application for the secure residential (MTCR) remains true today: there are involuntary inpatients who no longer meet hospitalization criteria but continue to require intense mental health treatment in a secure setting. DMH, as the Mental Health Authority, must assure that services are available to meet the level of care needs for individuals

who no longer require hospitalization but cannot safely be discharged to the services of an IRR or other community-based service programs. In addition, it is important to note that Act 79 requires DMH to provide a state-run, locked, secure residential treatment program if that is the right level of care for an individual when ready for timely discharge from an involuntary psychiatric hospitalization.

#### 4. 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.

The MTCR has operated as a state-wide resource for referral from inpatient providers for this population for nearly eight years. For persons who no longer require acute inpatient care but remain in need of treatment in a secure setting for an extended period, the level of care provided by MTCR has been essential in freeing up inpatient bed capacity that has been in short supply over several years. The increased bed capacity offered by the new residence will also provide greater access to this level of care and its services. The new DMH Recovery Residence, like the mission of the MTCR, will remain the only IRR in Vermont offering this step-down locked, secure capacity that is unavailable in other DA- or peer-run IRRs operating in Vermont.

The quality of the care environment in the new Residence will far surpass what has been available in what was envisioned to be a temporary structure and location of MTCR quickly erected following Tropical Storm Irene. The new construction and programming available to residents will improve resident well-being and will provide additional opportunities to enhance life skills and engage in evidence-based treatment in a program designed to be responsive to the varying needs of different residents in their course of recovery.

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

The DMH Residential Recovery remains the only such program in Vermont, having a unique mission and program with licensure as a Therapeutic Community Residence. Its purpose was defined in Act 79, and the ongoing need for the program and a permanent replacement has been the subject of acts and reporting requirements to the legislature for the past several years. The program continues to serve an unmet need, and DMH has not found an alternative, willing entity to entertain development of a comparable program even through an RFI and subsequent RFP processes. To date, DMH remains the only entity adequately fulfilling Act 79's statutory obligation to assure this level of care is both available and timely for persons ready to discharge from inpatient psychiatric hospitalization with an ONH requiring in this type of residential program. There will not be any adverse impact arising from this program on existing services provided by DMH or by the providers with whom DMH contracts for other residential and community-based mental health services and supports. In fact, it will replace the only such program currently available, MTCR.

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

As a matter of statute (18 V.S.A. §7511, Transportation), DMH policy, and increasingly prevalent practices of the law enforcement community, persons subject to an ONH will access

the DMH Residential Recovery program by involuntary transport or escort using the least restrictive means in each individual circumstance.

Family, friends, and other visitors will access the Recovery Residence by automobile as the site is 1.7 miles from Exit 15 of I-89 off Route 15 in Colchester. Green Mountain Transit also provides service to the site with a bus stop directly across Route 15 at the Ethan Allen Barnes Avenue intersection. (.5 miles or a 9-minute walk).

## 8. 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.

This CON application does not involve the purchase or lease of new health care information technology. Given the small size of the residence, the costs of acquiring an electronic health record as a single operating entity or as part of a larger system with necessary health information firewalls, have been prohibitive. Even as a 16-bed residence, the size does not warrant the level of IT time and cost investment with system specifications, configuration, security, and interfacing challenges for an electronic solution.

The DMH Recovery Residence will keep resident records in accordance with state, federal, and licensing laws and regulations. Medical charts will be kept in the staff information center, a secure locked area allowing authorized treating providers and direct care staff access for documentation of all health care and treatment services. Each resident will have an individual, organized medical record that contains information and documentation of past and current treatment. The record will be used to provide informed treatment of the resident in a holistic manner that includes assessments and treatment plans integrating mental health, physical health and substance abuse treatment as needed.

A resident record is used daily to complete and file daily notes, write and update treatment plans/behavior plans, and for case consultation. Each chart is kept up-to-date and is easy to navigate with a divider system that breaks into 15 sections including Physicians orders, Assessments, Treatment plans, Progress notes, MD Progress notes, Nursing notes, Social Work Progress notes, Psychologist Progress notes, Group notes, Meds and Treatment (MARS, Medical Screenings, Observation records), Labs and Medical reports, Referrals and Consultations, History, Legal, and Miscellaneous.

Medical records are organized and audited to ensure a high level of care for each resident. Daily, the night shift RN audits each resident record to make sure they adhere to the record-keeping requirements: that they are organized, that notes are properly written and filed, and that quality care is being provided and documented. This process assures that timely and quality care are not interrupted by a lack of information.

MTCR records policies are in place with inactive records remaining on-site for up to five years. The management of the resident records follows the record retention in the State's approved DMH Record Retention Schedule and/or health records retention requirements as a health care program.

9. The applicant must show the project will support equal access to appropriate mental health care that meets the Institute of Medicine's triple aims. 18 V.S.A. § 9437(9).

Like MTCR today, the DMH Recovery Residence, when completed, will operate as a state-wide resource for this level of care, affording equal access to individuals meeting the requirements of residence eligibility for its services regardless of ability to pay. The proposed residence will operate as a licensed TCR and be subject to all applicable inspections and regulatory standards of designated state entities. Residents in this program will also have access to and oversight by Disabilities Rights Vermont in its capacity as the state Mental Health Care Ombudsman and legal representation by the Mental Health Law Project of Vermont Legal Aid. Rates established for residents of this state-run program are determined consistent with requirements for other residential care settings making its affordability equivalent to other healthcare facilities. As mentioned earlier, the Residence will be a state-run program available to any qualifying individual eligible for the program regardless of ability to pay. As outlined in response (8) above and CON Standard 4.6 (see page 26), resident care will be delivered in an integrated and holistic manner while also utilizing evidence-based practices as outlined in CON Standard 1.7.





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DESIGN DEVELOPMENT - NOT FOR CONSTRUCTION  
April 9, 2021

DMH RECOVERY  
RESIDENCE



COLCHESTER,  
VERMONT

FFF PROJECT NO:  
A2005.00

ORIGINATION DATE: 04/09/2021 SCALE: 1/8" = 1'-0"

DRAWN BY: ADH CHECKED BY: Checker

ISSUE LOG:

SHEET CONTENTS:

PLAN

SHEET NO:

P1

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DESIGN DEVELOPMENT - NOT FOR CONSTRUCTION  
April 9, 2021

DMH RECOVERY  
RESIDENCE



COLCHESTER,  
VERMONT

fff PROJECT NO:  
A2005.00

ORIGINATION DATE: 04/09/2021 SCALE: 1/8" = 1'-0"

DRAWN BY: ADH CHECKED BY: Checker

ISSUE LOG:

SHEET CONTENTS:

PLAN

SHEET NO:

P1

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**Vermont Department of Mental Health  
Secure Residential Recovery Facility**

C-Table 1  
Project Costs

<b>Construction Costs</b>	
1. New Construction	\$ 9,367,227
2. Renovation	\$155,614
3. Site Work	1,755,746
4. Fixed Equipment	162,250
5. Design/Bidding Contingency	\$978,136
6. Construction Contingency	\$592,682
7. Construction Manager Fee	622,642
8. Other (please specify)	55,121
Subtotal	\$ 13,689,418
<b>Related Project Costs</b>	
1. Major Moveable Equipment	\$ -
2. Furnishings, Fixtures & Other Equip.	\$400,000
3. Architectural/Engineering Fees	\$1,406,717
4. Land Acquisition	-
5. Purchase of Buildings	-
6. Administrative Expenses & Permits	\$977,250
7. Debt Financing Expenses (see below)	5,427,136
8. Debt Service Reserve Fund	-
9. Working Capital	-
10. Other (please specify)	-
Subtotal	\$ 8,211,103
<b>Total Project Costs</b>	<b>\$ 21,900,521</b>

<b>Debt Financing Expenses</b>	
1. Capital Interest	\$ 5,297,871
2. Bond Discount or Placement Fee	-
3. Misc. Financing Fees & Exp. (issuance costs)	129,265
4. Other	-
Subtotal	\$ 5,427,136
<b>Less Interest Earnings on Funds</b>	
1. Debt Service Reserve Funds	\$ -
2. Capitalized Interest Account	-
3. Construction Fund	-
4. Other	-

Subtotal	\$ -
<b>Total Debt Financing Expenses</b>	<b>\$ 5,427,136</b>
feeds to line 7 above	

**C-Table 2**  
**Debt Financing Arrangement, Sources & Uses of Funds**

1. Financing Instrument	GO Bond	
a. Interest Rate	3.75%	
b. Loan Period	Jun 2021	To: Jun 2040
c. Amount Financed		\$ 14,224,793
2. Equity Contribution		21,900,521
3. Other Sources		
a. Working Capital		-
b. Fundraising		-
c. Grants		-
d. Other		1,875,207
<b>Required Funds</b>		<b>\$ 38,000,521</b>

\$ (16,100,000)
-----------------

**Vermont Department of Mental Health  
Secure Residential Recovery Facility**

C-Table 3B  
Income Statement  
Project Only

	Latest Actual	Proposed Year 1 2023	Proposed Year 2 2024	Proposed Year 3 2025
<b>Gross Patient Revenues</b>				
Resident Care Revenue	N/A	\$ 8,728,727	\$ 8,878,982	\$ 9,189,747
(Free Care & Bad Debt)	N/A	\$ -	\$ -	\$ -
Other Operating Revenue	N/A	\$ -	\$ -	\$ -
<b>Total Operating Revenue</b>	<b>\$ -</b>	<b>\$ 8,728,727</b>	<b>\$ 8,878,982</b>	<b>\$ 9,189,747</b>
<b>Operating Expense</b>				
Salaries (Non-MD)	N/A	\$ 3,631,297	\$ 3,758,392	\$ 3,889,936
Fringe Benefits (Non-MD)	N/A	2,748,374	\$ 2,844,567	\$ 2,944,127
Operating Expense	N/A	\$ 1,871,641	\$ 1,781,898	\$ 1,844,265
Contracts	N/A	477,415	\$ 494,125	\$ 511,419
<b>Total Operating Expense</b>	<b>\$ -</b>	<b>\$ 8,728,727</b>	<b>\$ 8,878,982</b>	<b>\$ 9,189,747</b>
<b>Net Operating Income (Loss)</b>	<b>N/A</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
Non-Operating Revenue	N/A	-	-	-
<b>Excess (Deficit) of Rev Over Exp</b>	<b>N/A</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Secure Residential Recovery - no inpatient or outpatient services  
Cost of initial set up is included in year 2 - 2023

**Vermont Department of Mental Health  
Secure Residential Recovery Facility**

C-Table 6B  
Revenue Source Projections  
Project Only

	Latest Actual	% of	Proposed	% of	Proposed	% of	Proposed	% of
	0	Total	Year 1 2023	Total	Year 2 2024	Total	Year 3 2025	Total
<b>Gross Resident Revenue</b>								
Medicare	N/A		-	0.0%	-	0.0%	-	0.0%
Global Commitment (Federal portion)	N/A		4,848,356	55.5%	4,932,499	55.6%	5,106,527	55.6%
Commercial	N/A		-	0.0%	-	0.0%	-	0.0%
Self Pay	N/A		70,949	0.8%	70,949	0.8%	70,949	0.8%
(Free Care / Bad Debt)	N/A		-	0.0%	-	0.0%	-	0.0%
State General Fund matched	N/A		3,809,422	43.6%	3,875,535	43.6%	4,012,271	43.7%
	N/A		\$ 8,728,727	100.0%	\$ 8,878,982	100.0%	\$ 9,189,747	100.0%

Vermont Department of Mental Health  
Secure Residential Recovery Facility

Proposal to replace TABLE 7

UTILIZATION PROJECTIONS  
TOTALS

B: PROJECT ONLY		Proposed	Proposed	Proposed
	Latest Actual 0	Year 1 2023	Year 2 2024	Year 3 2025
<b>Inpatient Utilization</b>				
Staffed Beds	N/A	16	16	16
Admissions	N/A			
Resident Days	N/A	5,840	5,840	5,840
Average Length of Stay	N/A		-	-
<b>Adjusted Statistics</b>	N/A	-	-	-
Adjusted Admissions	N/A	N/A	N/A	N/A
Adjusted Patient Days	N/A	N/A	N/A	N/A

Footnote: staffing will equal a licensed bed



**Vermont Department of Mental Health  
Secure Residential Recovery Facility**

C-Table 9  
Staffing Projections  
Totals

<b>B: PROJECT ONLY</b>		<b>Proposed</b>	<b>Proposed</b>	<b>Proposed</b>
	<b>Latest Actual</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
	<b>0</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>
<b>Non-Clinical FTEs</b>				
Secure Residential Program Dir (Exempt?)	N/A	1.0	1.0	1.0
Administrative Services Coordinator III	N/A	1.0	1.0	1.0
(DMH) Quality Control Specialist III	N/A	1.0	1.0	1.0
Staffing Office Manager (Staffing)	N/A	1.0	1.0	1.0
Mental Health Scheduling Coordinator (Staffing)	N/A	5.0	5.0	5.0
Food Service Worker	N/A	2.0	2.0	2.0
Cook C	N/A	2.0	2.0	2.0
Supervising Chef	N/A	1.0	1.0	1.0
<b>Total Non-Clinical FTEs</b>		<b>14.0</b>	<b>14.0</b>	<b>14.0</b>
<b>Clinical FTEs</b>				
Nurse Supervisor	N/A	1.0	1.0	1.0
Registered Nurse II; Clinical Specialty Nurse (Med)	N/A	4.0	4.0	4.0
Registered Nurse III; Charge, Clinical Specialty Nurse	N/A	5.0	5.0	5.0
Activity Therapist	N/A	2.0	2.0	2.0
Social Worker	N/A	2.0	2.0	2.0
DMH Psychologist	N/A	2.0	2.0	2.0
Mental Health Recovery Specialist (Peer)	N/A	2.0	2.0	2.0
Mental Health Specialist	N/A	24.0	24.0	24.0
Associate Mental Health Spec	N/A	5.0	5.0	5.0
Senior Mental Health Spec	N/A	2.0	2.0	2.0
<b>Total Clinical FTEs</b>		<b>49.0</b>	<b>49.0</b>	<b>49.0</b>
<b>Total FTEs</b>		<b>63.0</b>	<b>63.0</b>	<b>63.0</b>