STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Application of Department of Mental Health For the Construction of Secure Residential Treatment Program in Essex	))))	GMCB-002-21con

STATEMENT OF DECISION AND ORDER

Introduction

In this Decision and Order we review the application of the Vermont Department of Mental Health (DMH or "the applicant") for a certificate of need (CON) to develop a 16-bed secure residential treatment program in Essex for individuals requiring residential treatment program services for mental health conditions. The cost of the project is $21,900,521.

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

Procedural Background

1. On February 5, 2021, DMH submitted a Letter of Intent (revised on February 23, 2021) for its plan to develop a 16-bed secure residential treatment program in Essex for individuals requiring residential treatment program services for mental health conditions.

2. On February 11, 2021, the Board issued a Jurisdictional Determination confirming that the project is subject to CON review under 18 V.S.A. § 9434(a)(1).

3. On February 26, 2021, and March 1, 2021, respectively, Disability Rights Vermont, Inc. (DRVT) and MadFreedom, Inc. (MFI) submitted requests to intervene. Both DRVT and MFI were granted status as amicus curiae, but not as interested parties, on March 11, 2021. On March 8, 2021, the Office of the Health Care Advocate (HCA) filed a notice of intervention as an interested party under 18 V.S.A. § 9440(c)(9) and Green Mountain Care Board Rule 4.000, §4.406.

4. On May 1, 2021, DMH filed a CON application in this matter.

5. The Board requested additional information regarding the project on May 27, June 9, June 23, July 2, and July 16, 2021, which we received from DMH on June 7, June 17, June 28, July 15, and July 20, 2021, respectively.

6. The Board closed the application on July 23, 2021, and a hearing was held via Microsoft Teams and in person at GMCB Offices at 144 State Street, Montpelier, on August 4, 2021.

7. On August 2, 2021, DMH submitted a presentation for the hearing at the Board's request and on August 3, 2021, the HCA submitted questions for DMH to address at the hearing.

8. At the August 4 hearing, a representative of DRVT supported the outdated Middlesex facility's replacement but expressed concern that the planned facility is too large and questioned classifying it as a community facility because of its institutional nature. Public comments reflected concern about the size of the facility and the ability to attract and retain staff given housing shortages in the region. In addition, public comment recommended the following CON conditions, that the project be identified as institutional, not community-based; that it be able to separate into two fully functional wings; and that stakeholders be involved in choosing amenities such as furniture.

9. Following the hearing, the HCA submitted written comments on August 9, 2021, in which the HCA recommended that the Board adopt the conditions suggested during the public comment period. The applicant submitted Responses to Post Hearing Questions on August 10, 2021, with a correction submitted on August 11, 2021. Public comments were open until August 17, 2021, with written comments, including letters from DRVT, reflecting similar concerns to those expressed at the public hearing, a comment urging quick approval of the application, and a comment expressing support for the project's potential to ease burdens on Level 1 hospitals and emergency rooms.

Jurisdiction

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

Findings of Fact

10. The Vermont Department of Mental Health (DMH) proposes to build a 16-bed secure residential treatment program at 26 Woodside Drive located off Route 15 in Essex. The former Woodside Youth Rehabilitation Facility located on the property will be substantially demolished except for a portion of the gymnasium and a new building will be constructed to house the secure residential treatment program. The property is owned by the State of Vermont and the facility will be state-operated. The site includes 10.2 acres, 5.4 acres of which is developed. Application (App.), 12-13. The secure residential treatment program replaces a 7-bed program in Middlesex known as the Middlesex Therapeutic Community Residence (MTCR), which was developed on a temporary basis to meet a critical need following Tropical Storm Irene. App., 10, 12.

11. 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 *Vermont State Hospital Futures Plan. (VSH Futures Plan)*. App., 10; DMH August 4, 2021 PowerPoint Presentation (DMH pres.) at 9; Testimony of Karen Barber, Tr. 16:22 – 25. When Tropical Storm Irene closed the Vermont State Hospital in 2013, 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." Act 79 (2012) § 1a (codified at 18 V.S.A. § 7255); Act 160 (2012); App., 10.

12. Under the Mental Health System of Care Bed Continuum (Continuum), mental health care is classified based on level of intensity. From most intensive to least intensive the range of care options are: 1) Level One Inpatient Hospital Beds, 2) General Inpatient Hospital Beds, 3) Secure Residential Beds, 4) Specialized Enhanced-Funded Beds, 5) Intensive Recovery Residential (IRR) Beds, 6) Mental Health Crisis Beds, 7) Mental Health Group Homes, 8) Transitional Staffed Housing, and 9) Independent Living vouchers with services attached. DMH pres. at 24. Testimony of Karen Barber, Tr. 23:22 – 24:16.

13. The secure residential facility is the third most intensive level of care under the Continuum. *See* DMH pres. at 24. The 16-bed facility will be licensed as a Therapeutic Community Residence (TCR) pursuant to 33 V.S.A. § 7102(11) and will meet the definition of a "secure residential recovery facility" for an individual who no longer requires acute inpatient care but who does continue to need treatment in a secure setting for an extended period of time. The term "secure" in this context means that residents can be physically prevented from leaving the facility by means of locking devices or other mechanical or physical mechanisms. App., 22, 29-30; 8 V.S.A. § 7620(e). The facility would meet the federal definition of an institution of mental disease (IMD) if it had more than 16 beds. It is a goal of the applicant not to be considered an IMD so that Medicaid funding can be used. Testimony of Karen Barber, Tr. 80:6 – 14. *See* 42 U.S.C. § 1396d(i).

14. The project will address the needs of persons for whom the Commissioner of Mental Health seeks continued treatment in a secure setting other than an inpatient psychiatric hospital, pursuant to an Application for Continued Treatment filed in Superior Court, family division. App., 22, 29-30. The admissions process to a secure residential facility occurs only through an order of non-hospitalization (ONH) as the result of a legal proceeding through which the resident is placed involuntarily into the custody of the Commissioner of Mental Health. The prospective resident is represented by counsel during the proceeding. Through the ONH, a judge makes a specific finding that there is no less restrictive alternative than a secure residential placement. Testimony of Karen Barber, Tr. 17:16 – 24 and 36:1 – 5.

15. The average current occupancy at the existing seven-bed program in Middlesex typically exceeds 90% capacity for services at this level of care. Lack of additional capacity leaves Vermonters without access to the mental health services needed when they are ready to step down from inpatient hospitalization. App., 22, 29.

16. The existing state-run MTCR was opened in 2013 under an Emergency CON issued in 2012. Docket No. 11-106-H. The existing facility is comprised of trailers and was intended to be temporary. It is functionally obsolete and requires constant repair to the structure, ramps and

fencing. DMH pres. at 20; Testimony of Karen Barber, Tr. 21:20 – 22:2. The 7-bed facility has had annual occupancy rates between 82% and 95% over the past seven years. DMH pres. at 21.

17. The Legislature has given consideration to the quality and organization of mental health care within the state. DMH has been directed to study the need for secure residential beds by the Legislature on multiple occasions. In 2014, pursuant to Act 178 (2014), DMH identified a need for a secure residential facility that could accommodate at least 14 residents. Act 178 (2014) § 35. Resp. (June 17, 2021), 4.

18. In 2019, DMH presented a report to the Legislature pursuant to the requirements of 2018's Act 200. Subsequently, in January 2020, DMH presented to the Legislature a 10-year plan, *Vision 2030, A 10-Year Plan for an Integrated and Holistic System of Care. (Vision 2030)*. App., 11; DMH pres. at 14; *see* Act 200 (2018) § 9.

19. In December 2019, pursuant to Act 26, 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), IRR facilities, and secure residential recovery facilities. This report outlined the population served, number of beds needed, justification for ongoing need, and the funding request in the FY capital bill. In 2019, the legislature allocated $3 million in FY 2020 and $1.5 million in FY 2021 for land acquisition and predevelopment activities for the new secure residential facility. DMH pres. at 15-16; *see* Act 26 (2019) § 2; Act 42 (2019) §§ 3(a)(1) and (c)(1).

20. In 2020, DMH submitted the *Analysis of Residential Bed Needs Report* (*2020 Needs Report*) which found that at any given time, seven to ten individuals could step down from an inpatient psychiatric hospital level of care to a physically secure recovery residence if capacity were available. Resp. (June 17, 2021), 5; App., 17.

21. Funding of $11.6 million was allocated to the Secure Residential Recovery Facility design and construction of a 16-bed facility in 2021. Act 50 (2021) §§ 3(a)(1) and (c). DMH testified before House and Senate committees in support of this funding, as did psychiatric survivors, peers, and advocates. DMH pres. at 17, 23.

22. The proposal of a 16-bed program will address the current need, unmet demand, and future need illustrated by the data. According to the *2020 Needs Report*, several factors contribute to the need for 16 beds to replace the current 7-bed facility. These factors include the number of inpatient individuals with no discharge options due to the acuity of their conditions; MTCR's waitlist from Level 1 inpatient psychiatric hospital units; and the number of individuals who, without a residential option such as MTCR, would require inpatient treatment. DMH pres. at 23.

23. The decision to construct a facility with 16 beds was made by the Legislature. In appropriating the funds, the Legislature specified that the funds "shall be used to construct a 16-bed Secure Residential Recovery Facility … for transitional support for individuals who are being

discharged from inpatient psychiatric care." Act 50 (2021) § 3(c); Testimony of Karen Barber, Tr. 44:2 – 9.

24. The legislation further required that "through interior fit-up, versus building redesign, the 16-bed facility shall include two eight-bed wings designed with the capability to allow for separation of one wing from the main section of the facility, if necessary. Both wings shall be served by common clinical and activity spaces." Act 50 (2021) § 3(c). This potential separation is currently made possible by using fire doors. Laundry facilities and the serenity room are on only one side of the fire door. Testimony of Karen Barber, Tr. 55:14 – 56:16.

25. The need for a secure residential level of care of has continued despite an 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 the Middlesex facility are from inpatient (Level 1) psychiatric facilities unable to identify other adequate discharge options. Resp. (June 17, 2021), 5. Individuals served by the physically secure recovery residence have higher treatment needs and risk factors that impact public safety and exceed what community providers can offer. *Id.* The population proposed for this project requires support and supervision that would exceed staff-secure community care, as opposed to a physically secure recovery residence. Community care rarely is a viable option for the population to be served by the secure residential treatment program. App., 17.

26. Recent attention on "patient flow" highlights the need to increase bed capacity at the secure residential level of care and programming. With the current wait times at MTCR, patients in Level 1 beds who are ready to move to a secure residential facility cannot make that transition. In turn, this back-up results in additional wait times in emergency departments for individuals in need of placement in an inpatient psychiatric hospital setting. Resp. (June 17, 2021), 5. To achieve the desired outcome of improving flow in the mental health system of care and providing individuals step-down treatment from Level 1 inpatient care, the clinical attributes and programming that will be available at the secure residential treatment program are critical to Vermont's system of mental health care. Such settings have been shown effective with users experiencing high satisfaction. Such residential services help to prepare a resident for discharge by developing domestic and vocational skills, relating to others, and finding and maintaining suitable housing. App., 21. The program will allow people with challenging mental illness to continue their path to recovery in the community. The secure residential treatment program will improve movement of individuals through the system of care as each is ready, improve outcomes and satisfaction and ensure that the right level of care is available and delivered at the right time and setting. Research has shown that residential step-down models may offer an alternative, and less costly, approach to increasing acute psychiatric bed capacity for individuals with serious mental illness and may reduce emergency department stays. App., 22.

27. The health and well-being of Vermonters with serious mental illness is dependent on timely access to the proper level of care and treatment. Without such access, individuals may wait in an emergency room for many days, and in some cases, weeks before a bed in an appropriate setting

is available. Expanding the clinical and bed capacity of the secure residential treatment program is critical to improve flow and access to the appropriate level of care in the mental health system of care, which in turn, is expected to improve outcomes. App., 20. In addition to degraded care, the wait times incur unnecessary costs. The Level 1 hospitals, from which most referrals to secure residential treatment originate are more expensive than the proposed facility. Brattleboro Retreat costs $1,838.00 per day; Rutland Regional Medical Center costs $2,063 per day, and Vermont Psychiatric Care Hospital costs $2,660 per day. In contrast the proposed facility will cost approximately $1,661 per day (assuming 90% occupancy, or $1,776.00 per day including depreciation and interest). Post Hearing Questions (August 11, 2021), 2.

28. The residence will operate as a state-wide resource for adults meeting assessed need and eligibility for secure residential treatment program services. The length of stay is projected to be an average of six to eighteen months of treatment before transitioning to other community-based residential and mental health support services. App., 13.

29. The new building to house the secure residential treatment program will be a single-story residential-looking building with three wings and full attic for access to mechanical equipment and maintenance. The residence will offer locked-secure program services within the approximately 17,000 square foot structure. App., 13.

30. Design input was sought from current MTCR staff and residents, the advocacy community, and staff at similar-sized facilities. Testimony of Tabrena Karish, Tr. 25:11 – 14. Design plans include typical residential dining, living and relaxation spaces and single occupancy bedrooms with private bathrooms. Service space includes offices, treatment and wellness service space, and meeting spaces for residents, staff and visitors. The existing gym located on the site will be renovated for use and there will be outdoor and recreation space sufficient for a program of this size. A modern, privacy-enhanced, no-climb security fence will be installed. App., 13. The 11,840 sq. ft. outdoor space amenities include a paved walking loop, raised garden beds to support the greenhouse program, and lawn and patio areas with various seating options. A gazebo will be moved from Middlesex to this new site. There is also a covered patio area located outside of the dining room which accommodates seating for dining. Resp. (June 17, 2021), 4. Testimony of Karen Barber, Tr. 56:17 – 57:3.

31. The project will achieve the Quadruple Aims of healthcare: increasing the quality of care and patient experience; improving population health, wellness, and equity; lowering per-capita costs; and creating a better environment for Vermont's providers. DMH asserts that by embracing an integrated system that works collectively to address population health, wellness and equity, Vermonters will have improved access to care, and a more positive experience with care, which in turn may realize economic benefits. In particular, the project addresses the principle espoused in *Vision 2030's* Action Area 2, "Influencing Social Contributors to Health," that all Vermonters most basic needs are met, including food stability, housing, employment, transportation, affordable, accessible childcare, a medical home, and mental health services. App., 14-15; 32-34; 39.

32. The Essex program will remain the only IRR in Vermont offering a step-down locked, secure residential treatment program capacity. This level of care is not available in other Designated Agency (DA) or peer-run IRRs operating in Vermont. The quality of the care environment in the new residence will surpass what has been available in MTCR's temporary structure and location. The new living environment and programming available to residents will improve both access to, and quality of, services and programming and will improve resident well-being and 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 residents in their course of recovery. App., 37.

33. Expanding the secure residential treatment program will not duplicate an existing service. It will be the only state-wide setting for individuals with an ONH and will provide secure (locked) residential services. The additional beds in a locked residential setting will allow timely discharge of individuals requiring this level of care who might otherwise be held longer in an emergency department if this level of care was not available. App., 22-23. DMH efforts to solicit interest in developing comparable programs at this level by the private sector have been met only with preferences for staff-secure residential program development that would not be adequate for the population needing a secure, locked residential treatment level of care. App., 36.

34. The applicant has addressed how it will continue to collect and monitor data relating to quality and outcomes at the Essex program. The existing seven-bed secure residential treatment program tracks data elements similar to data tracked by DAs and peer-operated community-based IRRs. Tracked metrics include length of stay; discharge disposition; number of admissions over-all and by year; referral sources; staff training; client or staff event reporting and bed occupancy rates; reasons for not admitting referrals; resident level of care (LOCUS) scores; employment outcomes; and consumer, family member, and community partner survey outcomes. The Broset Violence Checklist (BVC) is utilized with residents to assist in reviewing indicators of violent or dysregulated behavior when planning activities, group participation and appointment transport. Medication side-effect monitoring tools such as Abnormal Involuntary Movement Scale (AIMS) are used if certain psychotropic medications are part of the treatment plan. Wellness Recovery Action Plan (WRAP) is utilized when residents have completed such plans. Staff are, and will continued to be, trained to engage residents, and support them in the initiation and development of the WRAP self-help and supporter-help tools if residents wish to develop their plans during residency. The Essex program will continue to track these metrics and regularly review satisfaction rates and measures of engagement with residents, their significant others, and family. While screening for co-occurring treatment needs for each resident is part of admission screening and on-going assessment and individualized treatment plan development, tool tracking and scoring for the subset of the current population has not been consistently collected but will include additional quality metrics at the new program. App., 23.

35. The applicant has addressed how staff members will be made aware of evidence-based practice guidelines and how they will be incorporated into decision-making. The existing seven-

bed program 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 psychiatric hospitalization to a secure residential program need a higher level of oversight and support services than an unlocked residential program. Additional capacity at the Essex program allows individuals to transfer out of Level 1 inpatient units to a secure but less restrictive level of care facilitating progress in their overall health and recovery goals. The treating team at the existing and new program are actively engaged in on-going evidence-based practices development and skill training to enhance their engagement strategies and tools with the residents in the program. Staff are trained in using Beck Institute's Recovery-Oriented Therapy (CR-T), a cognitive therapy model embodying the principles and spirit of the recovery movement to promote empowerment, recovery, and resiliency in individuals with serious mental health conditions. Staff are also familiar with Open Dialogue, a model of mental health care that emphasizes listening and understanding and engages the social network from the very beginning with the resident, rather than relying solely on medication. In addition, staff use dialectical Behavioral Therapy (DBT), motivational interviewing, de-escalation skills, decision-making strategies, and de-briefing with residents. The use of best practices will allow individuals to transition from the most restrictive level of care and receive intensive residential support services. The residential design of the new program facility is also important and calming with easy access to outdoor settings. Large windows allow in as much natural light as possible and neutral colors throughout the residence helps create a calming environment. Adding capacity at the new secure residential treatment program is expected to improve the movement of individuals through the mental health system, improve outcomes, and ensure that care is delivered at the right time and in the right setting. App., 24-26.

36. Staff members are trained in informed care. DMH has established an anti-racism working group to address trainings in cultural competency and health equity. They are working on trainings with the deaf and hard-of-hearing communities. Testimony of Samantha Sweet, Tr. 48:5 – 19.

37. The new secure residential treatment program residence will follow 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 and other evidence-based systems. The residence will also have a Respirator Protection Program Policy following the guidance of OSHA to keep staff and residents safe and prevent the spread of infection in the facility. App., 26-27.

38. The project will implement an integrated and holistic treatment approach including mental health treatment, substance use disorder, and physical health. The program will have trained mental health specialists staffing the daily function of the program. Psychiatrists, psychologists and licensed social workers/licensed mental health counselors will be available to provide on-going assessments, treatment plans, and discharge planning. Treatment plans will incorporate goals based on a holistic approach to wellness including mental, substance use and physical health. In-house licensed professionals will support residents with counseling, group therapy and wellness activities. The program will also work with community partners to help residents meet treatment

and discharge goals. Residents will be supported in applying for financial benefits they may be eligible to receive. The program will have 24/7 on-site nursing to address any healthcare concerns of residents. The program will work collaboratively with community partners at local community health centers and primary care providers to ensure that health concerns of residents are addressed, and that follow-up occurs. Residents will be scheduled for an annual physical with their provider and additional services such as dental and vision care will be available to residents. App., 31. Resp. (June 17, 2021), 10-12.

39. Group work will address holistic health issues including, but not limited to, nutrition, sleep, hygiene, mindfulness, stretching, fitness, exercise, gardening, stress management, and Wellness Recovery Action Plans (WRAP). Mental health coordination with community partners and DAs will be central to the program. This is vital to successful discharge for residents to reintegrate back into their communities. The All-Payer Model's goals of increasing access to primary care, reducing deaths due to suicide and drug overdose, and working on reducing the incidence and morbidity of certain chronic diseases, are addressed by the new programming for the project. An assigned DA case manager for residents enrolled in a DA will be part of the treatment team to assure a smooth transition from the residential program into the community. DMH will work with community providers to access substance use disorder services that will be beneficial to the treatment and success for residents that are in addition to the counseling and group services provided at the residence. DMH will also ensure annual physicals and other primary care health needs, such as vision and dental concerns, are met. App., 31. Testimony of Kathy Hentcy, Tr. 50:10 – 52:9; DMH pres., 66-70.

40. DMH has planned to address staffing for the new facility. The MTCR staff accounts for half of the staff required for the new facility. The location, in the state's largest population center, will assist recruitment. DMH will engage with local undergraduate and graduate programs to recruit staff and interns. When needed, DMH will draw on its MTCR and Vermont Psychiatric Care Hospital contracts with traveling nurse companies to fill gaps in staffing, although it is still working on providing housing for traveling nurses. The project will require the addition of one additional social worker and one additional psychologist, which is expected to be feasible, given the presence of several local graduate level mental health degree programs in the area. Resp. (June 7, 2021), 2 and Resp. (July 15, 2021), rev. table 9. Testimony of Karen Barber, Tr. 68:23 – 70:11.

41. The expanded secure residential treatment program will not have an undue adverse impact on any other existing services provided by the applicant. The new 16-bed residential treatment program in Essex will expand and replace the existing seven-bed program which remains the only program of its type in the state. The ongoing need for this level of care and programming has been the subject of acts and reporting requirements to the legislature for the past several years. DMH remains the only entity fulfilling Act 79's statutory obligation to assure this level of care is both available and timely for persons ready to discharge from inpatients psychiatric hospitalization with an ONH requiring this type of secure residential treatment program. App., 37. DMH asserts that it will not take away funding from any other community program. DMH pres., 25. Testimony of Karen Barber, Tr. 24:20 – 22.

42. Occupancy rates were revised from the initial application to reflect 90% occupancy or 5,256 bed days per year. Resp. (July 15, 2021), 3 and Revised Table: Utilization Projections.

43. The State of Vermont will own and operate the project which has a total cost of $21,900,521. The project will be financed with $14,224,793 of General Obligation (GO) bonds at 3.725% interest and $1,875,207 in bond premium proceeds. An equity contribution by the State of $5,427,136 for debt financing expenses and an additional $373,385 in State funds are also available for the project. Resp. (July 15, 2021), 1-3 and Revised C-Table 2.

44. Original cost estimates were developed from the applicant's history building similar facilities and having their contractors provide estimates; they also looked at facilities in other states and found roughly the same cost. Testimony of Ralph Irish, Tr. 61:17 – 25. DMH is using a construction manager to prepare competitive bid packages. Testimony of Tabrena Karish, Tr. 30:2 – 3.

45. The applicant has requested CON approval by August 31, 2021, to allow site work to begin by October 1, 2021. In addition to needing time to demolish existing buildings, the soil conditions must be addressed before the ground freezes. If the applicant is not able to begin this fall, occupancy will be delayed by roughly five months and costs will increase between $250,000 and $650,000. Testimony of Tabrena Karish, Tr. 30:3 – 15; App., 6.

46. The project is not expected to increase the cost of medical care or have an undue impact on the affordability of medical care for consumers. The project may reduce the cost of medical care by reducing the number of unnecessary days of continued psychiatric hospitalization and waits in an emergency department for the population served. Timely transfer of persons to the right level of care when they need it supports the most efficient use of the health care system from both a cost and treatment perspective. App., 35.

47. The project does not need to be fully occupied to be financially viable. Federal medical assistance and state Medicare funds support the operations needs and expenditures of the facility, regardless of the number of residents. Testimony of Karen Barber, Tr. 44:22 – 45:3. No one will be denied care based on ability to pay and no one will be denied services on the basis of race, gender, sexual orientation, or age. Testimony of Karen Barber, Tr. 39:11 – 15.

48. The impacts on services, expenditures and charges are outweighed by the benefits of the project. Building a secure residential treatment program to replace the existing seven-bed program and add capacity at this level of care should reduce the institutional and individual harms created from shortages in this step-down level of care. Less expensive alternatives do not exist. The level of care and programming is not offered at any other hospital or clinical setting. The project will not negatively impact hospitals or other clinical settings. The site is suitable including its community location, privacy afforded by the site and potential availability of staff for the program. App., 35-36. Testimony of Karen Barber, Tr. 74:14 – 21; Post Hearing Questions (August 11, 2021), 2.

49. DMH anticipates that this project will fit within AHS's Global Commitment to Health Section 1115 Waiver Budget Cap. AHS's current Global Commitment to Health Section 1115 Waiver expires in December 2021 and AHS anticipates negotiating a budget neutrality cap that incorporates sufficient expenditure authority to capture all necessary costs of the demonstration waiver, including the future operating costs of the Secure Residential Treatment Facility. Testimony of Anna Strong, Tr. 63: 11 – 64:1; Post Hearing Questions (August 11, 2021), 1.

50. The project involves new construction and renovation to the existing gym located on the premises. The project is compliant with applicable 2018 Facility Guidelines Institute (FGI) guidelines or waivers have been sought in some instances. App., 28 and Resp. (July 20, 2021), 1-19. To the extent possible, energy efficiency measures have been incorporated into the project including the use of 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 pump system which allows for building heating, air conditioning and ventilation systems to be provided. App., 27-28 and 36. Efficiency Vermont provided a letter representing that the ground source heat pump system has the lowest life cycle cost. The primarily electric system aligns with the State's Comprehensive Energy Plans goal of reducing dependence on fossil fuels. Resp. (June 7, 2021), 57. The heating, cooling and ventilation systems will be supported via a closed loop geothermal system. The domestic hot water heating and snowmelt will utilize gas fired appliances as it was not economically feasible to utilize electric based systems for these items. Resp. (June 28, 2021), 1-2. The project aims to exceed the requirements of the Vermont Commercial Building Efficiency Standards. Testimony of Tabrena Karish, Tr. 26:5 – 7.

51. As a matter of statute (18 V.S.A. §7511), and DMH policy, persons subject to an ONH will access the Essex residential treatment program by involuntary transport or escort using the least restrictive means in each individual circumstance. Family, friends, and other visitors may access the residence by car, as the site is 1.7 miles from Exit 15 off I-89, or by Green Mountain Transit with a bus-stop that is 0.5 miles or an approximate nine-minute walk from the bus stop to the facility. App., 38.

52. The project does not involve the purchase or lease of new health information technology. DMH will maintain resident records in accordance with state, federal and licensing laws and regulations. Acquiring an electronic health record for this facility was cost prohibitive, given the small size of the residence. App., 38. DMH will consider adding an Electronic Medical Records if they go out to bid again for the Vermont Psychiatric Care Facility. Testimony of Karen Barber, Tr.58:19 – 22. Medical charts will be kept in the staff information center, a secure, locked area allowing treating providers and direct care staff access for documentation of all health care and treatment services. Each individual will have an individual, organized medical record that contains information and documentation of past and current treatment. Records 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 use treatment. App., 38

Standard of Review

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

Conclusions of Law

I.

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

All-Payer Model

Vermont's All-Paper Model is the state's payment and delivery system reform initiative which seeks to reduce cost growth for certain health care services and improve both the health of Vermonters and the quality of care they receive. The quality and population health goals of the All-Payer Model reflect statewide needs and priorities for health system reform and for improving the health of Vermont's population. *In re: Vermont All-Payer Accountable Care Organization Model Agreement* (Oct. 31, 2016), 6. The project addresses the All-Payer Model goals of increasing access to primary care, reducing deaths due to suicide and drug overdose, and working on reducing the incidence and morbidity of certain chronic diseases through the programming, mental health care, and medical care provided at the secure residence. Wellness skills, onsite individual and group counseling, coordination with community mental health partners, annual physicals, and dental and vision care are incorporated into the care provided on site. Findings, ¶ 38-39.

Current and Future Needs

The Applicant has shown that, with the conditions added, the proposed project aligns with statewide health care reform goals and principles. Development of a step-down secure residential treatment program with more bed capacity will facilitate the transition for individuals who no longer require acute inpatient care but who do continue to need treatment in a secure setting for an extended time. The existing gap in the current continuum of care is the provision of services that meet both the security and treatment needs of for this population. The project will address the needs of persons for whom the Commissioner of Mental Health seeks continued treatment in a secure setting other than in the most restrictive inpatient hospital setting, pursuant to an ONH. The existing seven-bed MTCR needs to be replaced because it is functionally obsolete and requires constant repair to the structure, ramps, and fencing. The demonstrated lack of sufficient beds at this level of care requires construction of additional capacity. The average current occupancy at MTCR exceeds 90% capacity for services at this level of care. Lack of additional capacity leaves

Vermonters without access to mental health services needed when they are ready to step down from inpatient hospitalization. *See* Findings, ¶¶ 13–16, 20.

Health Resources Allocation Plan

The project is also consistent with the HRAP,[1] which identifies needs in Vermont's health care system, resources to address those needs, and priorities for addressing them on a statewide basis. *See* HRAP Standards: 1.2 (expanding a specific health care service has been shown to improve health), Findings, ¶ 26-27; 1.3 (a collaborative approach to delivering service has been taken or is not feasible or appropriate), Findings, ¶¶ 33, 38-39 ; 1.6 (explain how the applicant will collect and monitor data relating to health care quality and outcomes), Findings, ¶ 34; 1.7 (the project is consistent with evidence-based practice), Findings, ¶ 35; 1.8 (the applicant has a comprehensive evidence-based system for controlling infectious disease), Findings, ¶ 37; 1.9 (construction projects show that costs and methods of construction are necessary and reasonable), Findings, ¶¶ 43-44, 50; 1.10 (that projects requiring construction are energy efficient), Findings, ¶ 50; 1.11 (that new construction is more appropriate compared to renovation), Findings, ¶¶ 16, 48; 1.12 (construction complies with current edition of Facility Guidelines Institute (FGI) Guidelines), Findings, ¶ 50; 3.3 (applicants adding inpatient capacity demonstrate that such capacity is needed by the service area population and that services are not available at neighboring hospitals), Findings, ¶¶ 11, 15, 20, 22-26, 32-33; 4.1 (applicants for inpatient mental health service shall include specific information about how the proposal relates to the VSH Futures Plan or subsequent plan), Findings, ¶ 11; 4.6 (demonstrate how integration of mental health, substance abuse and primary care will occur, including whether co-location of services is proposed), Findings, ¶ 38-39.

The replacement of the secure residential facility in Middlesex which was erected as a temporary facility following Tropical Storm Irene will ensure the availability of this step-down level of care to Vermonters. The new program in Essex will be the only program in the state at this level of care. DMH will continue to collaborate with community services, programs, and facilities during residents' stays, and in discharging residents from the secure residential program to community-based programs. Findings, ¶¶ 10-11, 32-33, 38-39.

Based on the information above, and with the conditions we impose in the CON, we conclude that the applicant has met the first criterion.

II.

Under the second statutory CON criterion, an applicant must demonstrate that the cost of the project is reasonable because the applicant's financial condition will sustain any financial burden likely to result from completion of the project and because the project will not result in an undue increase in the costs of medical care or an undue impact on the affordability of medical care for consumers. The Board must consider and weigh relevant factors, such as "the financial implications of the project on hospitals and other clinical settings, including the impact on their

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

services, expenditures and charges [and whether such impact] is outweighed by the benefit of the project to the public." Under the second statutory criterion, the applicant must also demonstrate that less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate; and if applicable, that the project has incorporated appropriate energy efficiency measures. 18 V.S.A. § 9437(2).

The State of Vermont will own and operate the project which has a total cost of $21,900,521. The project will be financed with $14,224,793 of General Obligation (GO) bonds at 3.725% interest and $1,875,207 in bond premium proceeds. An equity contribution by the State of $5,427,136 for debt financing expenses and an additional $373,385 in State funds are also available for the project. Findings, ¶ 43.

We further find that the project will not unduly increase the cost of care, will not unduly impact the affordability of care for consumers, and any fiscal impact is outweighed by the benefit of the project to the public. Findings, ¶¶ 46-48. The benefits of the project to the public are that the number of beds at this level of care will increase and that these 16 beds are the only beds available on the continuum of care at this level in the state. Findings, ¶ 48.

Efficiency Vermont provided a letter representing that the ground source heat pump system has the lowest life cycle cost. The primarily electric system aligns with the State's Comprehensive Energy Plans goal of reducing dependence on fossil fuels. The appropriate energy efficiency measures have been included in the project. Findings, ¶ 50.

Finally, the applicant has demonstrated that less expensive alternatives do not exist. The selection of the site for the secure residential treatment program in Essex is owned by the State and is suitable including its community location, privacy afforded by the site and potential availability of staff for the program due to its location in Chittenden County. Findings, ¶ 10, 40, 48.

We conclude that the applicant has satisfied the second criterion.

III.

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

In appropriating the funds for the project and specifying its capacity to be 16 beds, the Legislature determined the need for the project after extensive study. Findings, ¶¶ 17-24. The project will address the needs of persons who are subject to an ONH and require treatment in a secure setting for an extended time. It will replace the applicant's MTCR, which was intended to be temporary, is in need of replacement, and typically exceeds 90% capacity. Virtually all referrals to MTCR are from inpatient psychiatric facilities unable to identify other adequate discharge options. Findings, ¶¶ 13-16, 25.

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

IV.

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

The project improves the quality of health care and maintains and supports access to a critical service in the continuum of care that is available to Vermonters. Findings, ¶¶ 31-32. Specifically, the project will greatly improve the care and programming available compared to the temporary facility that is currently in place.

We find that the applicant has met this criterion.

V.

The fifth criterion requires that an applicant demonstrate that the project will not have an undue adverse impact on any other services it offers. 18 V.S.A. § 9437(5).

The project is not expected to have an adverse impact on any other services offered by DMH. This project expands the number of beds DMH currently offers at an existing secure residential treatment program at a temporary location in Middlesex. DMH asserts that it will not take away funding from any other community program. Findings, ¶ 41.

The project will not take funding away from other projects under the Global Commitment budget cap. Findings, ¶ 49.

We find that this criterion has been satisfied.

VI.

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

VII.

The seventh statutory criterion requires that an applicant adequately consider the availability of affordable, accessible transportation services to the facility, if applicable. 18 V.S.A. § 9437(7).

As a matter of statute (18 V.S.A. §7511), and DMH policy, persons subject to an ONH will access the Essex residential treatment program by involuntary transport or escort using the least restrictive means in each individual circumstance. Family, friends and other visitors will access the residence by car, as the site is 1.7 miles from Exit 15 off I-89 or via Green Mountain Transit with a bus-stop which is .5 miles or an approximate nine-minute walk from the bus stop to the residence. Findings, ¶ 51.

We find that this criterion has been satisfied.

VIII.

The eighth statutory criterion states that if the application is for the purchase or lease of new Health Care Information Technology, it must conform to the Health Information Technology Plan. 18 V.S.A. § 9437(8).

The project does not involve the lease or purchase of a new Health Care Information Technology. DMH will maintain 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 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. Records 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 use treatment. While paper record-keeping is no longer the standard in health care with the shift to electronic medical records, DMH has established that a stand-alone EMR is cost-prohibitive and that they will consider procurement in conjunction with the Vermont Psychiatric Care Facility when its EMR is re-procured. Findings, ¶ 52.

We find that this criterion has been satisfied.

IX.

An applicant must show that the proposed project will support equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care, as appropriate. 18 V.S.A. § 9437(9).

No one will be denied services due to inability to pay, or on the basis of race, gender, sexual orientation, or age. Findings, ¶ 47. A variety of mental health professionals will be available to treat and support residents in a holistic manner, including assessments and treatment plans integrating mental and physical health and substance use treatment. Group work will address holistic health issues and mental health coordination with community partners will facilitate residents' reintegration back into their communities. Findings, ¶¶ 38-39. Consistent with research showing the benefits of residential step-down models, the program will improve movement of individuals through the system of care as each is ready, will improve outcomes and satisfaction, and will ensure that the right level of care is available and delivered at the right time and in the right setting. Findings, ¶ 26-27.

X.

Finally, an applicant must demonstrate that the proposed project "serves the public good." 18 V.S.A. § 9437. This aspect of our review is broad and necessarily includes our consideration, and the applicant's satisfaction, of the statutory criteria considered above. *See* GMCB Rule 4.000, § 4.402.3.

We have three concerns related to the project, which we seek to address with the conditions set forth in the certificate of need.

First, we recognize that extensive consideration and review led to the Legislature's determination that the project is needed, and that the capacity should be set at 16-beds. Findings, ¶¶ 17-24. The Legislature also added the requirement that "through interior fit-up, versus building redesign, the 16-bed facility shall include two eight-bed wings designed with the capability to allow for separation of one wing from the main section of the facility, if necessary. Both wings shall be served by common clinical and activity spaces." Act 50 (2021) § 3(c). We infer from this provision that the Legislature acknowledged a need for flexibility in configuration to address future shifts in system-wide needs and demands. The benefits of designing this facility to accommodate multiple future uses is readily apparent to us. Geriatric psychiatric care or IRR Beds are two of many possible uses if the building turns out to have excess capacity. We share the concern expressed by the HCA and some public comments that the fire door solution does not leave two fully functioning wings. Without access to the laundry facilities or the serenity room, the experience of the segregated rooms may fail to meet the standards DMH espouses. Therefore, we will add a condition to the certificate of need that DMH confer with stakeholders and architects to review alternatives to the current fire-door division without materially increasing the overall cost of the project. Ultimately, the decision lies with DMH.

Second, while we recognize the time and effort DMH has spent conferring with stakeholders about this project, we believe there is still an opportunity for affected individuals and groups to have input on furniture and finishes before the final selections are made. We want the voices of those with lived experience to be heard on this matter and, therefore, direct DMH to confer with stakeholders on furniture and finishes, without materially increasing the overall cost of the project. As with the interior fit-up, ultimately the decision lies with DMH.

Third, as the HCA, DRVT, and public comments observed, the classification of the secure residential facility as a community resource is inapt. DMH consistently acknowledged that residents of the facility are involuntarily placed there; the security requirements include physical barriers and are more than a community facility can provide. In addition, the facility would meet the federal definition of an "institution of mental disease," but for the number of beds. Findings, ¶¶ 13-14. When reporting on financial and health care data, DMH shall classify information pertaining to the facility either in its own category or distinguish it in some way from the community facilities that are less restrictive pursuant to the continuum of care.

With the conditions described above, and included in the certificate of need, we find that the applicant has satisfied this criterion.

XI.

The applicant has requested its Certificate of Need prior to August 31, 2021, so that it can address soil conditions prior to the ground freezing. Missing this window of opportunity could cost between $250,000 and $650,000 and delay occupancy by roughly five months. Findings, ¶ 45. According to Rule 4.000, § 4.500(2), the holder of a Certificate of Need may not obligate funds or

commence work until after the deadline for filing an appeal has passed, or all appeals are final. Given the time-sensitive nature of the soil remediation, and the importance of replacing the functionally obsolete MTCR, the Board Chair, pursuant to his authority under Rule 4.000, § 4.800(1), hereby waives the restriction set forth in Rule 4.000, § 4.500(2) and allows the applicant, at its own cost and risk, to begin the expenditure of funds at the time this certificate of need is issued. Provided, however, that if the HCA, the only intervenor in this matter, files a notice to appeal, all such work should cease immediately.

Conclusion

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

SO ORDERED.

Dated: August 18, 2021 at Montpelier, Vermont.

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

*Member Usifer was not present for the hearing and did not participate in the vote on this matter.

Filed: August 18, 2021

Attest: s/ Jean Stetter, Administrative Services Director
Green Mountain Care Board

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by email, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (email address: donna.jerry@vermont.gov).