Dartmouth Health

Southwestern Vermont Medical Center

June 17, 2024

Donna Jerry, Health Care Administrator
Green Mountain Care Board
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Montpelier, VT 05633

RE: **Docket No. GMCB-014-23con, Development of an Inpatient Mental Health Unit for Adolescents**
Answers to questions dated May 2, 2024

Below find answers to questions about the Certificate of Need (CON) application from Southwestern Vermont Medical Center (SVMC) to create an inpatient mental health unit for adolescents (ages 12-17) on SVMC's Bennington Campus.

Architectural

1. Explain in detail why a construction contingency of 15% is required.

The scale of the construction contingency was influenced by several factors;

- The original construction estimate was conducted in January 2023, nearly 2 years prior to the actual construction (see timeline in CON application). The uncertain construction marketplace is anticipated to continue to drive cost variability
- The original construction estimate was based on schematic diagrams only. Post obtaining the CON, adjustments to the schematic design will be made during detailed design to better accommodate the clinical program. These design adjustments typically increase construction costs.
- The original construction estimate was based on visual inspection of the space only. Accommodating hidden structural features or challenges may increase construction costs.
- The project will occur in one of the older buildings on the SVMC campus, for which infrastructure documentation is limited. It is very likely that the project will identify infrastructure challenges that will impact construction costs
- Building a mental health unit requires specialized materials (ligature free, shatter and shock resistant, etc.). The cost of specialized materials fluctuates more than typical construction materials

Building a mental health unit in an old hospital building carries significantly more cost risk than typical health care construction projects.

2. Explain in detail the need for the 15% construction materials and labor escalation and provide historical data supporting the 15% number.

The initial cost estimate was conducted in January 2023, nearly 2 years prior to the actual construction. Construction escalation factors typically anchor to the midpoint of the construction schedule, so projecting the project cost into the future for slightly more than 24 months was prudent. Current hospital construction is scaling at 6% per year.[1] Estimating construction costs for challenging healthcare projects with long and uncertain lead times is more art than science. Escalation factors and contingencies create necessary project cost buffers given the inherent project uncertainty. After obtaining the CON and advancing the project to the start of construction, SVMC would be willing to submit an updated project costs estimate (with contingency) that would include learnings from the detailed design process and an updated the project timeline.

Programmatic/Number of Beds/ED Stays/Other Levels of Care

3. The Brattleboro Retreat (Retreat) maintains it currently operates 23 adolescent inpatient beds with the ability to flex to 27, and on page 38 of the application it is stated that the Retreat maintains 10-14 beds, and that SVMC states on pages 37-38 of the application that queueing theory calculates the need for 0 to 12 additional adolescent inpatient beds. Explain in detail the number of existing inpatient adolescent beds at the Brattleboro Retreat you used in your planning and analysis and explain and quantify how you arrived at the need for 12 additional adolescent inpatient beds to be developed at SVMC.

At the time of the Request for Proposals from the Department of Mental Health and the development of the feasibility study, the capacity at the Brattleboro Retreat was constrained by staffing challenges to 10-14 staffed mental health beds for adolescents. In the feasibility study, the calculated statewide demand for beds was discounted by the known availability of staffed beds at the Brattleboro Retreat to determine the additional bed capacity needed in Vermont. The expansion of capacity at the Brattleboro Retreat since the development of the feasibility study alters the quantitative estimates of additional bed capacity needed. However, the demand for inpatient mental health care by Vermont adolescents continues to exceed the capacity of the Brattleboro Retreat, thereby supporting the need for a second inpatient unit in Vermont.

During the last seven months, 12 adolescents have waited in SVMC's chaotic emergency department for more than 48 hours before being transferred to an inpatient mental health facility. Across the state's emergency departments adolescents experiencing mental health crisis are still enduring similarly extended wait times.

As described in the feasibly study, two data sources are frequently offered to determine the state-wide need for inpatient adolescent mental health care:

[1] Hospital construction costs increase | Health Facilities Management (hfmmagazine.com)

- Vermont Association of Hospitals and Health Systems (VAHHS) wait time report that tracks the number of adolescents in VT emergency departments waiting for a mental health inpatient admission
- Vermont Department of Mental Health FY2021 statistical report which conveys the magnitude and pattern of inpatient admissions

Although both of these reports illuminate the need for more adolescent mental health beds because demand is high and adolescents are waiting for placement, neither report has sufficient detail to quantitatively estimate the number of needed inpatient beds in Vermont. For example, the VAHHS point-in-time count of individuals waiting in emergency departments across Vermont does not indicate whether the individuals are the same individuals that were in previous counts. Without more detail these reports are insufficient to quantitatively estimate the number of additional inpatient mental health beds needed for Vermont adolescents. However, the reports do indicate a need for additional inpatient mental health beds for adolescents.

The feasibility study attempted to use two quantitative approaches to approximate statewide demand for inpatient mental health care by Vermont adolescents;

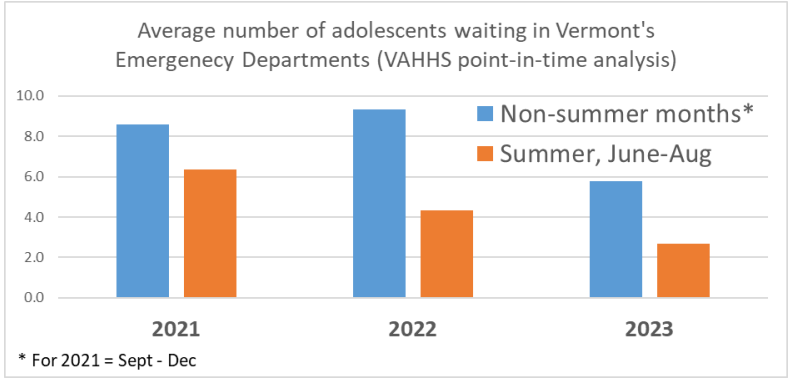
a. A population based analysis leveraged inpatient mental health beds per 100,000 youth in Massachusetts to estimate that Vermont needs 18 total inpatient mental health beds for adolescents. The current quoted adolescent bed capacity at the Brattleboro Retreat (23 beds, with ability to flex to 27) exceeds this demand estimate (18 beds) suggesting that no additional inpatient mental health beds for adolescents are required in Vermont. At the time of development of the feasibility study, the capacity at the Brattleboro Retreat was constrained by staffing challenges to 10-14 staffed mental health beds for adolescents. In the feasibility study, the calculated statewide demand for beds was discounted by the known availability of staffed beds at the Brattleboro Retreat to determine the additional bed capacity needed in Vermont; 18 statewide demand minus 10 to 14 staffed beds, equals 4 to 8 additional beds needed. The expansion of capacity at the Brattleboro Retreat since the feasibility study alters the estimates of additional bed capacity needed perhaps suggesting that no additional inpatient mental health beds for adolescents are required in Vermont. However, this simple calculation is likely incorrect.

   The population analysis described above is limited because more than 60 youth are still boarding in Massachusetts emergency departments according to the most recent Massachusetts Behavioral Health Boarding Metrics Report (appendix 1). The boarding is acerbated by full capacity of all statewide staffed mental health beds nearly every day. The Massachusetts boarding report provides insufficient detail to quantitatively predict the additional bed capacity needed in Massachusetts. Together the data simply shows that the bed capacity in Massachusetts does not meet demand. If Vermont utilized the population based approach derived from Massachusetts and provided only 18 total inpatient mental health beds, adolescents would continue to board in Vermont emergency departments. The number of needed inpatient mental health beds for Vermont's adolescents cannot be precisely and quantitatively determined by this approach. As such, this approach cannot inform the number of additional inpatient

mental health beds needed in Vermont above those at the Brattleboro Retreat regardless of whether the Brattleboro Retreat has 10, 14, 23, or 27 available beds.

b. Claims data from the Vermont Association of Hospitals and Health Systems (VAHHS) and queueing theory offered an alternative method to estimate statewide demand. The approach suggested that between 0 and 12 additional inpatient mental health beds were required in Vermont. Again, this estimate utilized the historic limited capacity at the Brattleboro Retreat (10-14 staffed beds) to determine the number of additional beds needed. Claims from July 2021 to June 2022 indicate that approximately 48 Vermont residents age 12-17 per quarter were experiencing mental health crisis, in a Vermont hospital emergency department, and stayed in the emergency department for more than 2 midnights suggesting their need for a higher level of mental health care and a delay in accessing inpatient mental health care. Assuming a random start of the inpatient stay and a 15 day length of stay, queueing theory calculates the need for additional beds to be between 0 and 12. The broad range of the queueing prediction reflects the temporally variable demand created by the population of 48,000 Vermont adolescents.

The shortcomings of these approaches is why The American Psychiatric Association created a detailed model to estimate the number of adolescent psychiatric beds required to meet community demand[2]. Although effective, this comprehensive model requires more than 40 input parameters including; population size, incidence of acute mental health crisis per 100,000 adolescents, capacity of outpatient mental health counselors, capacity of school-based programs, availability of mobile crisis units, regulatory process times, and delays in admission approvals. Most of the model's parameters have not been quantified across Vermont, making the model's utility impractical for calculating the additional number of inpatient mental health beds needed. Moreover many of the parameters are dynamic. For example, the capacity of school-based programs changes during school vacations. The dynamism of the demand for inpatient mental health beds is also driven by changes in the number outpatient mental health services and capacity anywhere in the state. For example, an outpatient counselor reducing or expanding their hours of service in Middlebury or the opening an intensive outpatient program in St Albans would alter the demand for inpatient mental health beds across the whole state through secondary impacts. In addition, the demand for inpatient mental health beds for adolescents is dynamically related to other aspects of society. For example, the demand for adolescent inpatient mental health beds declines during summer months, when schools are

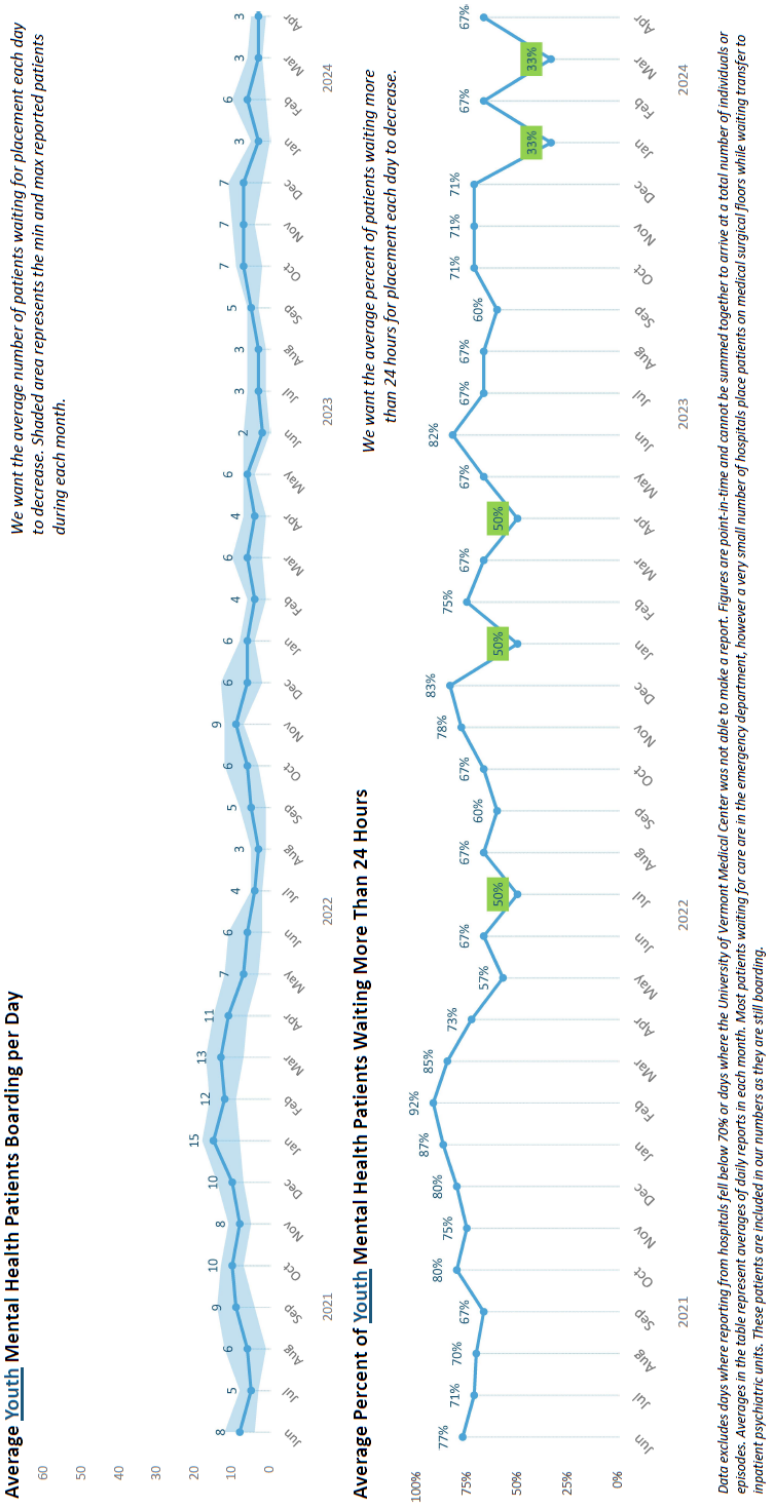


[2] Report of the Presidential Task Force on Assessment of Psychiatric Bed Needs in the United States. Published in August 2022 Issue of The American Journal of Psychiatry (Psychiatry.org - Psychiatric Bed Crisis Report)

typically not in session (see adjacent graph). This finding should not encourage Vermont to permanently close its schools to benefit the mental health of adolescents. Rather this fact should deepen the appreciation that so many factors influence the statewide demand for inpatient mental health care by adolescents that it is nearly impossible to definitively determine the number of inpatient adolescent mental health beds needed in Vermont. Because demand is difficult to determine and demand is dynamic, it is challenging to ascertain whether the capacity at the Brattleboro Retreat (10, 14, 23, or 27 beds) is sufficient to meet demand.

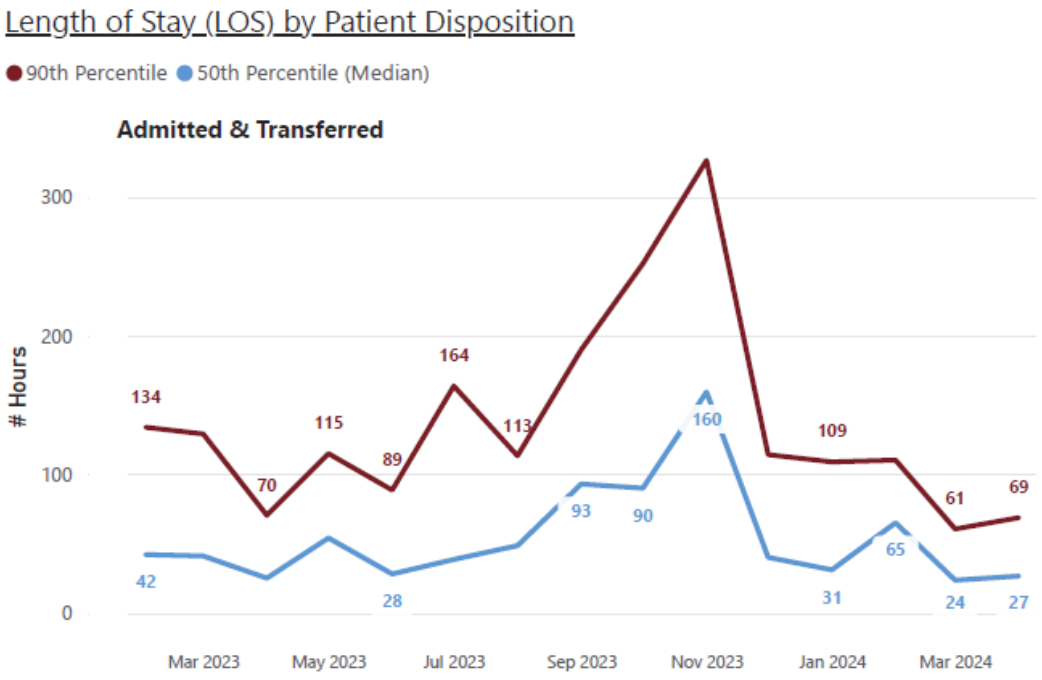
SVMC appreciates that this explanation can appear obtuse and frustrating and therefore offers an alternative qualitative perspective anchored in available facts. Adolescents across Vermont are waiting in emergency departments for excessive durations of time for inpatient mental health care. The most recent VAHHS wait time report shows that at any given time there are 3-8 adolescents waiting in Vermont's emergency departments (graph below and full report in appendix 2). The dark blue line in the top graph of the image below shows the average number of adolescents waiting gleaned from 6 to 8 point-in-time assessments throughout each month. The light blue shading shows the maximum and minimum number of adolescents waiting derived from point-in-time assessments throughout each month.

Waiting adolescents have been documented at every point-in-time assessment since 2021. The average wait time is frequently more than 24 hours as shown in the bottom graph. The majority of the waiting adolescents are deemed voluntary (appendix 2, page 6). Although the Brattleboro Retreat has expanded staffed bed capacity, adolescents in need of inpatient mental health care are still waiting an excessive amount of time in Vermont's emergency departments.



Data excludes days where reporting from hospitals fell below 70% or days where the University of Vermont Medical Center was not able to make a report. Figures are point-in-time and cannot be summed together to arrive at a total number of individuals or episodes. Averages in the table represent averages of daily reports in each month. Most patients waiting for care are in the emergency department, however a very small number of hospitals place patients on medical surgical floors while waiting transfer to inpatient psychiatric units. These patients are included in our numbers as they are still boarding.

Data from Vermont's syndromic surveillance system, which collects real-time data from Vermont's emergency departments also shows that adolescents in mental health crisis are waiting in emergency departments for long lengths of time (graph below and full report in appendix 3). Half of the adolescents are frequently waiting more than 24 hours and at least 10% of the adolescents are waiting longer than 2.5 days.



The data from SVMC's emergency department mirrors the VAHHS and state surveillance data and allows a more detailed analysis. During the first 7 months of SVMC fiscal year (October 1, 2023 – April 30, 2024), SVMC's emergency department treated 98 adolescents (age 12-17) with a mental health primary diagnosis. Twenty-two percent of those adolescents were eventually transferred to an inpatient mental health facility.

Disposition of Adolescents in SVMC Emergenecy Department

Primary Diagnosis	**Medical**	**Mental**
Number of patients	491	98
Percentage of patients	83%	17%
Discharge Disposition		
Home	90%	74%
Left Without Being Seen	8%	2%
Trans to Acute Care Hospital	2%	1%
Trans to psychiatric facility	0%	22%

Adolescents with a mental health condition, on average stay in SVMC's emergency department 9.5 times longer than their counterparts with medical conditions. Those adolescents being transferred to a mental health facility linger in SVMC's emergency department 19 times longer than adolescents being transferred to an inpatient medical facility.

Length of Stay In SVMC Emergency Department (hours)

Patient type and discharge disposition	Average (hours)	Multiple of Medical Ave LOS (x-times)	Minimum (hours)	Maximum (hours)	Multiple of Medical Maximum LOS (x-times)
Medical	**3.40**		**0.50**	**23.00**	
Home	3.35		0.50	23.00	
Left Without Being Seen	3.36		0.72	10.15	
Trans to Acute Care Hospital	5.16		1.58	15.83	
Mental	**32.39**	**9.5**	**0.48**	**384.65**	**16.7**
Home	11.28	3.4	1.15	99.55	4.3
Left Without Being Seen	3.98		2.65	5.32	
Trans to Acute Care Hospital	94.88		94.88	94.88	
Trans to psychiatric facility	102.20	19.8	0.48	384.65	24.3
Grand Total	**8.22**		0.48	384.65	

More than 80% of the adolescents that were eventually transferred to a mental health facility for inpatient care, waited in SVMC's emergency department for longer than 24 hours. ***More than 50% of the adolescents waited for more than 2 days.*** Four patients remained in the chaotic, non-mental health healing environment of SVMC's emergency department for more than 10 days.

Percent of cases relative to Length of Stay in SVMC Emergency Department

	Total pts	0-6hrs	6-12 hrs	12-24 hrs	24-48 hrs	more than 48 hrs
Medical	**491**	**94%**	**5%**	**1%**	**0%**	**0%**
Home	440	95%	5%	1%	0%	0%
Left Without Being Seen	39	90%	10%	0%	0%	0%
Trans to Acute Care Hospital	12	67%	25%	8%	0%	0%
Mental	**98**	**52%**	**11%**	**9%**	**10%**	**17%**
Home	73	66%	15%	8%	5%	5%
Left Without Being Seen	2	100%	0%	0%	0%	0%
Trans to Acute Care Hospital	1	0%	0%	0%	0%	100%
Trans to psychiatric facility	22	5%	0%	14%	27%	55%

Lastly, Vermont adolescents deserve choice. The care approach provided by the Brattleboro Retreat is excellent, however, it does not align with the needs of all of Vermont's adolescents. Independent outpatient mental health counselors have indicated that some adolescents have request that they not be sent back to the Brattleboro Retreat. This is not an indictment of the care or patient experience at the Brattleboro Retreat but rather affirmation that patients should have choice. SVMC's mental health unit would be an alternative for these patients that need inpatient care and currently go without.

The need is apparent for an inpatient mental health unit for adolescents in addition to the unit at the Brattleboro Retreat.

4. **Explain in detail the extent to which SVMC considered whether the mental health impacts of the COVID-19 pandemic temporarily led to an increased need for adolescent inpatient mental health services and whether as the pandemic recedes, the need for inpatient services may also recede. Additionally, please explain whether SVMC's data and statewide data has observed a decline in the number of adolescents waiting in EDs for inpatient mental health services since the end of the public health emergency.**

The feasibility study did not consider the impacts of the COVID-19 pandemic in creating temporary demand for inpatient mental health care by adolescents. No study was identified that indicates that mental health challenges in adolescents are waning. Although the recent months of the VAHHS wait-time data (see figure above) shows a slight decline in the

number of adolescents in mental health crisis waiting in emergency departments, adolescents are still waiting a very long time indicating a continued need for more inpatient mental health capacity in Vermont (appendix 2).

5. **The Feasibility Study states that the "available space could accommodate up to 12-bed rooms." Explain in detail whether SVMC considered constructing the inpatient unit with fewer bedrooms that might create an environment more conducive to healing. For example, is it clinically appropriate to locate a seclusion room directly across the hall from the "noisy social space"?**

   SVMC did consider a unit with fewer than 12 beds. However, SVMC attempted to maximize the unit's capacity for several reasons;
   a. Building a unit is expensive and maximizing the bed capacity provides the largest return for the state's investment. Much of the unit is support spaces that are required and beneficial regardless of the number of beds. To optimize the investment to build the support spaces, it is best to maximize bed capacity within the space available
   b. Recruitment of providers to a larger unit is easier than to a smaller unit
   c. Larger units allow more peer-to-peer connection and therapeutic gains in group therapy than do smaller units

   The design submitted with the CON application should be considered a schematic design developed only to estimate project costs as is required by the CON process and not a final layout. Refining the layout has been underway. Through collaboration between clinicians from the Department of Psychiatry and the architects, the updated unit design had already relocated the noisy social space to near the outdoor space and away from the seclusion room.

   Individuals with lived experience and those that care for them will provide input into the detailed design after the CON is obtained.

6. **Your application states that the average wait times for adolescents in SVMC's Emergency Department (ED) is 31 hours. Explain in detail how the wait time is calculated. For example, does the 31 hours include all time starting when the adolescent patient arrives at the ED, when the adolescent is determined to be an appropriate candidate for transfer to an inpatient psychiatric unit, or when all the referral materials, labs, and consents have been completed and the patient is ready to transfer? Explain in detail whether the average wait time of 31 hours excludes adolescent patients who discharge from the ED to a placement other than an adolescent inpatient mental health bed.**

   The length of stay in the emergency department was calculated from the time a patient arrives at the emergency department to the time the patient leaves. The length of stay includes all triage, diagnostic work-up including laboratory tests and imaging, consults with specialists, treatment implementation, discharge planning, and discharge. SVMC

emergency department providers do not reliably document nor track the precise time a patient was determined a candidate for admission to an inpatient mental health unit. As such, it is not possible to calculate the duration of time a patient waits for an inpatient mental health bed. However, the overall length of stay is a strong proxy, and adolescents with mental health conditions have excessively long lengths of stay in SVMC's emergency department.

Adolescents with a mental health condition, on average stay in SVMC's emergency department more than 30 hours and 9.5 times longer than their counterparts with medical conditions. This includes patients discharged to a community setting and those being transferred to an inpatient mental health facility. Adolescents being transferred to a mental health facility linger in SVMC's emergency department for 102 hours (more than 4 days, on average) and 19 times longer than adolescents being transferred to an inpatient medical facility.

Length of Stay In SVMC Emergency Department (hours)

Patient type and discharge disposition	Average (hours)	Multiple of Medical Ave LOS (x-times)	Minimum (hours)	Maximum (hours)	Multiple of Medical Maximum LOS (x-times)
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The need is apparent for an inpatient mental health unit in addition to the one at the Brattleboro Retreat.

7. Explain in detail whether the average 31-hour stay in SVMC's ED is inclusive of populations that will not be served by SVMC's adolescent inpatient mental health unit, e.g. adolescents with some presentations of autism spectrum disorder.

It is possible that the data described in the question above might include a very few patients that will not be served by SVMC's inpatient mental health unit. However, removal of a few patients would not dramatically alter the calculations or the conclusion that adolescents in need of inpatient mental health care are lingering in SVMC's emergency department and emergency departments across the state.

8. **For the most recent 12-month period (specify months and year), in a table format provide the data supporting the number/percent of adolescents in SVMC's ED that have waited less than six hours, waited 6-12 hours, waited 12-24 hours, and waited longer than 24-hours before transferring to an inpatient adolescent psychiatric bed.**

   See data above. Data was analyzed for the last 7 months to align with SVMC's most recent fiscal year. More than 50% of the adolescents in need of inpatient mental health care waited for more than 2 days in SVMC's emergency department.

9. **Weekly data provided by VAHHS indicates that the state-wide monthly average for adolescent patients boarding per day in EDs ranges between two patients per day and seven patients per day. As these are averages, for the most recent 12-month period, provide the number of days when there were no adolescents boarding in EDs both at SVMC and statewide.**

   The VAHHS data does not have the granularity necessary to answer the question as posed. However, according to the VAHHS data, since 2021, every point-in-time assessment identified adolescents in Vermont's emergency department that were waiting for inpatient mental health care. That is more than 300 assessments – two assessments per week for over 150 weeks (appendix 2). Frequently, these adolescents had been waiting for more than 24 hours (appendix 2). The need to address boarding in Vermont's emergency departments of adolescents experiencing mental crisis has been effectively documented.

10. **Explain in detail whether the proposed adolescent inpatient mental health unit will accept pregnant adolescents, patients with brittle diabetes, wounds requiring daily wound care, and severe dehydration that accompanies an eating disorder.**

    The mental health unit at SVMC will consider admission of pregnant adolescents and patients with brittle diabetes, wounds requiring daily care, and dehydration that accompanies an eating disorder. None of these conditions will result in automatic rejection of admission. The clinical team will review each case individually and determine the clinical capability and capacity and to deliver the high-quality treatment the patient needs and deserves.

    The mental health unit at SVMC will admit patients whose care is within the scope-of-practice of the clinical care team. Each patient will be evaluated relative to the capability and capacity of the clinical team available. No adolescent should be admitted to a mental health unit that does not have the clinical capability to address the adolescent's unique mental health and medical needs.

    In partnership with Dartmouth Health's Department of Psychiatry, the clinical care team will be assembled after approval of the CON. The care team will determine the conditions within the scope of their training and capabilities.

SVMC anticipates providing inpatient mental health services to adolescents experiencing the following conditions:

- Severe Anxiety and Depression
- Suicidality
- Bipolar disorder
- Post-traumatic stress disorder
- Personality disorders

Prior to admission to SVMC's mental health unit the match between the patient's clinical needs and the capability and capacity of the clinical team will be assessed. Through support from SVMC's pediatricians and emergency medicine providers, the unit will serve adolescents with stable medical conditions in addition to their mental health condition.

The clinical team of SVMC's inpatient mental health unit may not be proficient at providing therapeutic management and subsequent safe discharge of select disorders:

- Anticipated difficult detoxification
- Some presentations of autism spectrum disorder
- Some developmental neurological disabilities
- Severe repetitive self-harm (head banging)
- Severe eating disorders
- Some teen pregnancies
- Severe communication disorders that would prevent therapy

Adolescents with these conditions may be served better at facilities that specialize in treating and managing these conditions.

The clinical team serving SVMC's unit will be assembled after the CON is approved. At that time, the initial clinical capabilities of the team will be clearer. It is anticipated that the clinical capabilities of the team will evolve and shift as the team gains familiarity and additional skills to best match clinical demand of adolescents in mental health crisis in Vermont.

11. SVMC indicates it will accept patients with stable medical conditions that the Retreat cannot accept. Provide information that demonstrates the Retreat cannot accept patients with these same stable conditions.

SVMC is not aware of admission practices at the Brattleboro Retreat, nor does it yet know the specific clinical capabilities of the clinical team serving SVMC's unit. Thereby it is not possible to accurately answer this question with a level or certainty that the question portends to request.

The original Request for Proposals (RFP #87) from the Department of Mental Health (appendix 4) sought to develop an inpatient mental health unit for children that included the ability to manage co-morbid medical conditions. Below is an excerpt of the scope of work from the Request for Proposals.

IV. SCOPE OF SERVICES REQUESTED

Vermont's System of Care is designed to serve a variety of emotional, behavioral, and mental health needs of children and adolescents by expanding the State's capacity to provide early and effective home- and community-based services to reduce reliance on residential and inpatient services, unless clinically required. While the goal may be to avoid inpatient treatment through early intervention, at times this level of care is needed and will result in the best possible outcomes for those youth and their families. Inpatient treatment for youth in Vermont is limited and only provided in one location in the state. This level of care for young Vermonters needs to be diversified to ensure that children and youth can access inpatient care at the right time and have their emergent needs fully addressed.

This RFP specifically addresses the unique needs of the population for the most intensive level of care provided through inpatient services. Psychiatric hospitalization provides intensive inpatient care designed to help stabilize the youth, provide for immediate treatment needs, and quickly return the youth to their prior care setting (often a lower level of residential or home-based care) in order to continue their course of treatment.

A. Population overview and additional information

1. **General target population for services**
   a) Children and youth up to age 18, male, female, and transgendered youth. Youth with high mental health acuity, including:
      (1) Acute mental health symptoms
      (2) Self-harming behaviors, suicidal attempts, and significant suicidal ideation
      (3) Homicidal ideation
      (4) Significant aggressive and violent behaviors
      (5) Substance use
      (6) Trauma and exposure to violence
      (7) Possible co-morbid medical or developmental disability needs
   b) Youth on voluntary and involuntary status
   c) Children and youth with Medicaid, commercial coverage, and private pay.

2. **Bed needs for the target population**
   a) Up to 12 beds, could involve age-specific units.

SVMC's mental health unit will admit patients with co-morbid medical and surgical conditions that typically would require hospitalized on a medical unit of a community hospital. For example, SVMC anticipates admitting adolescents:

- With severe asthma
- Requiring wound care
- Treated with medications through a peripherally inserted central catheter (PICC line)
- Necessitating an indwelling catheter.

SVMC has continuous pediatrician and surgeon coverage available to manage the inpatient medical and surgical needs of adolescents throughout everyday (24 hours / 7 days per week).

12. Explain in detail how the proposed inpatient adolescent mental health unit will contribute to a "comprehensive mental health ecosystem" (p. 29) when its services appear to replicate those available at the Retreat without adding capacity for specialized needs, such as adolescents with some presentations of autism spectrum disorder, some developmental neurological disabilities, or severe communication disorders.

The data presented above demonstrates that Vermont adolescents without specialized neurological or mental health disorders struggle to access inpatient mental health care. Because access to inpatient mental health care has been chronically limited some adolescents self-select to defer or delay seeking inpatient mental health care. The need is apparent for a non-specialized inpatient mental health unit in addition to the one at the Brattleboro Retreat.

The feasibility study noted that individuals with highly specialized neurological or mental health disorders are best treated in units that have particular capabilities for managing their care. Although, the mental health unit at SVMC wishes it could treat all patients in need of care, the capabilities of the care team will dictate the scope of patients admitted and thereby ensure that all patients treated at SVMC receive the high-quality care they deserve.

13. The application represents that the coordination of care in the SVMC adolescent inpatient mental health unit will prompt discussions about outpatient mental health resources available to adolescents after discharge (p. 30) and that the SVMC team will develop timely systems of discharge of adolescents to independent counselors and designated mental health agencies across the state. (Feasibility Study, p. 8.) Explain in detail the planning that SVMC had completed to avoid extended adolescent inpatient stays for patients who are ready to be discharged to a lower level of care, but for whom residential and outpatient services are not available.

SVMC has not conducted this work yet. The project time line submitted with the CON application indicates that this work will be conducted while the unit is being constructed (Nov

2024 – April, 2025). The SVMC clinical care team needs to be in place to facilitate relationships and coordination with other members in the mental health care ecosystem across Vermont. The SVMC clinical team will be recruited after CON approval (see timeline below that was submitted with the CON application), and this work will commence as soon as the team is assembled.

Time Line for Developing SVMC's Inpatient Adolescent Mental Health Unit

	2023			2024									2025											
	SVMC FY2024												SVMC FY2025											
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Approval Process																								
Compile CON application documents																								
Obtain CON																								
Preconstruction																								
Permitting (including Act250 permitting)																								
Design RFS																								
Task 1: Existing Conditons & Project Goals																								
Task 2: Schematic Design																								
Task 3: Construction Documents																								
Bidding and contractor selection																								
Construction																								
Demolition																								
Construction																								
Staffing																								
Recruit Staff																								
Establish contract with DH pediatric psych providers																								
Programming																								
Contract with LearnWell																								
Recruit teacher																								
Process for coordination with VT designated agencies																								
First patients																								

14. Explain in detail whether you have assessed that there are adequate resources to support adolescents both before and after an inpatient mental health admission, including sufficient residential beds, outpatient mental health counselors, school-based programs, crisis stabilization beds, and intensive outpatient programs. Also explain whether you are aware of any studies that have been conducted to determine whether Vermont youths are being recommended to inpatient services due to the lack of available services at the residential and outpatient levels of care.

The feasibility study conducted in collaboration with the Vermont Department of Mental health did not assess the entire mental health care ecosystem and thereby SVMC is not fully versed in which aspects of the ecosystem exhibit gaps beyond the inadequate number of inpatient mental health beds for adolescents. SVMC's subjective perspective is that many aspects of the mental health care ecosystem in Vermont could be bolstered to increase access and better meet the needs of adolescents. SVMC is not aware of any studies or anecdotal reports that "Vermont youths are being recommended to inpatient services due to the lack of available services at the residential and outpatient levels of care." Individuals experiencing mental health challenges recommended for inpatient care but must meet strict presentation and diagnosis criteria in order to be admitted. Only patients that meet the criteria for inpatient care will be admitted to SVMC's mental health unit. It is possible that adolescents without ready access to outpatient mental health services experience an escalation in their condition to a degree that requires inpatient care. Greatly expanding outpatient mental health services for adolescents might decrease demand for inpatient care, however, the current ecosystem likely needs additional access across the continuum – outpatient, inpatient, residential, etc. The successful healing of adolescents experiencing mental health crisis requires access to high quality inpatient care as well as consistent access to supportive outpatient care.

15. The Feasibility Study notes there may be other considerations beyond state-wide quantitative demand that might influence the decision of the number of inpatient adolescent mental health beds to build and operate at SVMC including whether all new inpatient adolescent beds should be in a single location and whether all new beds should be in southern Vermont in proximity to existing inpatient beds at the Retreat. Explain whether SVMC evaluated the feasibility of family members travelling to and from Bennington and what additional support and assistance families might need, such as lodging, to be near their child during the course of care.

As part of the feasibility study, SVMC did not evaluate travel challenges for families and did not create a plan to provide additional supports and assistance for families whose adolescents would be in SVMC's care. Although family travel and connectivity is an important consideration, such operational features were beyond the feasibility study scoped and completed in collaboration with the Department of Mental Health. SVMC and the Dartmouth Health Department of Psychiatry, which will be partnering to manage the unit, will establish processes to maintain communication and connectivity with family members that

supports the mental health healing of the adolescents receiving care.[3] SVMC's mental health unit will be fit with video technology allowing connectivity to distant technology-enabled family members. SVMC will work with families, for which technology-enabled connectivity is not possible or undesirable, to ensure adolescents and families remain connected and participate in mental health healing together.

We appreciate the Green Mountain Care Board's attention to the details of this important project.

James Trimarchi, Director Planning
802 440 4051
James.Trimarchi@svhealthcare.org

[3] Family members can be protective factors or sources of strain for an adolescent's mental health. The appropriate level of connectivity between an adolescent and each family member will be adjusted to maximize mental health healing of the adolescent. The evaluation and determination of the level of connectivity during inpatient care at SVMC will be done in close collaboration between the care team, patient, and family members.

Appendices:

Appendix 1 – Massachusetts behavioral health boarding metrics report

Appendix 2 – VAHH mental health patient wait time in emergency departments report

Appendix 3 – Vermont's syndromic surveillance report of lengths of stay in emergency departments

Appendix 4 – Department of Mental Health Request for Proposals to build an inpatient mental health unit for children

Appendix 1

CAPTURING A CRISIS
MASSACHUSETTS BEHAVIORAL HEALTH BOARDING METRICS

MASSACHUSETTS Health & Hospital ASSOCIATION

A Weekly Report from the Massachusetts Health & Hospital Association

The Current Behavioral Health Crisis

Behavioral Health (BH) boarding occurs when a patient must wait in an emergency department (ED) or medical-surgical floor until a BH bed is available. While boarding was a major issue for Massachusetts patients and hospitals before the pandemic, the effects of COVID-19 and increasing workforce shortages have worsened the situation and intensified the behavioral health crisis.

For years, the behavioral health system in Massachusetts and nationally has struggled with serious challenges relating to patient access, inadequate reimbursement, and workforce vacancies. The long-term effects of the COVID-19 pandemic and increased need for BH services continue to exacerbate these issues. Healthcare providers are also seeing a rising acuity of patients' behavioral health presentations, making the challenges facing the behavioral health system – including the paucity of clinical and support staff – more complex. EDs and medical-surgical units were not designed to handle the long-term needs of acute behavioral health patients, yet these settings now serve as the last available refuge for patients as they await appropriate placement.

This report examines both weekly and trending data from Massachusetts acute care hospitals on the number of behavioral health patients who are waiting for a psychiatric evaluation or who have had an evaluation and are awaiting a bed. The information is further broken down by patient age, and geographic region, and effect on staffed ED bed capacity.

Addressing the behavioral health boarding challenge will require a coordinated effort to:
1. increase physical capacity;
2. bolster and expand the entire behavioral healthcare workforce, including entry level mental health worker positions, as well as nurses, social workers, psychiatrists, and more; and
3. ensure the financial stability of behavioral health units and facilities.

Through partnership with the Executive Office of Health and Human Services and the state legislature, the inpatient psychiatric system added nearly 450 new inpatient psychiatric beds in 2021 and 2022, including both in psychiatric units at acute care hospitals and in freestanding psychiatric facilities, with additional beds to come in 2023. But fully staffing existing and newly licensed beds is a considerable barrier to opening new or expanded services. Much more needs to be done to ensure behavioral health patients have access to needed care, in particular by increasing the pipeline of staff, improving retention, and ensuring the sustainability of services.

Identified solutions to address the remaining behavioral health challenges include:

Ensuring hospitals are reimbursed for the care they provide to behavioral health patients accessing care in the ED, including commercial coverage for BH crisis evaluations and services provided to patients while they board. This provides facilities with the staffing and programmatic resources needed to care for those patients.

Continued development of the behavioral health workforce pipeline across all positions, including the use of American Rescue Plan Act funds in the Behavioral Health Trust Fund.

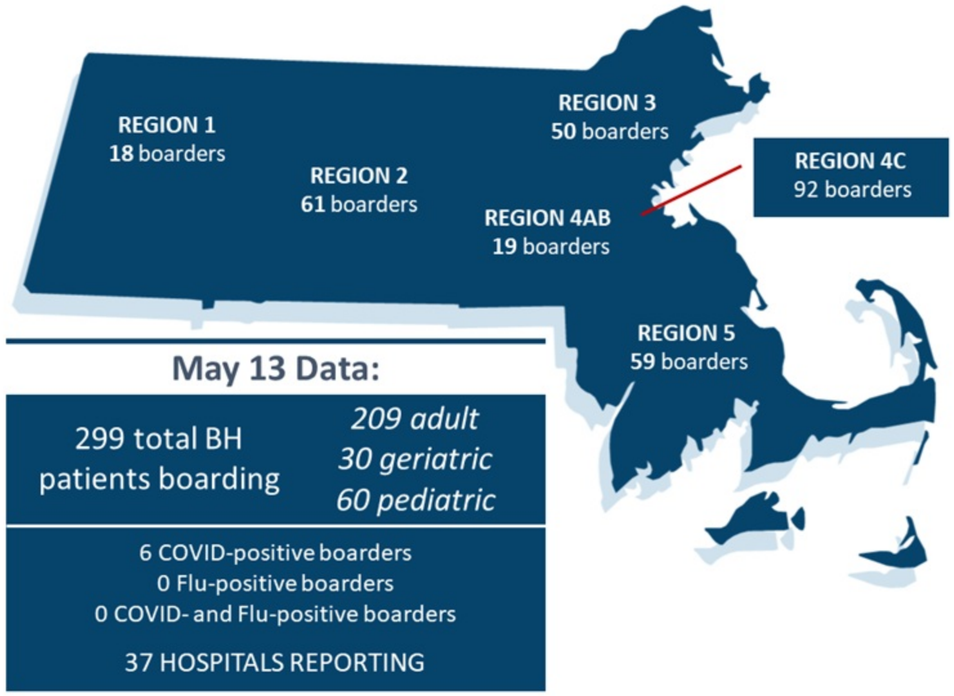
Creation of a Behavioral Health Rate Task Force to evaluate ways to ensure the financial stability of behavioral health units and facilities, and to allow behavioral health providers to pay their workforce adequate salaries.

Prohibiting clinical denials due to an administrative or technical defect in a claim, and requiring coverage of all medically necessary mental health services.

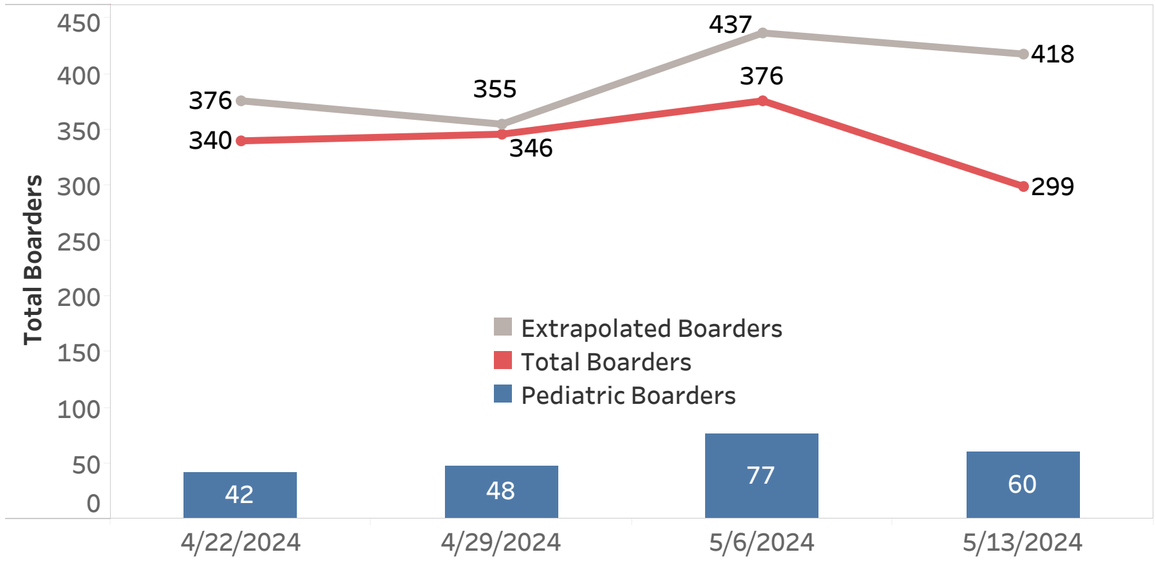
Reducing continuum of care challenges that create bottlenecks in the behavioral health system and limit patient access to needed services. Solutions include expanding availability of continuing care services, post-acute care transitions, community wraparound services, and congregate care programs.

Addressing administrative barriers such as Determination of Need requirements for providers expanding BH services, and insurance prior authorization/notification processes for providers.

MHA will continue to work collaboratively with its members, our partners in the behavioral health space, and the state to improve behavioral healthcare in these areas.



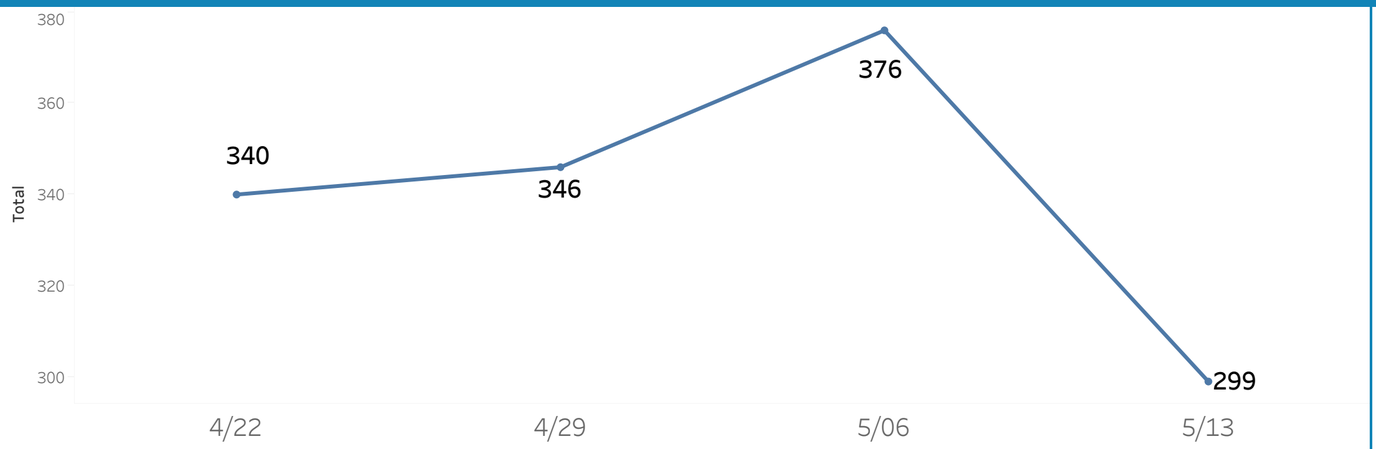
Statewide Total Trend:
All Boarders, Pediatric Boarders, and Extrapolated Total Boarders
(Including Non-Respondents) 4/22 - 5/13



The extrapolated total boarders line calculates the projected total number of boarders in a given week by including non-respondent hospitals' average number of boarders from its previous three weeks of submitted data. Pediatric numbers do not include extrapolated data for non-respondents.

Behavioral Health (BH) Patients Awaiting BH Evaluation & Boarding: Statewide Trend 4/22 - 5/13

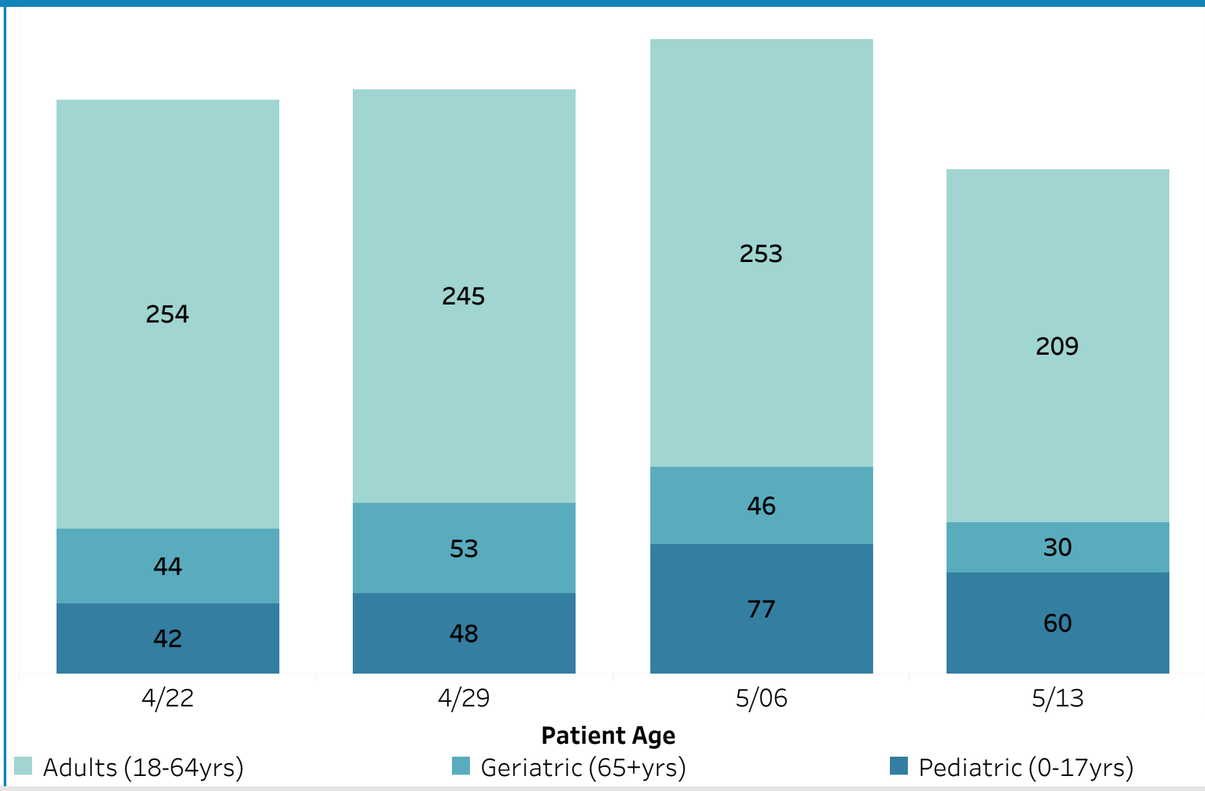
Statewide Total Trend: BH Patients Awaiting BH Evaluation & Boarding 4/22 - 5/13



Statewide Total Trend: COVID+ & Flu+ Patients Awaiting BH Evaluation & Boarding 4/22 - 5/13

	4/22	4/29	5/06	5/13
Total COVID-Positive Patients	4	6	5	6
Total Flu-Positive Patients	0	0	0	0
Total COVID-and Flu-Positive Patients	0	0	0	0

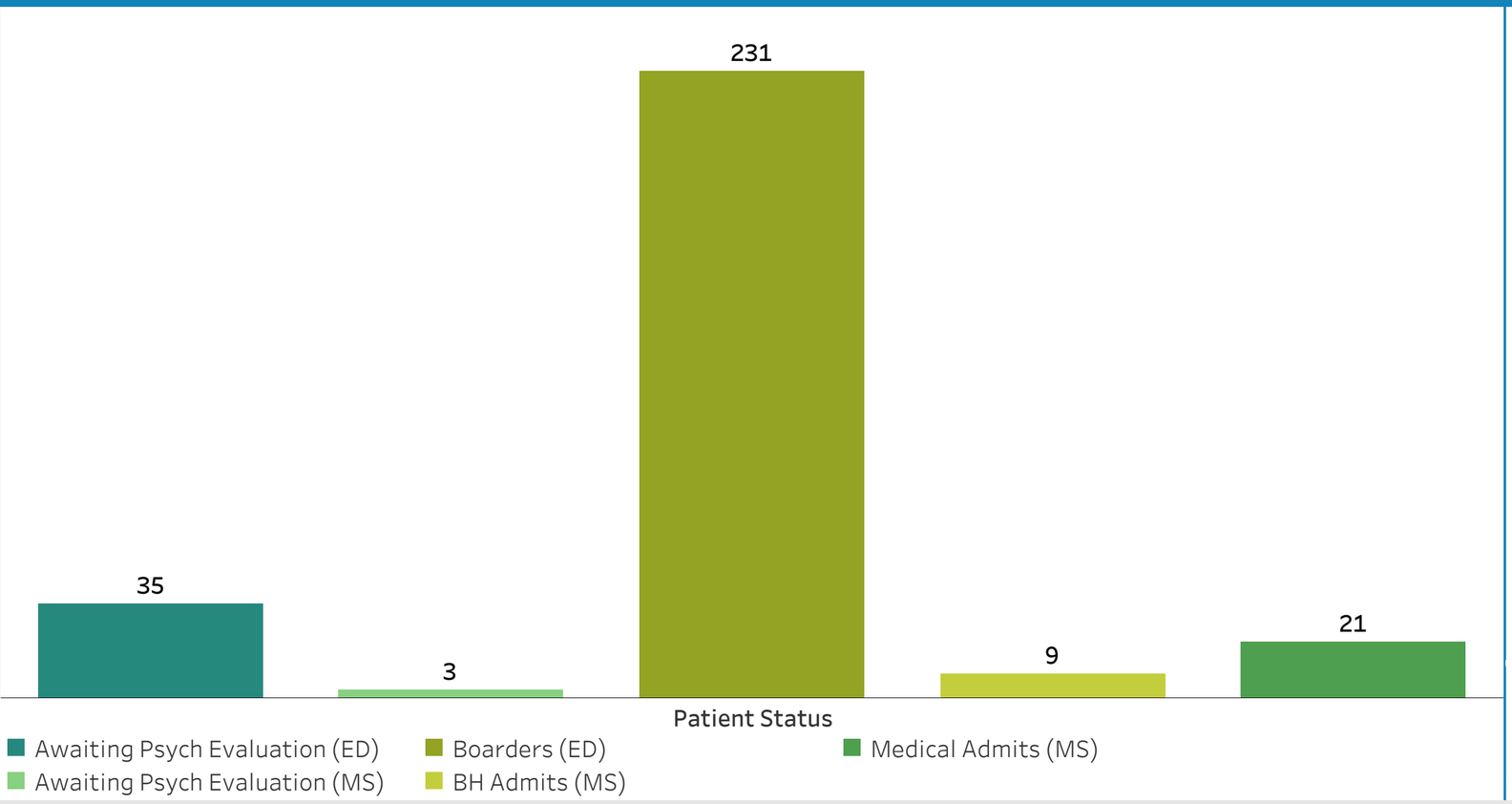
Statewide Age Distribution Trend: BH Patients Awaiting BH Evaluation & Boarders 4/22 - 5/13



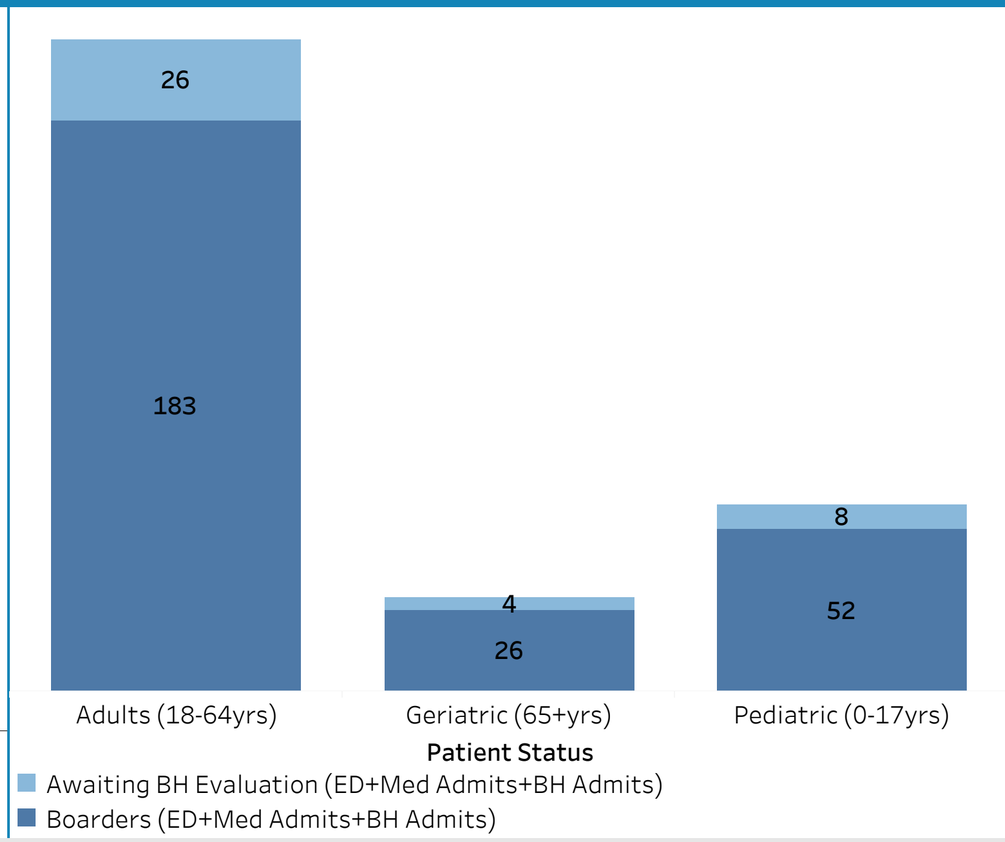
Please note that the number of hospitals reporting each week varies and can impact the statewide total. The number of respondents is as follows: 4/22 n=44; 4/29 n=50; 5/6 n=37; 5/13 n=37

BH Patients Awaiting BH Evaluation & Boarding: Statewide Snapshot on 5/13

Statewide Snapshot: Location and Patient Status 5/13



Statewide Snapshot: Age Distribution 5/13

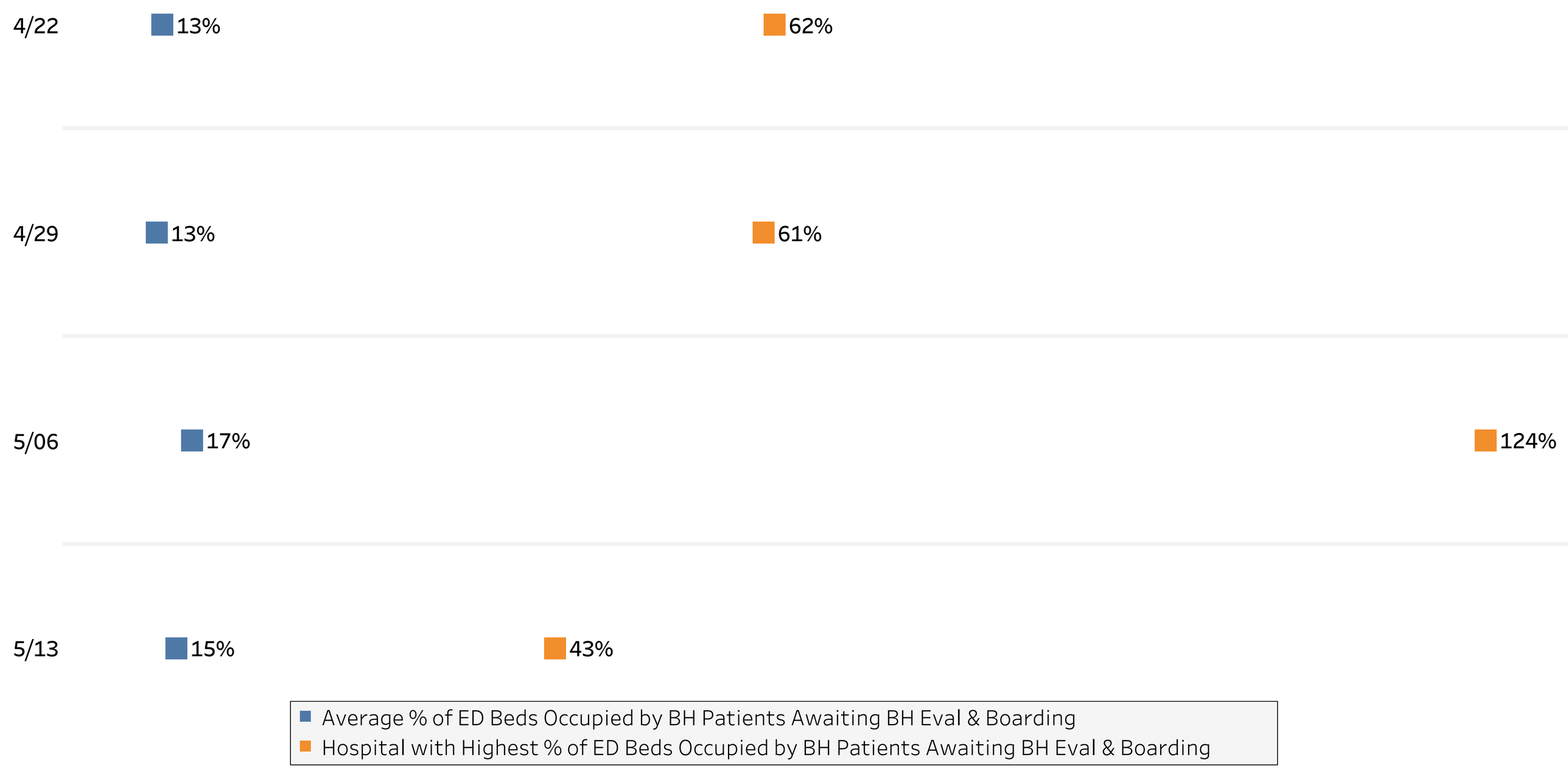


Psych = Psychiatric; Geri = Geriatric; Pedi = Pediatric. Please see page 7 for detailed notes, definitions, and categorizations.

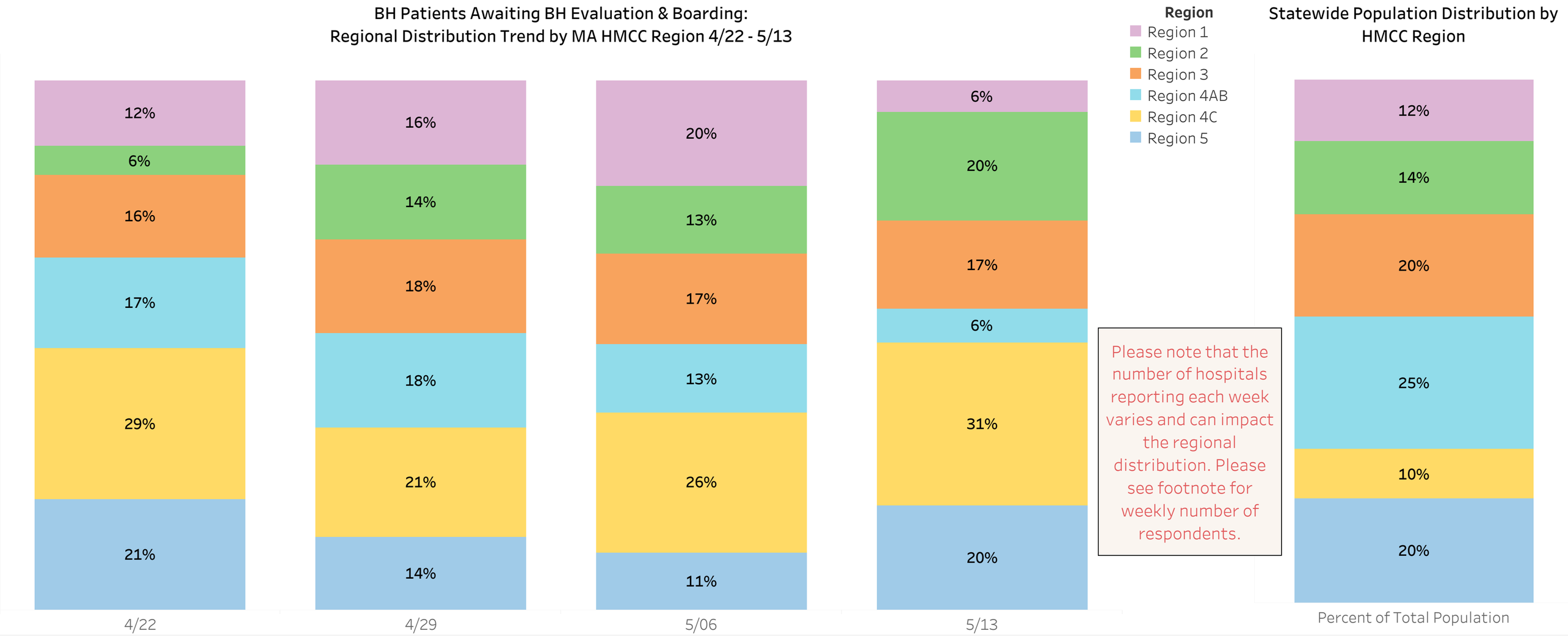
BH Patients Awaiting BH Evaluation & Boarding In Emergency Departments: Shown as Percentage of ED Staffed Beds

For the chart below, the blue square represents the **average** percentage of BH patients awaiting BH evaluation and boarding in the Emergency Department across reporting hospitals statewide as a percentage of reporting hospitals' staffed ED Beds. The orange square represents the hospital with the **highest** percentage of its staffed ED bed capacity occupied by BH patients awaiting BH evaluation and boarding in the ED. The number of staffed ED beds was obtained using data entered by each hospital into the Massachusetts Department of Public Health's (MDPH) WebEOC (Emergency Operations Center) system as part of daily COVID reporting. This data reflects the number of ED staffed beds for the previous week and is used to estimate the ED occupancy. **This chart does not include patients boarding or awaiting a BH evaluation on a medical-surgical floor.**

BH Patients Awaiting BH Evaluation & Boarding in the ED as % of Staffed ED Bed Capacity: **Statewide Average and Highest Individual Hospital** 4/22 - 5/13

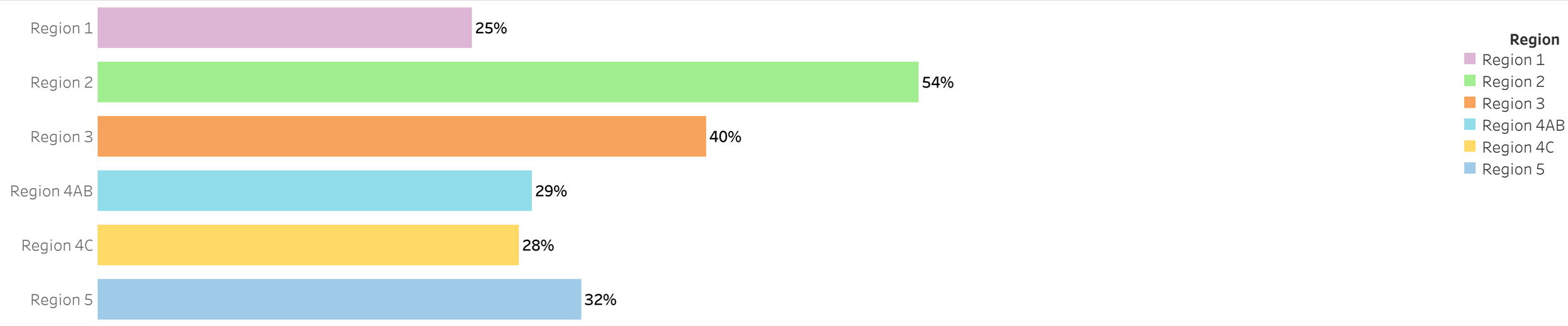


BH Patients Awaiting BH Evaluation & Boarding:
Regional Distribution by MA Health and Medical Coordinating Coalition (HMCC) Regions 4/22 - 5/13



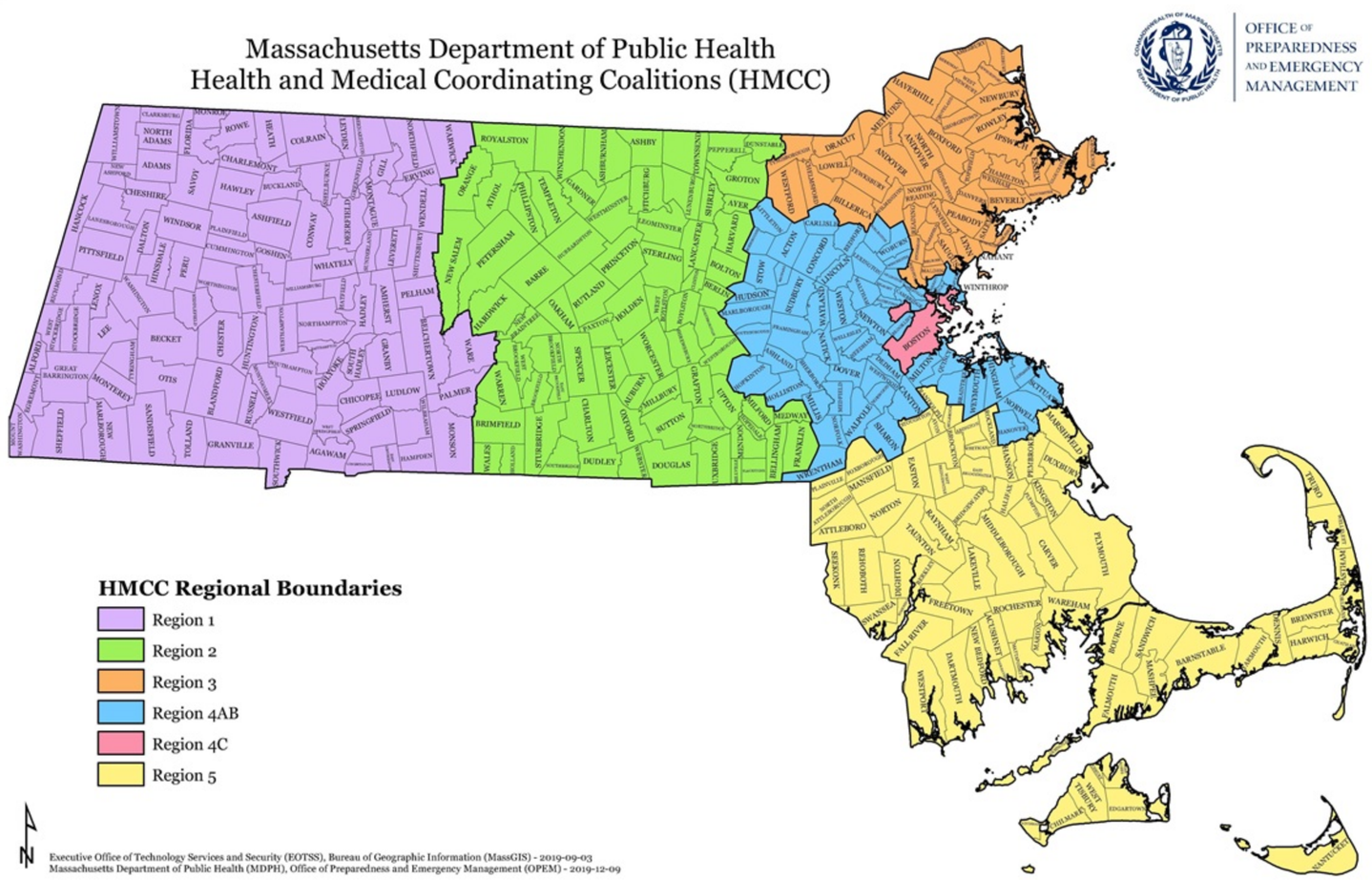
For each of the regions below, the peak percentage of BH patients awaiting psych evaluation and boarding in the Emergency Department (for the weeks covered in this report) is shown as a percentage of that region's staffed ED bed capacity. This calcuation is meant to illustrate the highest burden of ED Boarding for that region for the weeks covered in this report. The number of staffed ED beds was obtained using data entered by each hospital into the Massachusetts Department of Public Health's (MDPH) WebEOC (Emergency Operations Center) system as part of daily COVID reporting. **This chart does not include patients boarding or awaiting a psychiatric evaluation on a medical-surgical floor.**

BH Patients Awaiting BH Evaluation & Boarding in the ED:
Peak During the Weeks Covered in This Report as % of Staffed ED Bed Capacity, by MA HMCC Region



Please note that the number of hospitals reporting each week varies and can impact the statewide total. The number of respondents is as follows: 4/22 n=44; 4/29 n=50; 5/6 n=37; 5/13 n=37

MA Health and Medical Coordinating Coalition (HMCC) Regions

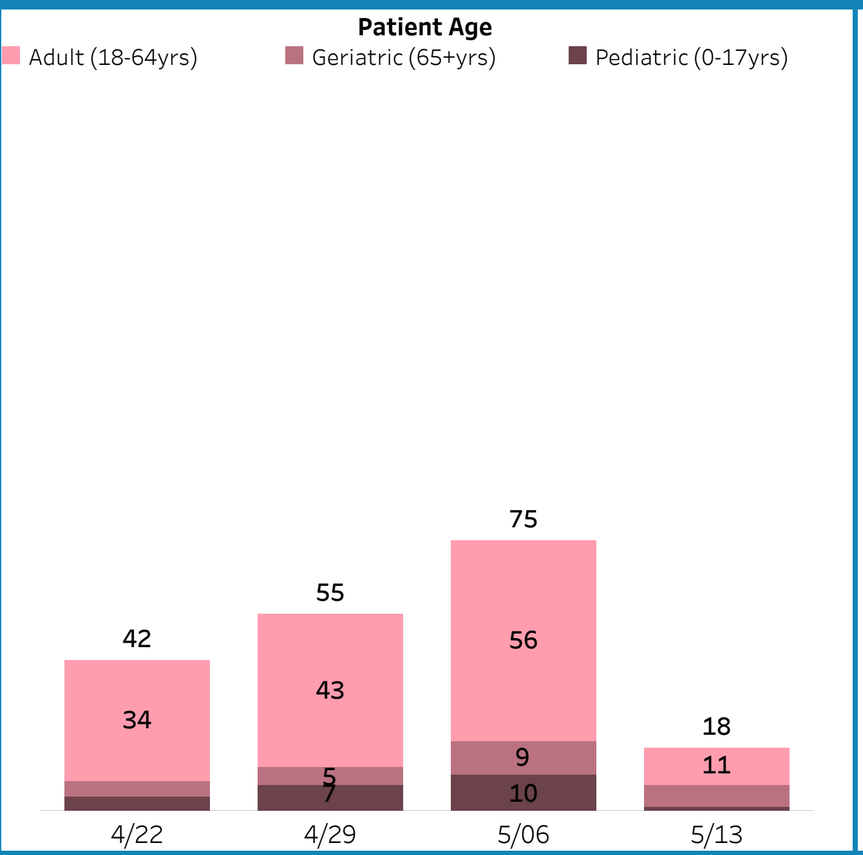


Region 1	Region 2	Region 3
Baystate Franklin Medical Center	Athol Hospital	Addison Gilbert
Baystate Medical Center	Harrington Hospital	Anna Jaques Hospital
Baystate Noble Hospital	Heywood Hospital	Beverly Hospital
Baystate Wing Hospital	Milford Regional Medical Center	Lawrence General Hospital
Berkshire Medical Center	Nashoba Valley Medical Center	Lowell General Hospital
Cooley Dickinson Hospital	Saint Vincent Hospital	MelroseWakefield Hospital
Fairview Hospital	UMass Memorial HealthAlliance-Clinton Hospital	North Shore Medical Center
Holyoke Medical Center	UMass Memorial Medical Center	Steward Holy Family Hospital
Mercy Medical Center		

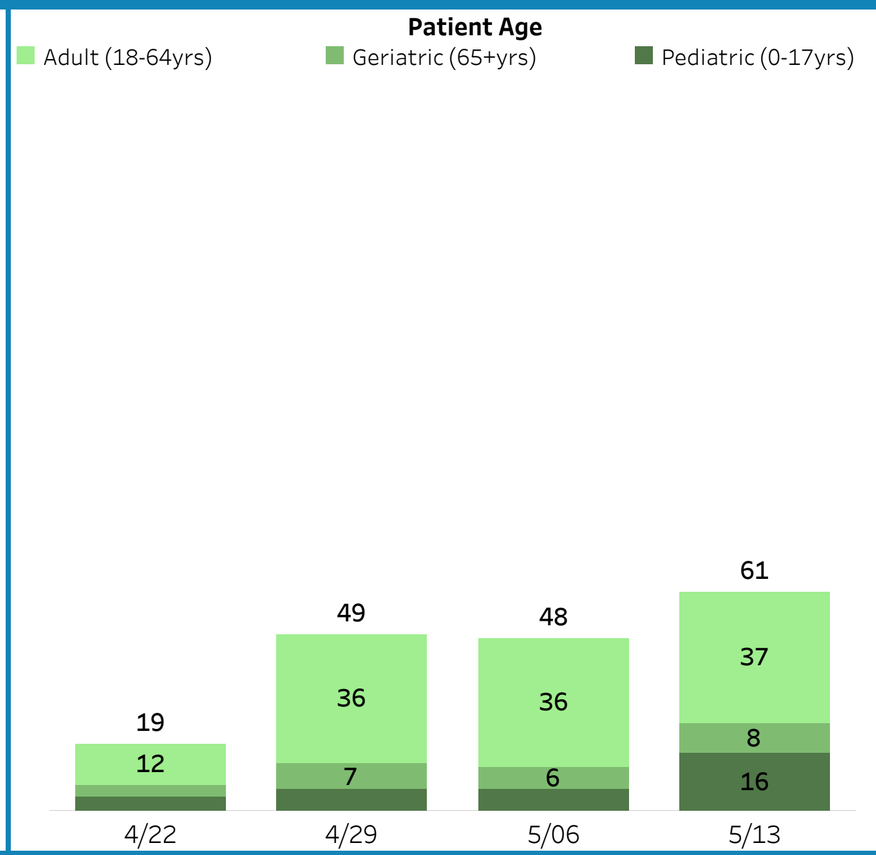
Region 4AB	Region 4C	Region 5
Beth Israel Deaconess Hospital-Needham	Beth Israel Deaconess Medical Center	Beth Israel Deaconess Hospital-Plymouth
Beth Israel Deaconess Hospital-Milton	Boston Children's Hospital	Cape Cod Hospital
Cambridge Health Alliance	Boston Medical Center	Falmouth Hospital
Emerson Hospital	Brigham and Women's Faulkner Hospital	Martha's Vineyard Hospital
Lahey Hospital & Medical Center	Brigham and Women's Hospital	Morton Hospital and Medical Center
MetroWest Medical Center	Massachusetts General Hospital	Nantucket Cottage Hospital
Mount Auburn Hospital	Steward Carney Hospital	Signature Healthcare Brockton Hospital
Newton-Wellesley Hospital	Steward St. Elizabeth's Medical Center	Southcoast Hospitals Group - Charlton Memorial Hospital
South Shore Hospital	Tufts Medical Center	Southcoast Hospitals Group - St. Luke's Hospital
UMass Memorial Marlborough Hospital		Southcoast Hospitals Group - Tobey Hospital
Winchester Hospital		Steward Good Samaritan Medical Center
		Steward Saint Anne's Hospital
		Sturdy Memorial Hospital

BH Patients Awaiting BH Evaluation & Boarding: Regional Age Distribution Trend, by MA HMCC Region 4/22 - 5/13

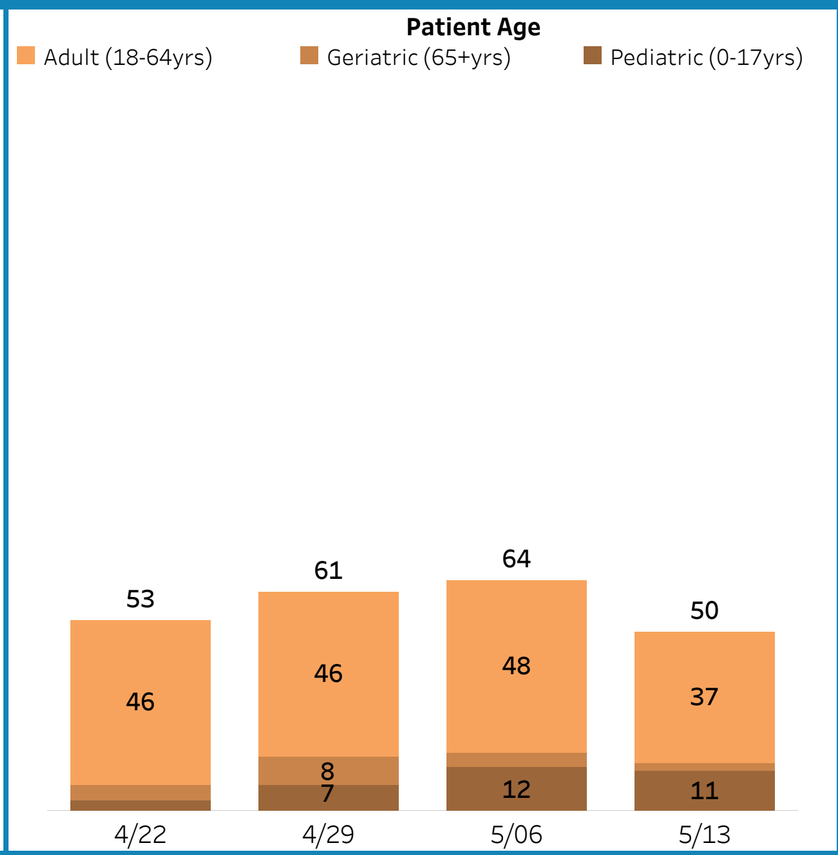
Region 1: 4/22 - 5/13



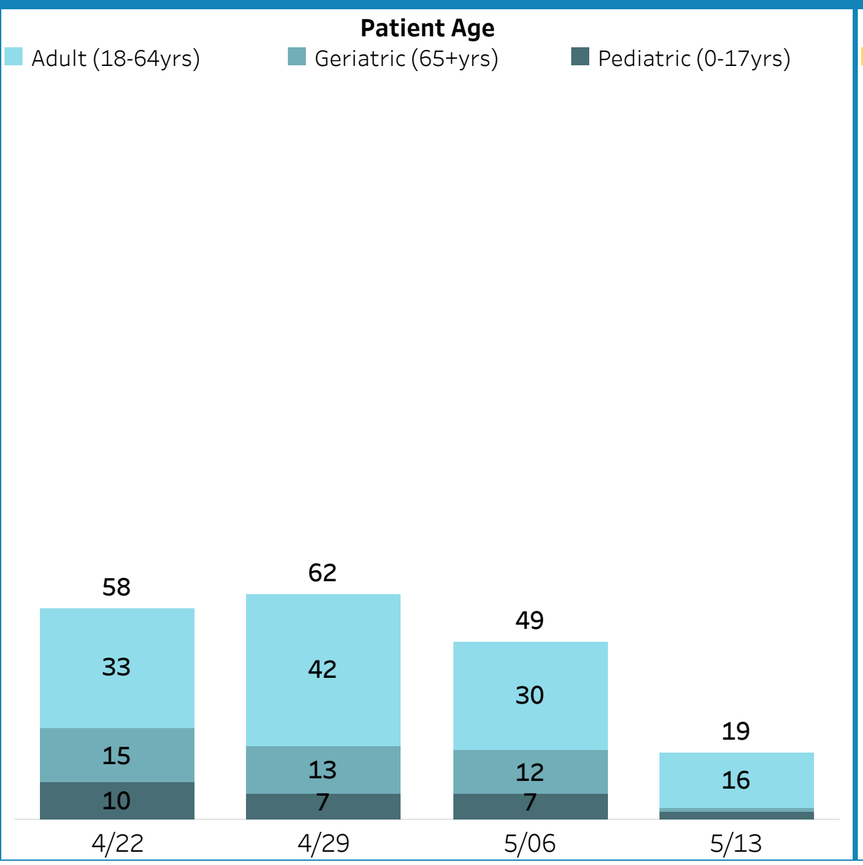
Region 2: 4/22 - 5/13



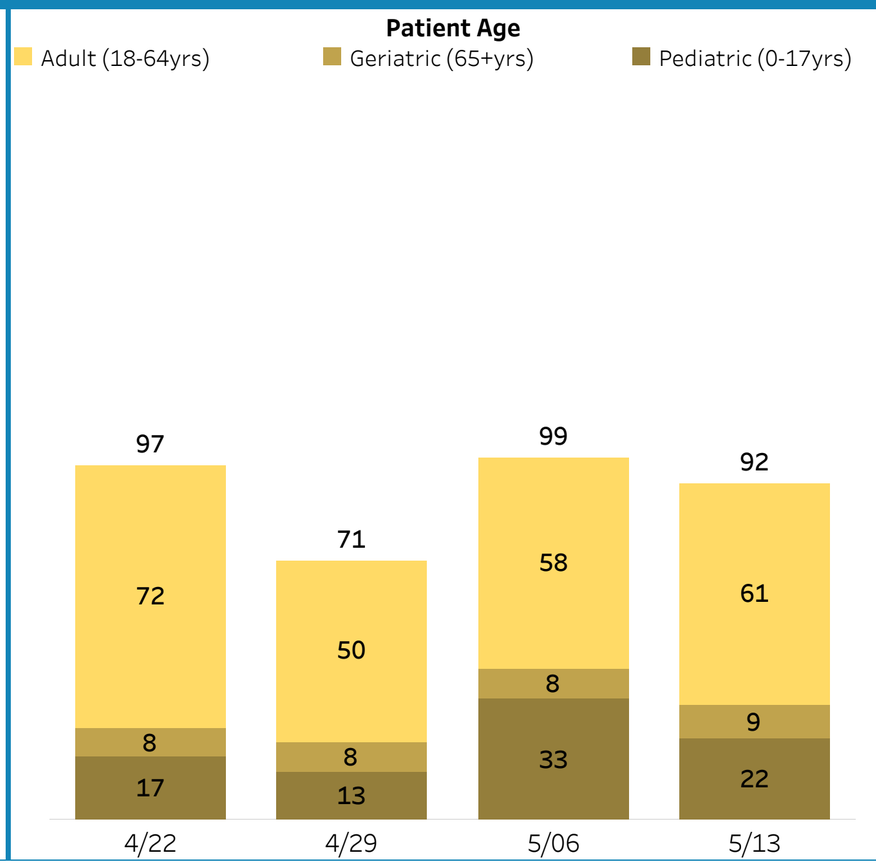
Region 3: 4/22 - 5/13



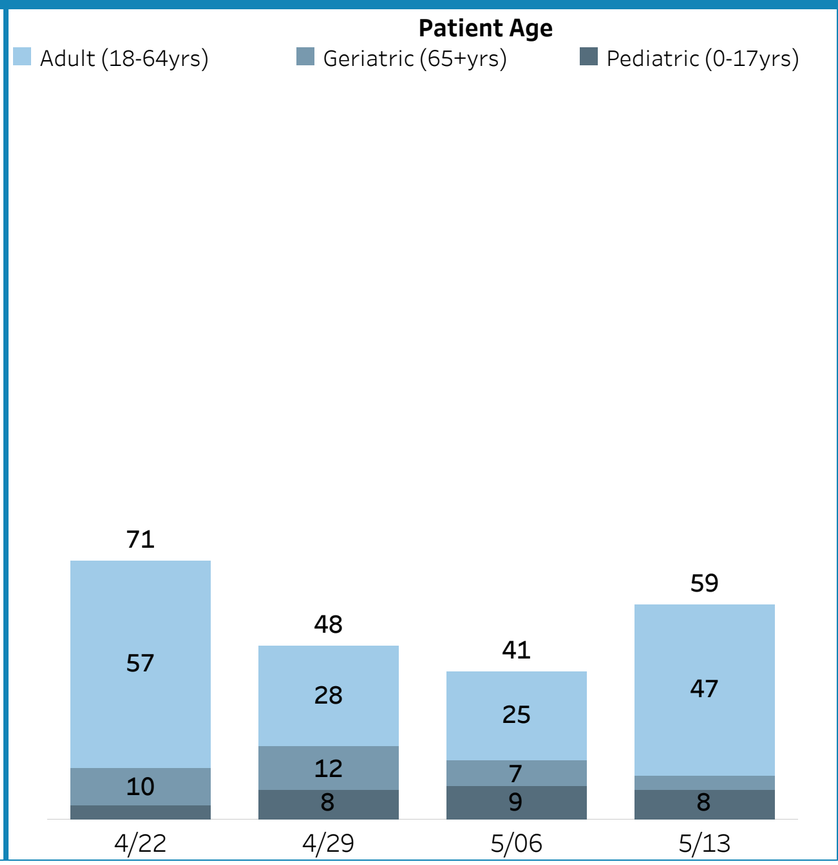
Region 4AB: 4/22 - 5/13



Region 4C: 4/22 - 5/13



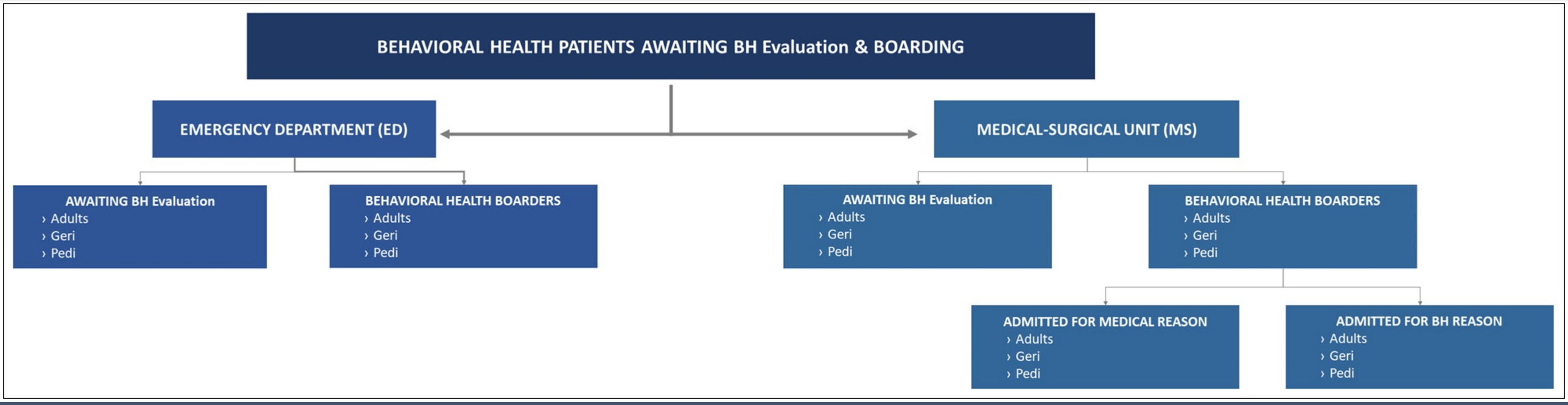
Region 5: 4/22 - 5/13



Please note that the number of hospitals reporting each week varies and can impact the statewide total. The number of respondents is as follows: 4/22 n=44; 4/29 n=50; 5/6 n=37; 5/13 n=37

Notes and Definitions

Overview Chart



Survey Template

Data Submission

Date:	

A. Waiting to be seen *Patients in either the ED or Medical Surgical (MS) unit that are awaiting BH evaluation.* *Note: A and B are mutually exclusive.*		Adult (18 to 64yrs)	Geri (65+yrs)	Pedi (under 18 yrs)
In ED, awaiting BH evaluation	ED			
Admitted to MS bed for medical reasons, awaiting BH evaluation	*MS			

B. TOTAL Boarders/Bed Search Patients *Patients that have been evaluated but are awaiting a BH IP bed either in the same hospital or a different hospital.* *Note: A and B are mutually exclusive.*		Adult (18 to 64yrs)	Geri (65+yrs)	Pedi (under 18 yrs)
Awaiting BH bed in ED	ED			
Medically cleared BH boarders outside of the ED, boarding on MS floor for non clinical reasons ONLY, awaiting BH bed	*MS			
Admitted for primary medical reason, now resolved, awaiting BH bed	*MS			

***C. Total number of patients with only **confirmed COVID-19 *Note: C, D, and E are mutually exclusive.*		Adult (18 to 64yrs)	Geri (65+yrs)	Pedi (under 18 yrs)
In ED, awaiting BH evaluation or awaiting BH Bed	ED			
Admitted to or boarding in MS bed and awaiting BH evaluation or BH bed	*MS			

***D. Total number of patients with only confirmed Flu. *Note: C, D, and E are mutually exclusive.*		Adult (18 to 64yrs)	Geri (65+yrs)	Pedi (under 18 yrs)
In ED, awaiting BH evaluation or awaiting BH Bed	ED			
Admitted to or boarding in MS bed and awaiting BH evaluation or BH bed	*MS			

***E. Total number of patients with both confirmed **COVID-19 and Flu *Note: C, D, and E are mutually exclusive.*		Adult (18 to 64yrs)	Geri (65+yrs)	Pedi (under 18 yrs)
In ED, awaiting BH evaluation or awaiting BH Bed	ED			
Admitted to or boarding in MS bed and awaiting BH evaluation or BH bed	*MS			

Metric Definitions

Data Metric	Definition
ED	Emergency Department
MS	Medical Surgical Unit
Awaiting BH Evaluation - ED	Patients in the ED unit that are awaiting a BH evaluation.
Awaiting BH Evaluation - MS	Patients in the MS unit that have been admitted to an MS bed for medical reasons and are awaiting BH evaluation.
Boarders	All patients that have had a BH evaluation and are awaiting a bed are considered BH boarders regardless of duration.
Boarders - ED	Patients in the ED that have been evaluated but are awaiting a BH inpatient bed either in the same hospital or a different hospital.
Boarders - BH Admits MS	Patients that are medically cleared BH boarders outside of the ED, boarding on an MS floor for nonclinical reasons only, and awaiting a BH inpatient bed either in the same or different hospital.
Boarders - Medical Admits MS	Patients that have been admitted for primary medical reason that is now resolved and are awaiting a BH inpatient bed either in the same hospital or a different hospital.

Appendix 2

Vermont Association of Hospitals and Health Systems

People Waiting for Mental Health Placement Monthly Summary June 2021 - April 2024

VAHHS is collecting point-in-time data on patients stuck in emergency departments waiting transfer or discharge to mental health care—also called patient boarding. This data collection effort is a work in progress and may change over time as we refine data points or streamline collection efforts. This point-in-time data is collated and shared with the Department of Mental Health, hospital representatives, and other interested parties.

The VAHHS data collection process is described below:

FREQUENCY— Hospitals report manually to VAHHS on patients awaiting placement as of each Monday and Thursday morning.

SCOPE— The scope of this report includes all patients waiting for mental health care in Vermont emergency rooms. Data are collected on all patients waiting, regardless of legal status or insurance.

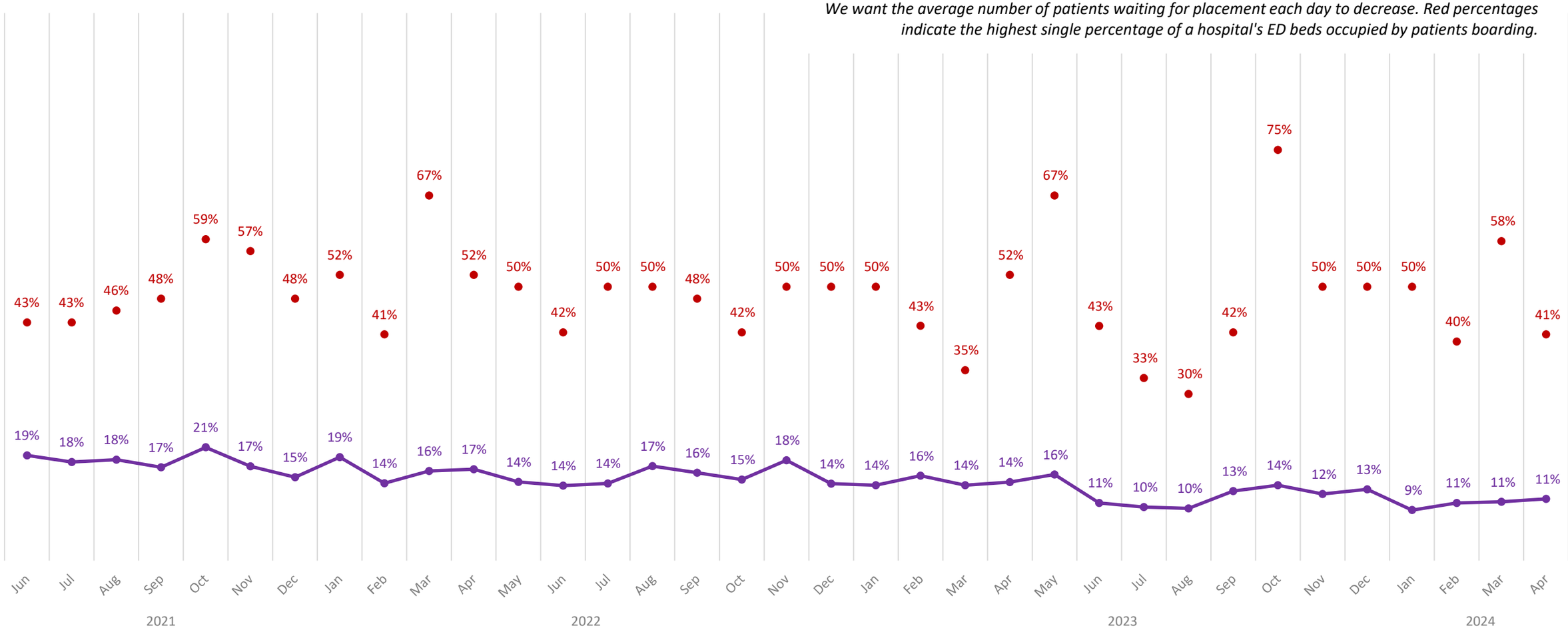
STRUCTURE— Hospitals report person-level data to VAHHS for comparison with DMH counts. Person-level records include age, legal status, Medicaid status, and reason for wait so data discrepancies with DMH can be identified easier.

COMPARISON WITH DMH – The scope of data that VAHHS is collecting is more expansive than the data reported to DMH, as VAHHS is collecting data on all patients regardless of legal status and reason for waiting. Data differences in DMH counts and VAHHS counts of patients waiting are driven by voluntary patients and/or patients waiting for community placements not being reported to DMH.

Notes on Monthly Summary Table:
Data excludes days where reporting from hospitals fell below 70% or days where the University of Vermont Medical Center was not able to make a report. Figures are point-in-time and cannot be summed together to arrive at a total number of individuals or episodes. Averages represent averages of daily reports in each month. Most patients waiting for care are in the emergency department, however a small number of hospitals place patients on medical surgical floors while waiting transfer to inpatient psychiatric units. These patients are included in our numbers as they are still boarding.

ED Mental Health Boarding Impact
Average % of ED Beds Occupied

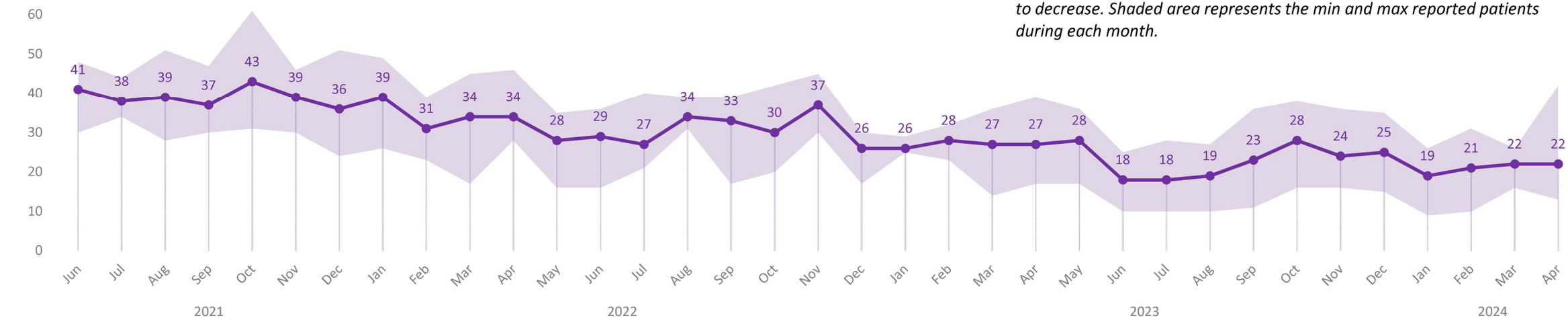
We want the average number of patients waiting for placement each day to decrease. Red percentages indicate the highest single percentage of a hospital's ED beds occupied by patients boarding.



ED OCCUPANCY MEASURES – *% ED beds occupied* represents the total number of all ED beds in Vermont hospitals currently occupied by a patient waiting for mental health placement. *Highest % at an ED* represents the highest percentage of a single hospital's ED beds occupied by patients waiting for mental health placement. Total ED beds used as a denominator for these measures represent dedicated ED rooms. However, during times of high-volume hospitals may expand ED treatment space into adjacent departments and hallway spaces which are not included in the denominator for this measure.

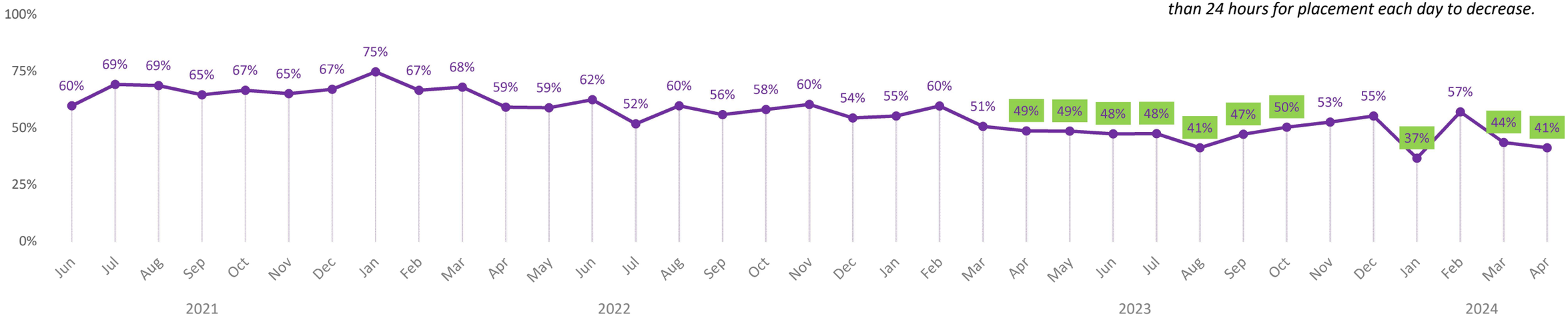
Average Total Mental Health Patients Boarding per Day

We want the average number of patients waiting for placement each day to decrease. Shaded area represents the min and max reported patients during each month.



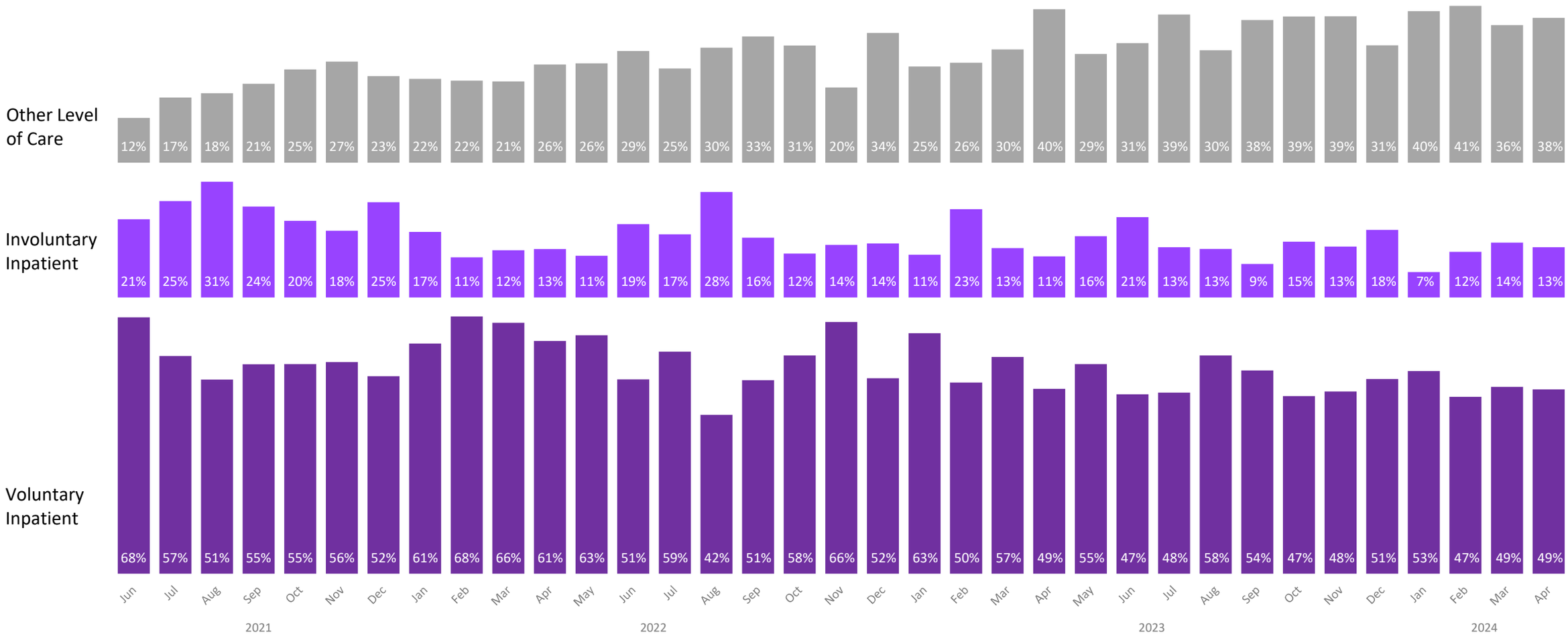
Average Percent of Mental Health Patients Waiting More Than 24 Hours

We want the average percent of patients waiting more than 24 hours for placement each day to decrease.



Data excludes days where reporting from hospitals fell below 70% or days where the University of Vermont Medical Center was not able to make a report. Figures are point-in-time and cannot be summed together to arrive at a total number of individuals or episodes. Averages in the table represent averages of daily reports in each month. Most patients waiting for care are in the emergency department, however a very small number of hospitals place patients on medical surgical floors while waiting transfer to inpatient psychiatric units. These patients are included in our numbers as they are still boarding.

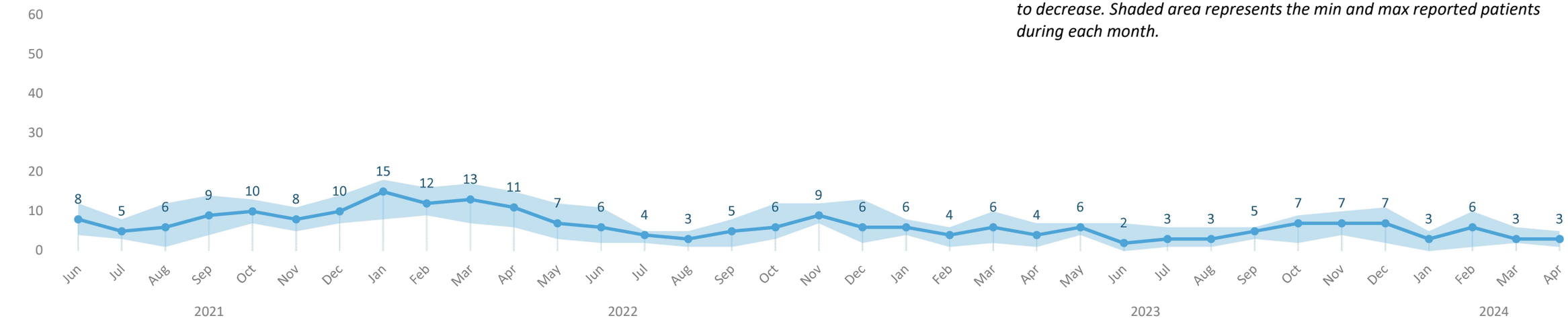
Mental Health Patients Waiting for Placement
Level of Care Needed
Average Percentages Each Month



Data excludes days where reporting from hospitals fell below 70% or days where the University of Vermont Medical Center was not able to make a report. Figures are point-in-time and cannot be summed together to arrive at a total number of individuals or episodes. Averages in the table represent averages of daily reports in each month. Most patients waiting for care are in the emergency department, however a very small number of hospitals place patients on medical surgical floors while waiting transfer to inpatient psychiatric units. These patients are included in our numbers as they are still boarding.

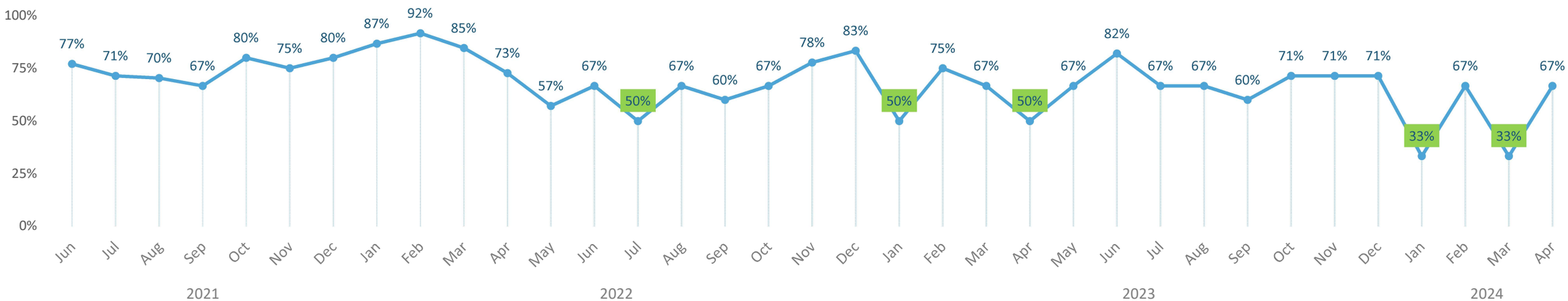
Average Youth Mental Health Patients Boarding per Day

We want the average number of patients waiting for placement each day to decrease. Shaded area represents the min and max reported patients during each month.



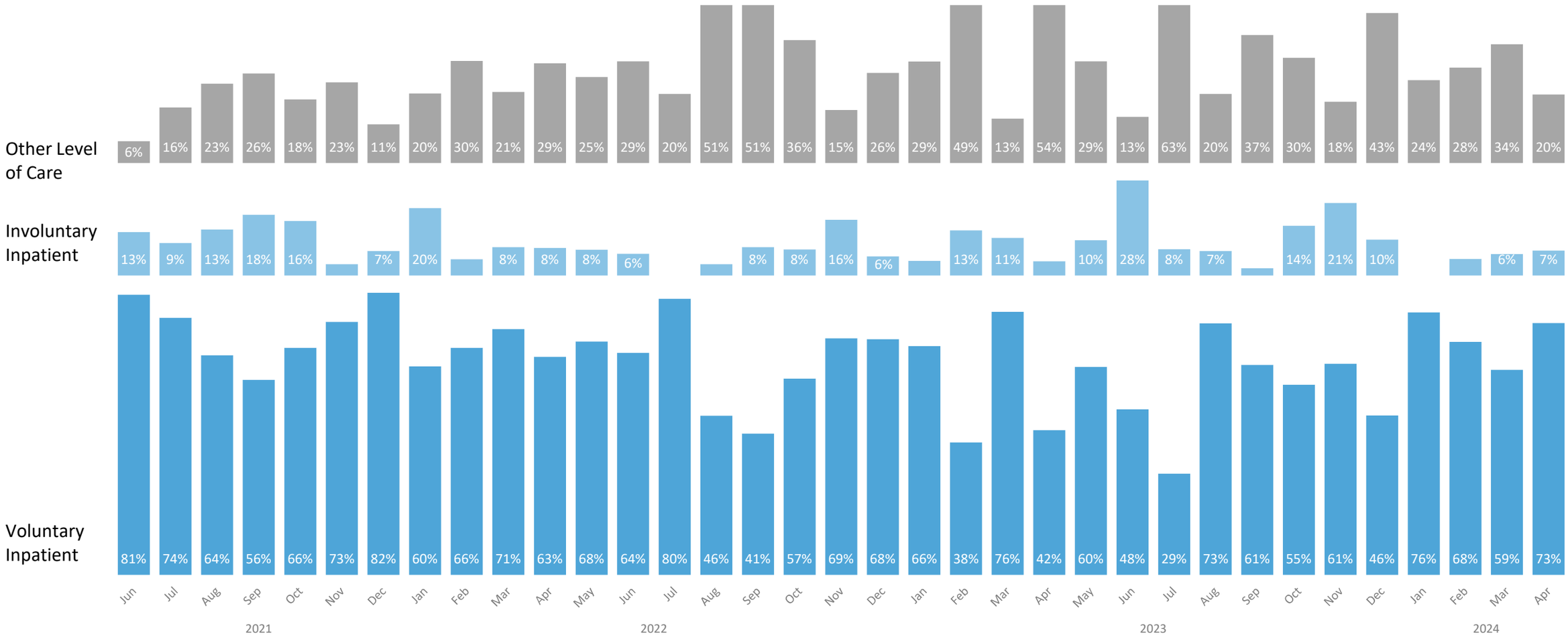
Average Percent of Youth Mental Health Patients Waiting More Than 24 Hours

We want the average percent of patients waiting more than 24 hours for placement each day to decrease.



Data excludes days where reporting from hospitals fell below 70% or days where the University of Vermont Medical Center was not able to make a report. Figures are point-in-time and cannot be summed together to arrive at a total number of individuals or episodes. Averages in the table represent averages of daily reports in each month. Most patients waiting for care are in the emergency department, however a very small number of hospitals place patients on medical surgical floors while waiting transfer to inpatient psychiatric units. These patients are included in our numbers as they are still boarding.

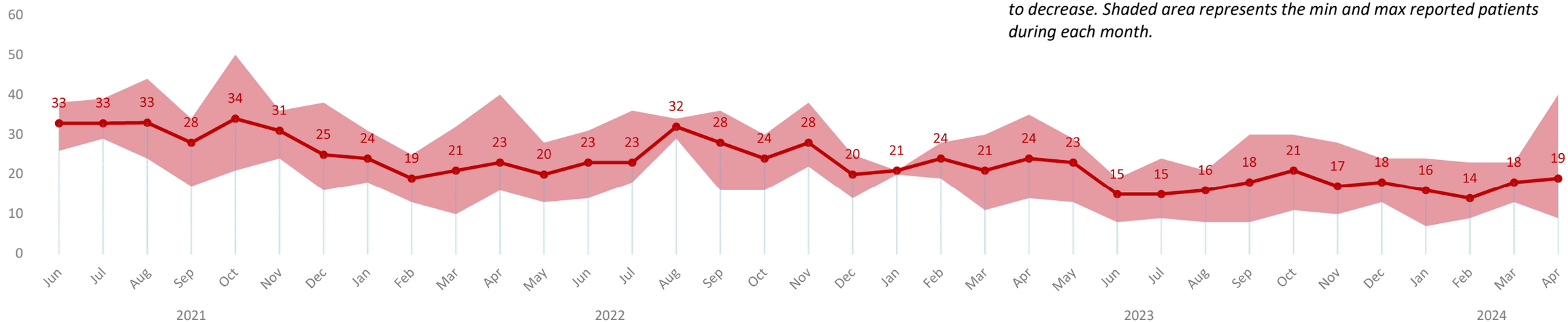
Youth Mental Health Patients Waiting for Placement
Level of Care Needed
Average Percentages Each Month



Data excludes days where reporting from hospitals fell below 70% or days where the University of Vermont Medical Center was not able to make a report. Figures are point-in-time and cannot be summed together to arrive at a total number of individuals or episodes. Averages in the table represent averages of daily reports in each month. Most patients waiting for care are in the emergency department, however a very small number of hospitals place patients on medical surgical floors while waiting transfer to inpatient psychiatric units. These patients are included in our numbers as they are still boarding.

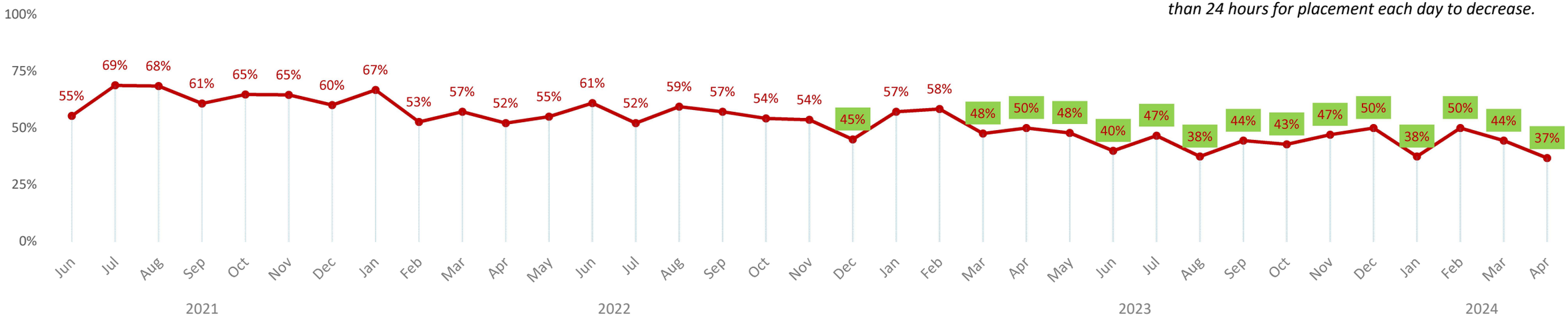
Average Adult Mental Health Patients Boarding per Day

We want the average number of patients waiting for placement each day to decrease. Shaded area represents the min and max reported patients during each month.



Average Percent of Adult Mental Health Patients Waiting More Than 24 Hours

We want the average percent of patients waiting more than 24 hours for placement each day to decrease.



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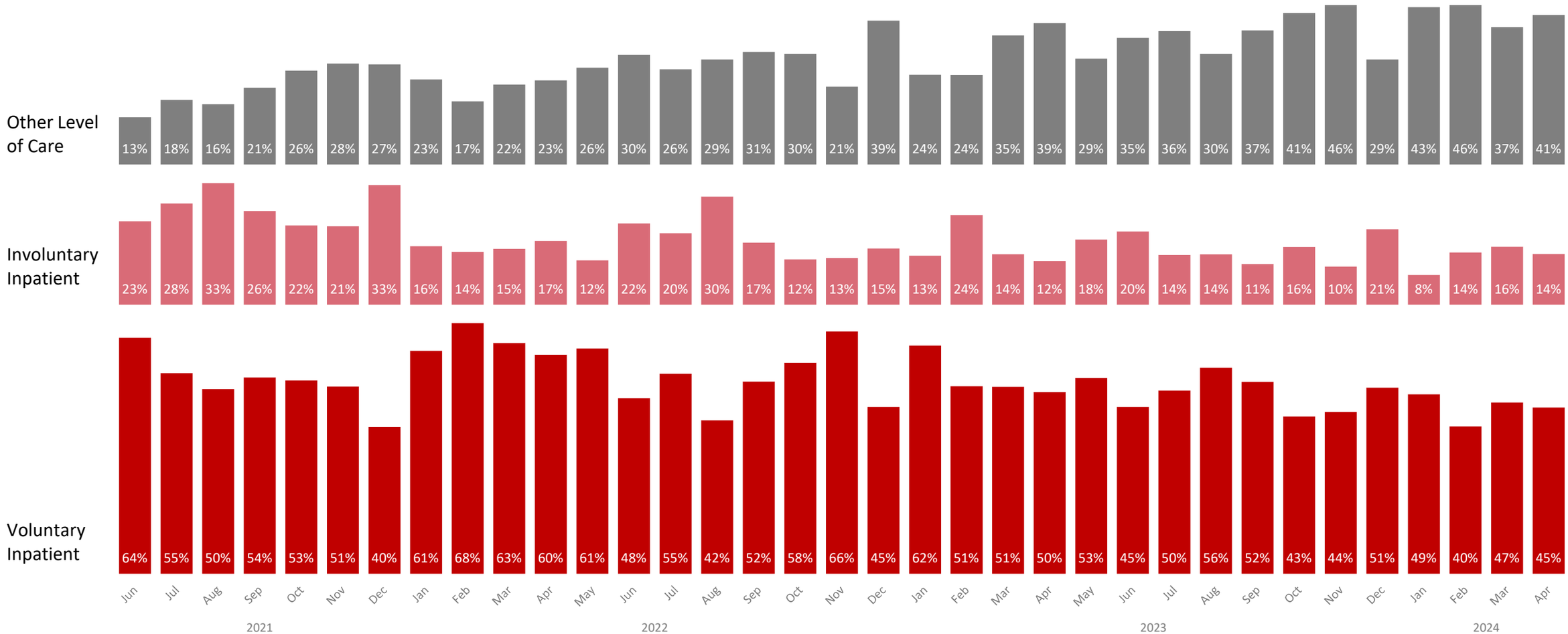
Adult Mental Health Patients Waiting for Placement
Level of Care Needed
Average Percentages Each Month



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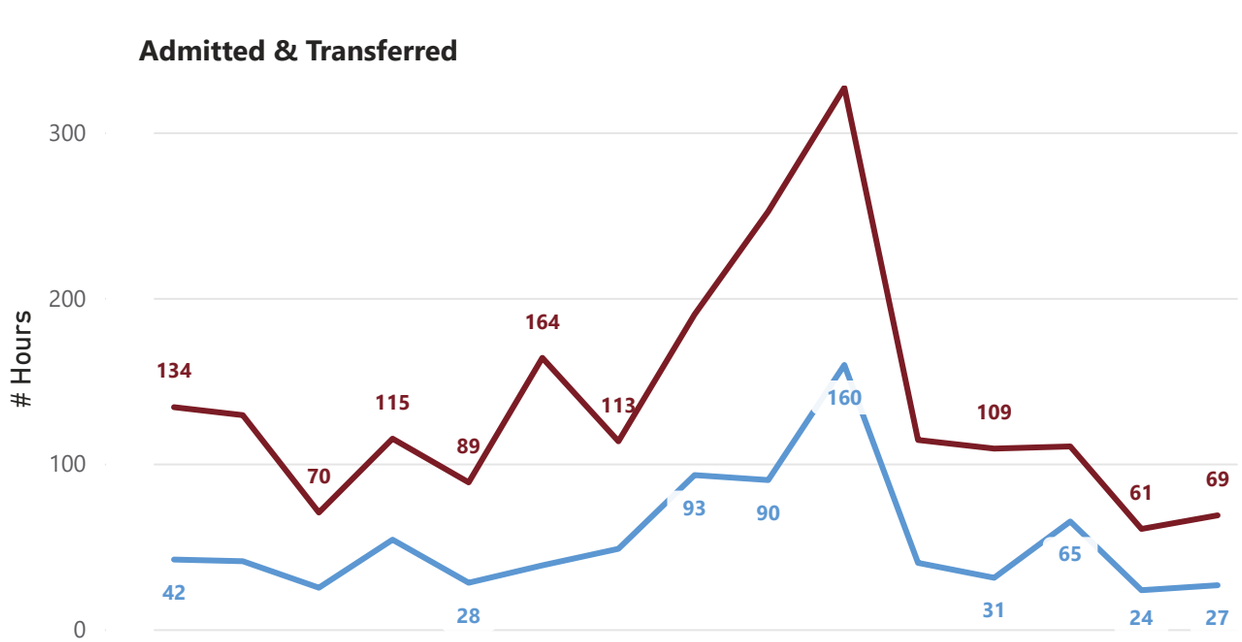
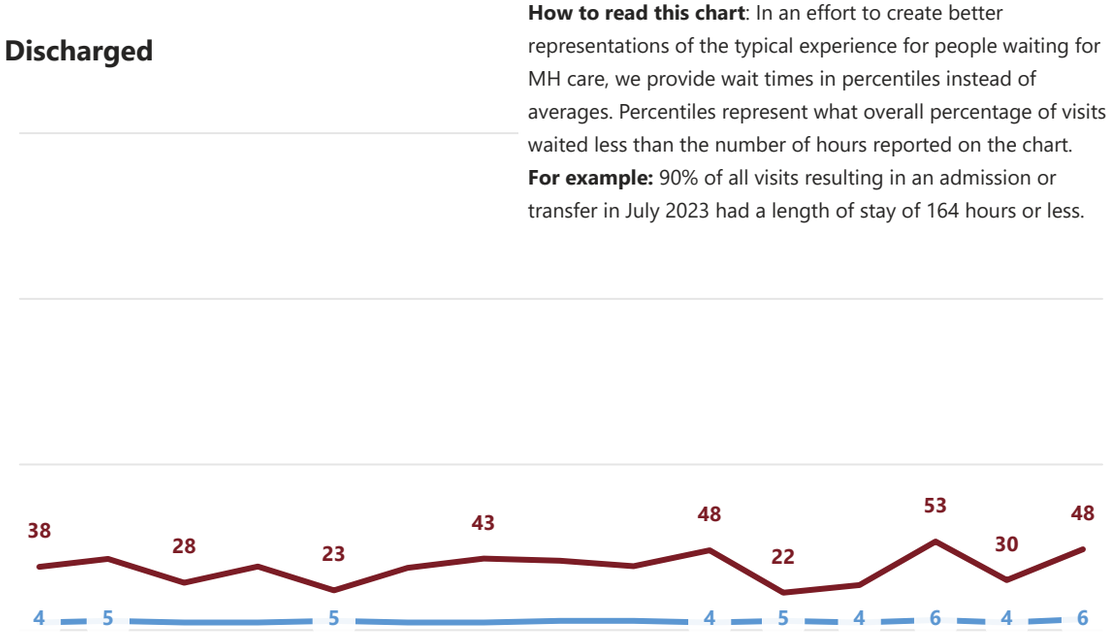
Appendix 3

Vermont Emergency Department Visits for Mental Health
Trends in Lengths of Stay by Patient Disposition for Youth Age 12-17

Length of Stay (LOS) by Patient Disposition

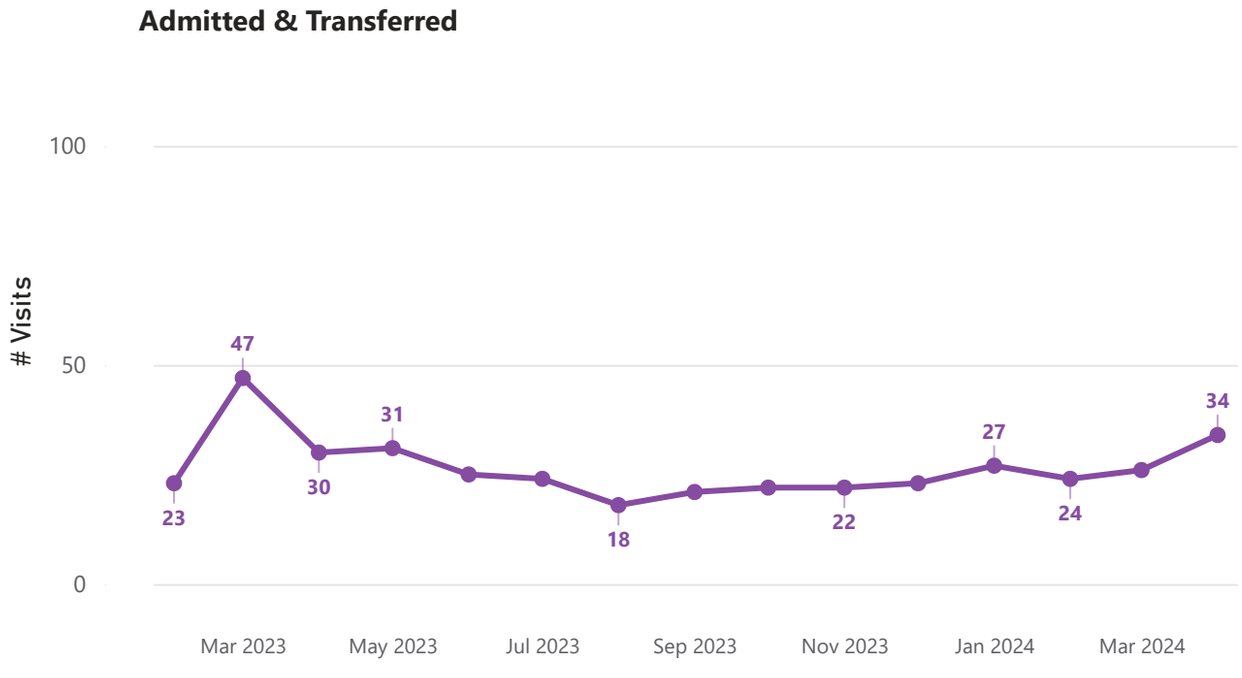
90th Percentile 50th Percentile (Median)

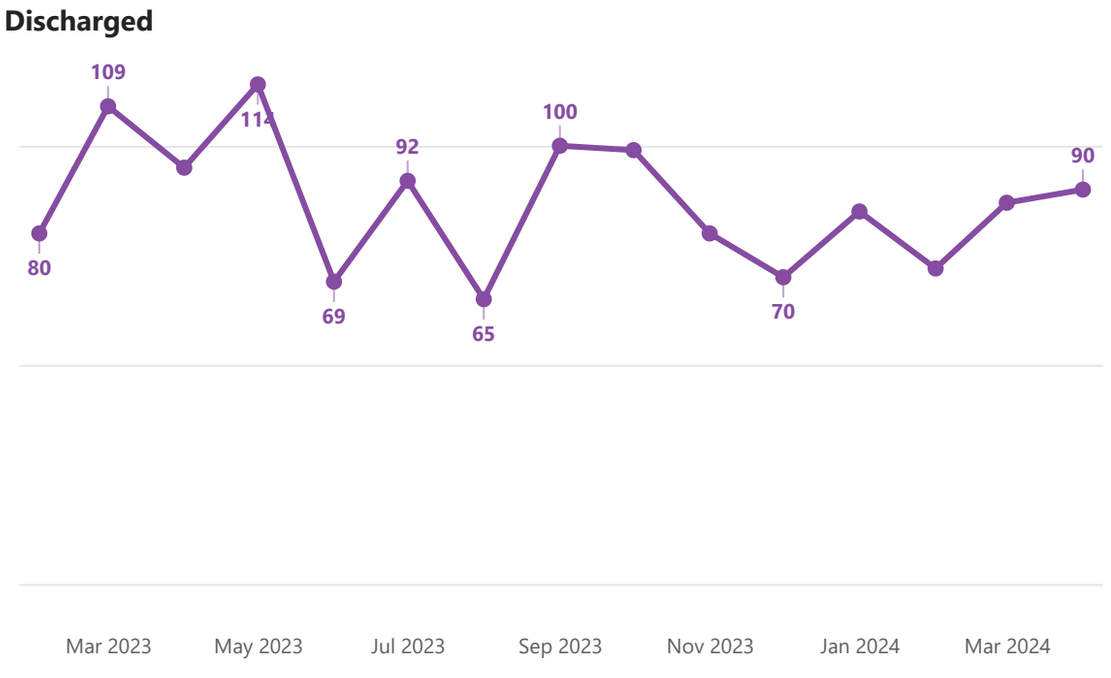




How to read this chart: In an effort to create better representations of the typical experience for people waiting for MH care, we provide wait times in percentiles instead of averages. Percentiles represent what overall percentage of visits waited less than the number of hours reported on the chart. **For example:** 90% of all visits resulting in an admission or transfer in July 2023 had a length of stay of 164 hours or less.

Number of Visits by Patient Disposition





Emergency Department Visits for Mental Health

Vermont's syndromic surveillance system, called ESSENCE, collects near real-time data from emergency departments (ED) in Vermont. A hospital's participation in ESSENCE may fluctuate over time.

Mental health-related visits are defined as visits where the patient's chief complaint history contains information that indicates they are presenting for a mental health complaint or where the first reported discharge diagnosis is mental health-related.

Codes included:

- F20-F29 Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
- F30-F39 Mood [affective] disorders
- F40-F48 Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
- F60-F69 Disorders of adult personality and behavior
- F90-F98 Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- F99-F99 Unspecified mental disorder
- R45 Symptoms or signs involving emotional state

Codes excluded to maintain population focus on mental health primary diagnoses:

- F01-F09 Mental disorders due to known physiological conditions
- F10-F19 Mental and behavioral disorders due to psychoactive substance use
- F50-F59 Behavioral syndromes associated with physiological disturbances and physical factors
- F70-F79 Intellectual disabilities
- F80-F89 Pervasive and specific developmental disorders

Patient Disposition:
Patient disposition categories are automatically generated by ESSENCE using patient discharge information. Based on feedback from Vermont hospitals, additional visits coded as discharged were changed to admitted based on additional status change information reported on the visit record that indicated the patient was admitted to inpatient services.

Limitations:
There are limitations with syndromic surveillance data. The number of hospitals reporting can vary over time, data outages may occur, and the fields used to determine mental health-related visits or discharge status may be missing or incomplete. This may lead to an over or underestimation of visits related to mental health or patient disposition.

Any publication of this data is subject to VDH approval.

Appendix 4

State of Vermont
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Waterbury, VT 05671

Agency of Human Service

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STATE OF VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF MENTAL HEALTH

REQUEST FOR PROPOSALS (RFP#: 87)

FOR
INPATIENT PSYCHIATRIC UNIT(S) FOR CHILDREN AND ADOLESCENTS

ISSUE DATE: 6/22/2022
QUESTIONS DUE: 7/18/2022, 4:30pm EDT
RFP RESPONSES DUE BY: 8/1/2022, 4:30pm EDT

I. OVERVIEW

The Department of Mental Health (the State) is soliciting competitive sealed, fixed proposals (Proposals) for Inpatient Psychiatric Unit(s) for Children and Adolescents from qualified offerors. If a suitable offer is made in response to this Request for Proposal (RFP), the State may enter into a contract (the Contract) to have the selected offer (the Contractor) perform all or part of the work.

II. RFP OBJECTIVE

The purpose of the RFP is to solicit proposals from qualified health care organizations connected or affiliated with a general medical facility to provide inpatient psychiatric services for children under the age of 18 years. The State is seeking to stabilize and improve current availability of services for this population of Vermonters to ensure children and youth with mental health needs and possible comorbid medical or developmental disability concerns can access inpatient psychiatric care.

III. BRIEF DESCRIPTION OF THE ORGANIZATION

The Vermont Agency of Human Services (AHS) strives to improve the health and well-being of Vermonters today and tomorrow and to protect those among us who are unable to protect themselves. The scope of AHS is profound. Through its six departments, twelve district offices, and a network of community partners and providers, it is responsible for the implementation and delivery of all human service programs within the state. Each department has a distinct area of focus and responsibility and contributes to the creation and sustenance of an entire system of human service supports. The Department of Mental Health (DMH) resides under the Agency of Human Services and has the same critical mission in mind: to improve the conditions and well-being of Vermonters and protect those who cannot protect themselves. DMH continues to focus on its vision for self-determination, empowerment, recovery, and resiliency. This means being responsive to the needs of Vermonters and their families, as well as continuing to challenge ourselves to try to change society's culture, philosophy, and values, while working to fully embrace the concepts of recovery and resiliency. By improving our effectiveness and

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coordination of programs and services around the State, we will help Vermonters meet their needs.

IV. SCOPE OF SERVICES REQUESTED

Vermont's System of Care is designed to serve a variety of emotional, behavioral, and mental health needs of children and adolescents by expanding the State's capacity to provide early and effective home- and community-based services to reduce reliance on residential and inpatient services, unless clinically required. While the goal may be to avoid inpatient treatment through early intervention, at times this level of care is needed and will result in the best possible outcomes for those youth and their families. Inpatient treatment for youth in Vermont is limited and only provided in one location in the state. This level of care for young Vermonters needs to be diversified to ensure that children and youth can access inpatient care at the right time and have their emergent needs fully addressed.

This RFP specifically addresses the unique needs of the population for the most intensive level of care provided through inpatient services. Psychiatric hospitalization provides intensive inpatient care designed to help stabilize the youth, provide for immediate treatment needs, and quickly return the youth to their prior care setting (often a lower level of residential or home-based care) in order to continue their course of treatment.

A. Population overview and additional information

1. **General target population for services**
   a) Children and youth up to age 18, male, female, and transgendered youth. Youth with high mental health acuity, including:
      (1) Acute mental health symptoms
      (2) Self-harming behaviors, suicidal attempts, and significant suicidal ideation
      (3) Homicidal ideation
      (4) Significant aggressive and violent behaviors
      (5) Substance use
      (6) Trauma and exposure to violence
      (7) Possible co-morbid medical or developmental disability needs
   b) Youth on voluntary and involuntary status
   c) Children and youth with Medicaid, commercial coverage, and private pay.

2. **Bed needs for the target population**
   a) Up to 12 beds, could involve age-specific units.

B. Scope of Services

1. **Key Components**
   a) Psychiatric evaluation, service, medication management and consultation
   b) Daily therapeutic care and intervention following best practices for acute stabilization
   c) Use of Six Core Strategies for reduction of seclusion and restraint

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d) Trauma-responsive setting and treatment approaches
e) Family involved in treatment as clinically indicated
f) Discharge planning in collaboration with family, relevant community and State partners
g) Provide admission and discharge capacity 24 hours a day, 7 days a week

2. **Overview of Level of Care**
   a) Inpatient psychiatric care for voluntary and involuntary children and youth.
   b) Maintain compliance with all state and federal laws and regulations for licensed facilities.
   c) Maintain compliance with state regulations for designated psychiatric hospitals.

V. PROPOSAL EVALUATION

A. Process Overview

Proposals submitted to DMH for this solicitation will be reviewed by a scoring committee selected by the Department. The individuals selected to serve on the scoring committee will be selected based on their programmatic expertise and experience with the target population so that they can provide substantive input on the submitted proposals.

Vendors who do not meet the following criteria will be excluded from consideration:

- Facility is currently licensed as a health facility OR Vendor affirms their intention and plan to be licensed as a health facility when the contract is signed (or pending purchase/lease of new property).
- Facility is currently accredited OR Vendor affirms their intention and plan to become accredited by an agency approved by the Department of Mental Health.
- Facility is located within Vermont OR Vendor proposes to locate in Vermont pending purchase/lease of new property.

B. Evaluation Scoring

The State will use a scoring scale of 100 total points, with a maximum of 90 points awarded based on the Technical Proposal and a maximum of 10 points awarded based on the Cost Proposal. Points are divided into categories set forth below.

Technical Proposal	
Program design	40
Agency organizational capacity	30
Proposed timeline	20
Cost Proposal	
Budgets	10
Total Points	100

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VI. FINANCE

A. Financial Standards

The Department anticipates using Federal funds for the resulting contract(s). The Department may choose to modify the source of funding contingent upon the availability of funds at the time of award. Any selected Vendor will be subject to the requirements in the Catalog of Federal Domestic Assistance (CFDA) # 93.778, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

At this time inpatient services will be funded by billing for services through Medicaid, commercial coverage, and private payment.

B. Description of Payment Structure

The following provides an overview of the payment structure provided by DMH for the resulting contract(s), including start-up funding and per diem rate for children served through this contract.

1. **Start-up funding**

   The purpose of start-up funding is to support your agency to launch the inpatient psychiatric unit(s) for youth. Start-up costs are considered as one-time costs you anticipate that will not be incurred on an ongoing basis. DMH anticipates that such initial start-up periods will require funding to make key early investments such as: planning and feasibility studies, hiring program managers and clinicians, purchasing the rights to deliver selected Evidence-Based Practices (EBPs), train workers on the EBPs, and lease physical space (if applicable). Additionally, start-up costs may be required to bridge funding until your agency begins to serve clients and receive associated per diem rate payments.

2. **Per Diem Rate**

   This portion of the budget establishes a per diem rate for the corresponding scope of work. This amount will be paid on a daily basis per child per day they receive the service, starting on the date of admission, which will be submitted to the Department in a manner specified by the Department. This rate will be initially calculated using your cost proposal for operational costs.

VII. REQUIREMENTS FOR SUBMISSION

A. Proposal Format

Use standard 8.5” X 11” page size. Documents must be single-spaced and use not less than a twelve-point font. Pages must be numbered. The proposal should be comprehensive, yet concise. The proposal must follow the sequence of information requested in the “Bid Requirements” section below. State your organization’s name on each page of your program proposal/bid and on any other information you are submitting.

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1. A brief description of the organization which includes its history, organization structure and size, and qualifications to provide the required services.
2. A statement and discussion of the Proposer's analysis of the RFP requirements. This should include:
   a) How the staff and services needed will be provided
   b) Statement and discussion of anticipated major difficulties and problem areas (if any), together with potential or recommended approaches to their solution.

3. Acknowledgement of agreement with customary State and Agency terms and conditions contained in Attachments C-F.

B. Cover Letter

Please provide an introduction to your company and proposal via a cover letter. All bids submitted to the State are considered public records. Please note in your cover letter if any information in your proposal is considered proprietary and confidential.

1. **Confidentiality:** To the extent your bid contains information you consider to be proprietary and confidential, you must comply with the following requirements concerning the contents of your cover letter and the submission of a redacted copy of your bid (or affected portions thereof).

2. The successful response will become part of the contract file and will be a matter of public record, as will all other responses received. If the response includes material that is considered by the bidder to be proprietary and confidential under the State's Public Records Act, 1 V.S.A. § 315 et seq., the bidder shall submit a cover letter that clearly identifies each page or section of the response that it believes is proprietary and confidential. The bidder shall also provide in their cover letter a written explanation *for each marked section* explaining why such material should be considered exempt from public disclosure in the event of a public records request, pursuant to 1 V.S.A. § 317(c), including the prospective harm to the competitive position of the bidder if the identified material were to be released. Additionally, the bidder must include a redacted copy of its response for portions that are considered proprietary and confidential. Redactions must be limited so that the reviewer may understand the nature of the information being withheld. It is typically inappropriate to redact entire pages, or to redact the titles/captions of tables and figures. Under no circumstances can the entire response be marked confidential, and the State reserves the right to disqualify responses so marked.

VIII. QUESTION AND ANSWER PERIOD

Any vendor requiring clarification of any section of this RFP or wishing to comment or take exception to any requirements of the RFP must submit specific questions in writing no later than the deadline for questions indicated on the first page of this RFP. Questions may be emailed to: **Jennifer.Rowell@vermont.gov**, the point of contact. Any comments, questions, or exceptions not raised in writing on or before the last day of the question period are waived.

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IX. DELIVERY OF PROPOSALS

Please provide an electronic copy of the proposal no later than at 4:30 pm EDT on August 1, 2022, to: **Jennifer.Rowell@vermont.gov**

Please use Microsoft Office and standard PDF files.

X. ADDITIONAL INFORMATION

DMH reserves the right to accept or reject any or all bids. If a contractor is selected, representatives will be invited to negotiate a contract.

DMH will not pay any bidder costs associated with preparing or presenting any proposal in response to this RFP.

The contractor will agree to the State of Vermont usual contract and payment provisions. These specifications are posted with this RFP and include:

- Attachment C: Customary Provisions for Contracts and Grants
- Attachment E: Business Associate Agreement
- Attachment F: AHS Customary Contract Provision