Dartmouth Health

Southwestern Vermont Medical Center

August 21, 2024

Donna Jerry, Health Care Administrator
Green Mountain Care Board
1 National Life - Davis 3
Montpelier, VT 05633

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

Before providing answers to the questions, it might be useful to level set on the following;

A. **There is no specific data that definitively and quantitatively indicates the precise number of mental health beds needed to care for Vermont's adolescents** because the available data is incomplete or flawed, demand is highly variable, and demand is impacted by access to other mental health care resources. Thereby, it is not possible to calculate the number of additional beds needed above those currently available at the Brattleboro Retreat. Patients and their families deserve a choice of provider and establishing more than one inpatient provider would be beneficial for the state (service resilience, financial and operational comparison, sharing of quality care processes, etc.).

B. The scale of the proposed unit, **12 beds, was chosen**

- **to maximize the clinical capacity** of the space
- because it would be difficult to **attract talented providers and staff** to a unit with fewer patients, **and**
- because several published studies[1,2] demonstrate that inpatient mental health units with **higher patient volumes are positively correlated with better quality care**.

C. The anticipated arrangement with the Vermont Department of Mental Health will be designed such that **SVMC will be made financially whole for its capital and annual operational investment** in the inpatient mental health service for adolescents **regardless of the number of patients, the payer mix, and operating cost** (within reason), therefore, there is no volume-driven, break-even point or profit margin (see table on page 6 for potential per diem rates). SVMC seeks to deliver this mission-driven service with no positive or negative financial impact to SVMC.

[1] Rasmussen et al. (2018) Inpatient volume and quality of mental health care among patients with unipolar depression. Psychiatr Serv 69(7):797-803.
[2] Druss et al. (2004) The volume-quality relationship of mental health care: does practice make perfect? Am J Psychiatry 161:2282-2286.

D. The inpatient mental health **unit will serve only Vermont adolescents**, in respect for the large investment of Vermont's tax payer's dollars to launch and maintain the service.

E. On occasion it will be challenging to discharge patients from the SVMC's adolescent mental health unit to lower levels of care, such as intensive outpatient programs, residential sites, and even long-term intermittent counseling, because **investments are needed to build and expand capacity across the entire continuum of mental health care**. This challenge is not unique to Vermont.

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. The essence and specifics of many of these questions was addressed in the body of the CON application and detailed answers provided to the second round of questions. Rather than repeat those lengthy explanations here, for many of the questions I provide additional information and encourage review of the text in previous documents.

1. **On page 2 of your response to Q002 it is stated that: "The expansion of capacity at the Brattleboro Retreat since the development of the feasibility study alters the quantitative estimates of additional bed capacity needed." The feasibility study conducted by TaraVista Health Partners assumed 10-14 inpatient beds at the Brattleboro Retreat (Retreat); however, the Retreat currently has 23 staffed inpatient psychiatric beds for adolescents that can flex to 27 beds. Therefore, please update the feasibility study to reflect the current number of beds at the Retreat and demonstrate the number of additional inpatient psychiatric beds that are needed in Vermont for individuals ages 12-17.**

This question is effectively addressed in the lengthy answer to question 3 in the second round of questions- pages 2-9.

There is no specific data that definitively and quantitatively indicates the precise number of mental health beds needed to care for Vermont's adolescents because the available data is incomplete or flawed, demand is highly variable, and demand is impacted by access to other mental health care resources. Thereby, it is not possible to precisely calculate the number of additional beds needed above those available at the Brattleboro Retreat regardless of whether the Brattleboro Retreat has 10, 14, 23, or 27 available beds.

The response to question 3 in the second round of questions states;

"*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****."* (emphasis added for this answer).

Also note the statement;
"*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).*
As such, this approach cannot inform the number of additional inpatient mental health beds needed in Vermont above those at the Brattleboro Retreat…"

What is known is that in spite of additional staffed bed capacity at the Brattleboro Retreat, youth are still waiting in emergency departments.

- The latest point-in-time survey of hospitals by VAHHS on Thursday August 8, 2024 showed that 1 youth was waiting for more than 24 hours for inpatient mental health care.
- The length of stay of youth in mental health crisis in SVMC's emergency department is considerably longer than 24 hours as demonstrated by consistent and overwhelming data presented in the CON application, answers to the second round of questions, and here again.

However, in an effort to be abundantly clear this time, it is worth reiterating – there is no specific data that definitively and quantitatively indicates the precise number of mental health beds needed to care for Vermont's adolescents because the available data is incomplete or flawed, demand is highly variable, and demand is impacted by access to other mental health care resources. Thereby, it is not possible to precisely calculate the number of additional beds needed above those available at the Brattleboro Retreat regardless of whether the Brattleboro Retreat has 10, 14, 23, or 27 available beds.

2. In a table format, based on projected monthly occupancy at 4, 5, 6, 7, 8, 9, 10, 11, 12 beds respectively, provide the estimated revenues, by payer, associated with each and the breakeven point and when a profitable margin is attained for Year 1, 2 and 3.

Due to the nature of the anticipated reimbursement arrangement with the Vermont Department of Mental Health there is no occupancy level that will serve as a breakeven point above which SVMC will achieve a profitable margin. The arrangement can best be described as cost-based reimbursement. SVMC will receive reimbursement equal to, not above nor below, the cost for delivering the service. The proposed approach will never result in a profit margin.

The initial per diem rate[3] will be set based upon the modelled operating budget, payer mix, and patient volume (see the lengthy and detailed financial pro forma in appendix 2 of the feasibility

[3] The current assumption is that the per diem rate provided by all insurers (Medicaid and commercial payers) will be identical. Annual updates to the per diem rate will occur for all insurers. This assumption can only be validated after CON approval.

study that was submitted with the CON application). Here, we try to explain the proposed reimbursement process and how it will maintain sustainability of the unit without the traditional breakeven point and profitability margin. SVMC and the Department of Mental Health do not have a signed agreement yet. The signed agreement will be developed after approval of the CON.

At the end of the each fiscal year, details of the financial performance of the unit will be shared with the Department of Mental Health. By being fully transparent about the volume and length of stay of patients, the cost of delivering the service along with the revenue obtained and financial bottom line, the per diem rate will be adjusted for the subsequent year to both meet the projected expenses for the subsequent year and either make-up for the prior year's financial shortfall or claw back any profit (financial neutrality is the target and will be maintained by this annual adjustment). Below is a hypothetical example of how this cost-based and annual adjustment approach would work.

A	Year 1 per diem rate	$2,000
B	Number of children served	270
C	Patient days	4,000
D	Revenue (A*C)	$8,000,000
E	Operating Expense	$8,150,000
F	Operating Gain or (Loss) (D-E)	($150,000)
G	Year 2 Operating Budget (based off E)	$8,354,000
H	Year 2 Adjusted Budget to accommodate last year's performance (G-F) [Note increase by $150,000, make-up adjustment]	$8,504,000
I	Revenue need in year 2 for fiscal neutrality	$8,504,000
J	Anticipated patient days in year 2	4,000
K	Year 2 per diem rate (I/J)	$2,126
L	Year 2 actual patient days	4,025
M	Revenue (K*L)	$8,557,150
N	Operating Expense	$8,444,150
O	Operating Gain or (Loss) (M-N)	$113,000
P	Year 3 Operating Budget (based off N)	$8,655,000
Q	Year 3 Adjusted Budget to accommodate last year's performance (P-O) [Note decrease by $113,000, claw back adjustment]	$8,542,000
R	Revenue need in year 3 for fiscal neutrality	$8,542,000
S	Anticipated patient days in year 3	4,000
T	Year 3 per diem rate (R/S)	$2,135

The goals of this approach are to;

1. Ensure the unit is financially sustainable long term
2. Ensure the unit is persistently financially neutral to SVMC
3. Allow the SVMC/DH clinical team to focus on delivering quality care in most effective and cost efficient manner for the adolescents of Vermont.

There is one theoretical risk to the cost-based and annual adjustment approach – SVMC could be incentivized to increase expenses without financial controls. Although possible, full transparency of the detailed patient volume, expenses, and revenue of the unit will provide a strong check and balance;

- Provider and staff expenses, the largest expense of the unit (70% of all expenses), will be able to be directly compared to market rates
- Purchased services expenses, such as LearnWell to maintain educational advancement, will be apparent and could be scrutinized
- Pharmacy and supply expenses could be compared to similar units

Any expenses perceived as artificially elevated will be collaboratively investigated for cause and if necessary, a remediation plan implemented. This transparency will prevent SVMC from aberrantly overloading expenses to the unit.

SVMC has a strong track record of delivering high quality care in an expense efficient manner. The Vermont Hospital Financial Analysis Project Report completed last month, July 15, 2024, shows that SVMC is the lowest price and most operating cost efficient hospital in Vermont. The operations of the mental health unit at SVMC will be managed with similar rigor to high quality care and efficient costs.

It is worth noting that patient census will impact the per diem revenue required for fiscal sustainability of the unit with lower patient census requiring a higher per diem rate, and higher patient census requiring a lower per diem rate. The feasibility study describes a two tiered staffing model- one staffing model for when the unit is serving 8 patients or less and a slightly more complete staffing model when the unit is serving 9 to 12 patients. The same provider and staff resources (again 70% of the expense) is required for any number of patients from 1 to 8. Thereby the per diem rate required to cover expenses and achieve a fiscally neutral bottom line will be higher for a consistent census of 2 patients versus a census of 7 patients. A similar scaling of per diem rate occurs as the larger clinical team is brought aboard to care for a census of patients from 9-12.

Again in an effort to be clear, the operating expenses of the unit do not scale linearly with census. The operating expense do not scale at $1/12^{th}$ with the addition of each patient. Rather the expenses for a patient censes of 1 to 8 are similar and the expenses for a census of 9 to 12 are similar (e.g., a “step-wise” function). The per diem rate needs to annually flex to the census to maintain fiscal sustainability. The best solution to achieve sustainability without profit is the proposed approach- an annual per diem rate, transparency in operating financials, and annual financial true-up through setting the subsequent year’s per diem rate.

In summary, there is no occupancy level that will serve as a breakeven point above which SVMC will achieve a profitable margin. The arrangement can best be described as cost-based reimbursement with annual adjustment to achieve financial neutrality. Thereby we have not provided a table as requested in this question.

3. If beds were occupied by only Medicaid beneficiaries in Years 1, 2 and 3, show the projected Medicaid revenues that would be generated for 4, 5, 6, 7, 8, 9, 10, 11, and 12

occupied beds respectively, and at what point the Medicaid revenues are sufficient to cover the annual operating expenses in year 1, 2 and 3.

The current assumption is that the per diem rate provided by all insurers (Medicaid and commercial payers) will be identical. Annual updates to the per diem rate will occur for all insurers. This assumption can only be validated after CON approval.

Since the approach is for the unit to be financially neutral to SVMC, the per diem rate must flex to the annual number of patient days according to the table below. The answer to question 2 above describes how sustainability will be attained through a multiyear adjustment of the per diem rate.

			Year 1		Year 2		Year 3	
Census	Average Daily Census (accounts for bed turnover, 92% Occupancy)	Patient Days	Estimated Annual Operating Expense	Estimated Per Diem Rate	Estimated Annual Operating Expense	Estimated Per Diem Rate	Estimated Annual Operating Expense	Estimated Per Diem Rate
1	1	365	$ 5,519,862	$ 15,123	$ 5,728,090	$ 15,693	$ 5,944,172	$ 16,285
2	2	730	$ 5,519,862	$ 7,561	$ 5,728,090	$ 7,847	$ 5,944,172	$ 8,143
3	3	1,095	$ 5,519,862	$ 5,041	$ 5,728,090	$ 5,231	$ 5,944,172	$ 5,428
4	4	1,460	$ 5,519,862	$ 3,781	$ 5,728,090	$ 3,923	$ 5,944,172	$ 4,071
5	5	1,825	$ 5,596,578	$ 3,067	$ 5,807,700	$ 3,182	$ 6,026,785	$ 3,302
6	6	2,190	$ 5,826,726	$ 2,661	$ 6,046,529	$ 2,761	$ 6,274,624	$ 2,865
7	6	2,190	$ 5,826,726	$ 2,661	$ 6,046,529	$ 2,761	$ 6,274,624	$ 2,865
8	7	2,555	$ 5,870,934	$ 2,298	$ 6,092,405	$ 2,385	$ 6,322,231	$ 2,474
9	8	2,920	$ 6,003,558	$ 2,056	$ 6,230,032	$ 2,134	$ 6,465,049	$ 2,214
10	9	3,285	$ 6,634,083	$ 2,020	$ 6,884,343	$ 2,096	$ 7,144,043	$ 2,175
11	10	3,650	$ 6,715,362	$ 1,840	$ 6,968,688	$ 1,909	$ 7,231,570	$ 1,981
12	11	4,015	$ 6,823,734	$ 1,700	$ 7,081,148	$ 1,764	$ 7,348,272	$ 1,830

To directly answer question #3, the per diem rate will always cover the annual operating expenses, regardless of the number of occupied beds, because the per diem rate will flex annually to do so.

4. **Your projections assume that the Medicaid per diem rate negotiated each year will match total operating expenses and that commercial payers per diem rate will equal the Medicaid per diem. Please explain in detail your contingency plan if Medicaid and Commercial per diem rates do not keep pace with projected annual operating expenses in Years 1-3.**

The proposed financial agreement with the state will ensure sustainability of the unit by having the per diem rate flex annually and match operating expenses (cost-based reimbursement). If the revenue for the unit does not cover the operating expenses of the unit, then Vermont leaders have decided to not fund the unit and unfortunately the unit will be closed. SVMC will not launch the unit without an agreement with the state that ensures at least 5 years of cost-based reimbursement and sustainability. A five year guarantee of sustainability is necessary to

respect the large initial capital investment to construct the facility, the operating support required during the ramp-up period, as well as to effectively recruit talented providers and staff.

SVMC and the Vermont Department of Mental Health have been discussing a contact with the following elements;

1. Capital for the renovation
2. Operational support during the ramp up period
3. Modest initial per diem rate
4. Process for annual adjustment of the per diem rate
5. 5 year commitment

Final negotiation of this contract will occur after the CON is obtained.

5. Explain in detail whether adolescents from out-of-state can be admitted to any of the 12 planned beds at SVMC or whether a specific number of beds must be reserved for Vermont residents only.

The mental health unit for adolescents at SVMC will serve patients with a Vermont zip code only. Vermont tax payers are investing in the construction and launch of the unit, therefore, the capacity of the unit should be reserved for the adolescents of Vermont.

Adolescents in New York and Massachusetts have options for inpatient mental health services within their states and are not likely to seek services at SVMC's unit. Adolescents do not currently leave Massachusetts for mental health care. Patients from parts of SVMC's service area outside Vermont (namely NY) have other options for inpatient mental health care and will not need care in VT's mental health units.

6. The RFP issued by the Vermont Department of Mental Health notes that "up to 12-beds could involve age specific units." Please explain in detail whether the 12-bed facility SVMC is proposing requires any age specific units and if so, explain whether the proposed floor plan accommodates such units.

The 12-bed contiguous unit proposed by SVMC will serve ages 12-17. The unit will not be subdivided to serve specific subsectors of the 12-17 age range (for example ages 12-14 in one space, and ages 15-17 in separate space). SVMC does recognize that the psycho-emotional needs of youth of age 12 can be different from those of age 17. Consideration will be given to specific patient placement within the unit and the delivery of joint and peer programming. The detailed floor plan will be developed after CON approval and will consider the best manner to treat all patients within the contiguous unit regardless of their age (12-17).

7. SVMC assumes an average length of stay of 15 days (Table 7B, Utilization Projections). Explain in detail how SVMC will assure no extended stays in SVMC's inpatient unit given that there are limited residential and lower level of care mental health options available in the state for patient discharge. Explain SVMC's plan to manage discharges to appropriate lower levels of care following an inpatient stay and available options in Vermont and out-of-state.

SVMC cannot guarantee that NO patients will experience extended stays in the mental health unit. Certain circumstances result in extended stays despite all good-faith efforts of providers and staff (ex. complex custody arrangements that delay safe patent discharge).

Coordination between the SVMC clinical team and outpatient services are a priority and necessary to deliver excellent inpatient care. The SVMC clinical team will develop relationships with outpatient services across the state to ensure continuation of care plans post-discharge from the inpatient unit. The details of this coordination can only be developed once the CON is approved and the initial clinical team is on-board.

SVMC also encourages the state to explore strategic development additional mental health assets (residential care sites and intensive outpatient programs) across the state.

8. Based on Table 8B, Staffing Report, the proposed inpatient unit will require 44.1 non-MD FTEs and 1.9 MD FTEs. Explain in detail your plans for recruiting the numbers of FTEs by provider type required for the inpatient mental health unit. Additionally, address how your staff recruitment plan and strategy may impact staffing at the Retreat.

SVMC and the Dartmouth Health Department of Psychiatry have not yet made a detailed provider and staff recruitment plan. It is too premature to have developed a detailed recruitment plan. The plan will be developed after CON approval. There is sufficient time during the permitting and construction phase to develop an effective provider and staff recruitment plan (see timeline submitted with the CON application).

The recruitment plan, when developed, will leverage current recruiting assets and processes of both organizations that have proven successful for recruiting providers and staff for other specialties. For example, during the last 12 months more than 20 providers across many specialties have been recruited to SVMC. Staff, in particular Registered Nurses and individuals interested in the nursing profession, are attracted to SVMC because SVMC is a 5-time Magnet nursing awardee. SVMC has a strong culture of inclusivity that will positively impact recruitment of staff for the mental health unit.

It is unlikely that the new mental health unit at SVMC will impact staffing at the Brattleboro Retreat. Currently none of SVMC's registered nurses[4] hale from the Brattleboro zip code or the

[4] The register nurse workforce is the largest clinical category of employees at SVMC and nurses hale from the largest geographic range.

adjacent 7 Vermont zip codes near Brattleboro. SVMC's staff that hale from distances beyond local, more typically originate from the NY region. SVMC anticipates the staff employed to deliver care on the mental health unit will hale from the communities where current staff originate.

Although unlikely, it is impossible for SVMC to guarantee that no providers or staff currently at the Brattleboro Retreat would pursue career options at SVMC's new mental health unit. Note that it is possible that Brattleboro Retreat staff might seek career opportunities at existing mental health facilities in NH or Massachusetts. Recruiting and retaining staff always requires careful and continued attention.

9. **SVMC excluded May-September data in its assessment of need, but SVMC stated on pages 4-5 of its response to Q002 dated June 17, 2024, that the demand for inpatient beds typically declines during the summer months when schools are not in session. Explain in detail how excluding May-September occupancy data from the needs assessment does not result in the creation of excess capacity in the system. In your response, also address the issue of excess bed capacity and the related fixed costs that are incurred whether or not the beds are occupied.**

This is a recurring question. The original CON application (page 37) indicated that

"*Adolescents in mental health crisis spend an average of 31 hours in SVMC's emergency department compared to 6 hours for adolescents with a medical need (FY2023 data). In addition to spending 5 times longer in the emergency department, these adolescents return to the emergency department more frequently- adolescents with a mental health diagnosis are 50% more likely to have 3 or more emergency department visits in a year than do adolescents with only a medical diagnosis. These data are echoed in a letter of support from Bennington Cares (appendix 6)*"

Because data from fiscal year 2023 (Oct 2022-Sept 2023, including summer months) had been previously presented in the CON application, the answer provided to Q002 in June 2024 sought to update this analysis with the latest data available (fiscal year 2024 to date, Oct 2023-April 2024, which does not and could not include summer months). Page 8 of the answers to Q002 describes in detail the results of that analysis. SVMC did not omit summer months in an attempt to skew the data, the summer months were already included in the data presented in the CON application. Despite being independently conducted, both analyses showed nearly identical results;

The average length of stay in SVMC's emergency department for adolescent with a mental health primary diagnosis or comorbidity was:

- 31 hours for the time period Oct 2022-Sept 2023, including summer months
- 32.69 hours for the time period Oct 2023-April 2024, not including summer months

The difference between these results is negligible and are not enough to disqualify the finding that adolescents are spending excessive time in SVMC's emergency department, regardless of the time of year (summer or non-summer).

It is well recognized across the nation that pre-COVID the demand by adolescents for inpatient mental health care fluctuates seasonally, with the summer months having lower demand than non-summer months. However the historic difference in demand between summer and non-summer appears diminished since COVID and the demand for inpatient care is more similar across all seasons (anecdotal information gathered from Massachusetts that has not yet been quantified or published). During the reporting period of June 24, 2024 through August 5, 2024 the available mental health beds in Massachusetts were full, and an average of 31 adolescents were boarding in Massachusetts emergency departments (range of 22 to 44 adolescents).

There is another way to approach the question of whether the new inpatient unit at SVMC will 'create excess capacity within the system' particularly during the summer months. The first bullet on page 1 of this response is relevant here.
"*There is no specific data that definitively and quantitatively indicates the precise number of mental health beds needed to care for Vermont's adolescents* *because the available data is incomplete or flawed, demand is highly variable, and demand is impacted by access to other mental health care resources*."

If it is impossible to determine the precise number of beds needed, then it is impossible to determine whether the new mental health unit at SVMC will create excess capacity during a particular season of a future year.

The cost-based reimbursement model (described in the answer to question 2 above) will ensure fiscal sustainability of the new unit despite fluctuations in demand throughout the year. The per diem rate will flex annually in accordance with the prior year's census and to match operating costs. The table presented in the answer to questions 3 above illustrates how the per diem rate may fluctuate with the average daily census on an annualized bases.

10. In SVMC's June 17, 2024, response to the Board's question 6, SVMC indicated that, "it is not possible to calculate the duration of time a patient [in the emergency department] waits for an inpatient mental health bed" as opposed to discharge to a different level of care. If SVMC cannot quantify wait times for inpatient mental health beds relative to other appropriate levels of care, explain how SVMC has determined that access to additional inpatient mental health beds will reduce emergency room wait times.

The tables on page 8 and 9 of the answers to Q002 address this question. Twenty-two percent of the adolescents experiencing mental health crisis in SVMC's emergency department get admitted to an inpatient mental unit. These adolescents are in the emergency department for a very long length of time – more than 80% being in SVMC's emergency department for more than 24 hours, and 55% more than 2 days. The length of stay in SVMC's emergency department for adolescents in mental health crisis is 9.5 times longer than their counterparts

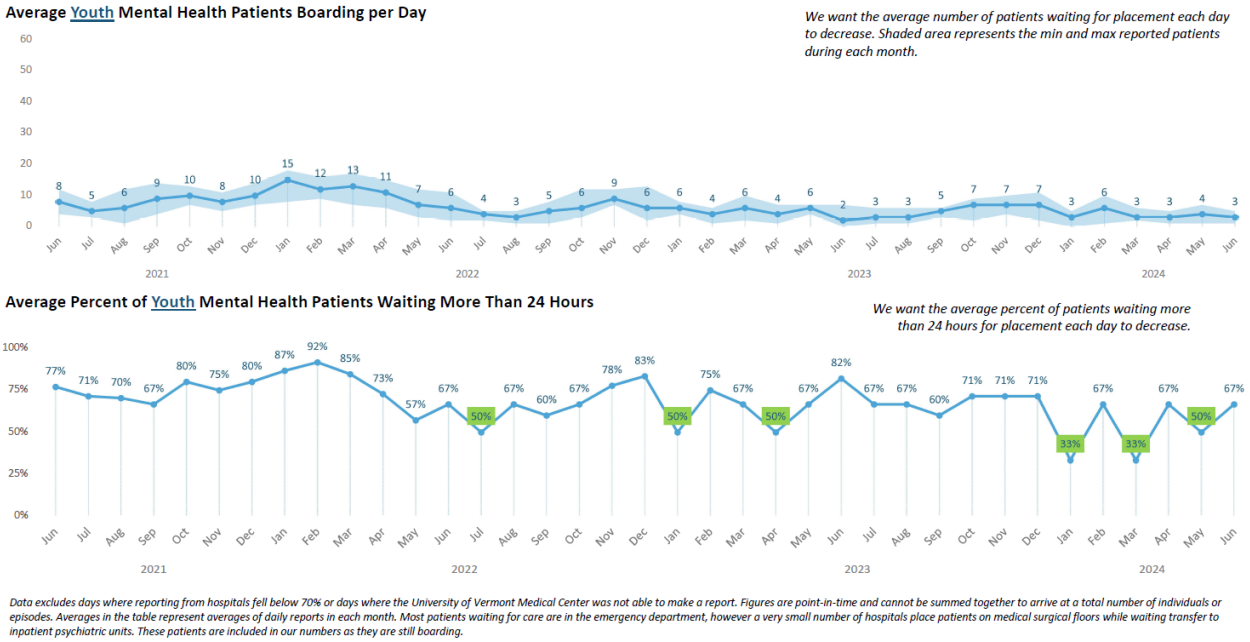
with medical conditions. For these adolescents in severe mental health crisis, the new inpatient mental health unit at SVMC will directly reduce the length of stay in the chaotic, non-healing environment of the emergency department. SVMC will be able to measure the reduced length of stay of adolescents experiencing mental health crisis in SVMC's emergency department.

Certainly if another level of appropriate care site was to be developed (ex. residential treatment), and the adolescent waiting in SVMC's emergency department could preferentially benefit from the speculative non-inpatient care site, then the length of stay of these adolescents in the emergency department would be reduced. However, we have no way of knowing the percentage of adolescents currently transferred to inpatient care that would still need inpatient care despite the speculative availability of another lower level of care site. Again, if the available data cannot inform a precise number of inpatient mental health beds needed for Vermont's adolescents, then the data cannot determine how another speculative non-inpatient care site might impact the demand for inpatient care. What is known is that youth in mental health crisis and currently slated for inpatient care are spending too long in the wrong non-healing environment of the emergency department.

A precise answer to the question posed requires considerable speculation and 'what if' scenarios ungrounded in data. What we know is that adolescents currently in need of inpatient mental health care are spending exhaustive time in emergency departments across the state.

11. In SVMC's June 17, 2024, response to the Board's question 3, please clarify whether the VAHHS report reflects monthly averages or individual patients and further clarify whether each of the patients in the VAHHS report was waiting for an inpatient bed.

On page 5 of the answers to the Q002, SVMC attempted to explain the source and methods of the data in the VAHHS report recording point-in-time surveillance of Emergency Department's mental health patients. Below is an attempt to clarify the methodology further. If this explanation remains insufficient, we respectfully recommend that future methodological questions be directed to VAHHS to better explain the data approach used to generate their report.



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.

Before the source and methodology for the data is explained, it is worthwhile to reiterate what the VAHHS point-in-time surveillance data shows and doesn't show;

- At every point-in-time surveillance check (more than 300 since 2021), youth in mental health crisis were identified in emergency departments across the state (bottom of the light blue shading in the top graph being greater than zero)
- The preponderance of these youth had been in the emergency department for more than 24 hours whenever the point-in-time surveillance occurred (dark blue line in the bottom graph)
- At NO point since June of 2021 (more than 300 assessments) were zero youth in mental health crisis identified waiting in emergency departments at the time of checking (bottom of the light blue shading in the top graph being greater than zero)
- The general data trend is that the number of youth waiting in emergency departments is decreasing (trend in dark blue line in top graph) and the percentage of youth waiting more than 24 hours is also decreasing (trend in dark blue line in bottom graph). Yet youth are still in emergency departments in Vermont and some are still waiting longer than 24 hours.

- The data is unclear whether individual youth are counted multiple times during successive surveillance checks
- The data is unclear whether all youth counted are waiting for inpatient care
- The data is unclear whether all youth that were counted subsequently received inpatient care or whether any of these youth were discharged to the community.
- The data is unclear on how long each youth waited and whether those waiting longer than 24 hours had been waiting for much longer than 24 hours or only slightly longer than 24 hours.

Because of the incompleteness of this data, multiple counterfactual interpretations are possible that range from 'there is no demand/capacity mismatch, Vermont has enough mental health inpatient beds for adolescents' to 'this is a significant and persistent crisis that should provoke action to immediately build another mental health inpatient unit for Vermont's adolescents'. As such, the VAHHS data is likely more reinforcing of one's biases than would resolve any dispute over whether the proposed mental health unit is quantitatively needed.

With that said, below is an attempt to explain how the VAHHS report is derived. Twice per week (Monday and Thursday), VAHHS receives a report from hospital emergency departments across the state that indicates the number of youth in mental health crisis in the emergency department and how many of those individuals have been in the emergency department for longer than 24 hours. Again, the data does not capture whether these youth have been indicated in prior reports, whether the youth are waiting for inpatient care, whether they've been waiting for much longer than 24 hours, whether the youth's mental disposition might change while waiting further thereby not necessitating subsequent inpatient care, or whether the youth would benefit from residential treatment.

Since the VAHHS system requires voluntary reporting, at each point-in-time surveillance, not all hospitals report. The most common causes for SVMC's emergency department to not report on a particular surveillance day are:

- The emergency department is too chaotically busy and all staff are strained caring for patients
- There is an ongoing crisis such as a violent patient that is commanding full attention of all staff
- A holiday.

As such, the report likely underestimates the count of youth in mental health crisis in Vermont's emergency departments and only loosely estimates the percentage of patient that have been waiting for longer than 24 hours.

The table below shows data extracted from the weekly VAHHS reports and shows how the data is summarized for the month of June.

	27-May	30-May	3-Jun	6-Jun	10-Jun	13-Jun	17-Jun	20-Jun	24-Jun	27-Jun	1-Jul	4-Jul
Hospitals reporting	Memorial	12	12	11	Not enough	11	13	11	11	10	11	Independ.
Youth in crisis in ED	Day no	1	4	1	hospitals	5	3	2	3	2	2	Day no
Youth in ED longer than24 hours	reporting	0	1	1	reporting	2	1	2	1	2	0	reporting

Average for June	2.75	Dark Blue Line in upper graphs above
Minimum for June	1	Lower light blue shade in upper graph above
Maximum for June	5	Upper light blue shade in upper graph above

The dark blue line in the top graph (above) is the average across the point-in-time surveillances for the month. For June 2024, the average of the number of youth in crisis in the ED is the average across the point-in-time surveillance for the days indicated by green in the table above (2.75 rounded to 3 in the graph above). The lower edge of the light blue shaded area is the minimum number of youth (1 patient) identified for any individual point-in-time surveillance during the month. For June 2024, this minimum occurred on the 6th.

The monthly percentage of patients waiting for longer than 24 hours is similarly derived from the daily point-in-time surveillance data.

In summary, the data presented in the VAHHS report is general data and not specific to the precise number of individuals waiting for placement for an inpatient bed. However, the VAHHS point-in-time surveillance report does indicate that some youth in mental health crisis are in Vermont's emergency departments and that many of the youth have been in these emergency departments for longer than 24 hours.

12. If the monthly average number of youths waiting in EDs in Vermont in the month of May 2024 was 4 patients, and 50% of those waited more than 24 hours, it appears that two patients per day across all of the reporting hospitals waited in the ED for more than 24 hours. Please confirm that these numbers are factual and provide the source for this statistic.

The source of the data is the VAHHS report. Please see the dark blue line in the graph in answer 11 above. The May data point indicates that on-average there were 4 youth in mental health crisis identified in Vermont emergency departments across all the point-in-time (Monday and Thursday) surveillances obtained by VAHHS. Moreover, 50% of these youth (2 per day) had been in the emergency department for more than 24 hours. However, we do not know if the same youth were counted multiple times.

In one possible scenario, four patients entered Vermont's emergency departments in mental health crisis on May 1. Two patients remained in the emergency department the entire month of May (through all 9 point-in-time surveillance checks in May), while each day 2 new patients arrived and were discharged on the same day. Thereby across the month of May, the average count of patients in mental health crisis in the emergency department would be 4, with 50% waiting longer than 24 hours, yet only 2 individual patients waited more than 24 hours.

In a counter possible scenario, rather than 2 individual patients remaining in the emergency department for the entire month of May, 2 uniquely new patients were waiting more than 24 for

each of the 9 surveillance checks – 18 patients. Thereby across the month of May, the average count of patients in mental health crisis in the emergency department would be 4, with 50% waiting longer than 24 hours, yet 18 individual patients waited more than 24 hours.

This is the challenge with the VAHHS data. The number of actual patients waiting in the emergency department for longer than 24 hours who needed inpatient mental health services in May is somewhere between 2 and 18. This number of inpatient beds required to serve a demand of 2 patients is vastly different from that required to serve 18 patients. If we assume a 15 day length of stay. The 2 patients represent 30 inpatient days, while the 18 patients represent 270 inpatient days – a huge difference in care demand. The 2 patients would require 2 beds (assume simultaneous need). The 18 patients would require between 9 and 18 beds depending on the overlap in timing of their need.

The statement in the question "**it appears that two patients per day across all of the reporting hospitals waited in the ED for more than 24 hours**" is indeed factually correct. However, the interpretation of that statement is wildly varied depending upon the precise details of the patients, their timing, and the situation. As such, SVMC is unclear as to why this question was posed except to attempt to suggest that few adolescents are in mental health crisis in Vermont's emergency departments, which cannot be determined by the data and likely incorrect. Perhaps the goal the question was to show that inpatient mental health beds are not needed, which again cannot be interpreted from the data.

There is no specific data that definitively and quantitatively indicates the precise number of mental health beds needed to care for Vermont's adolescents. However, Vermont adolescents deserve choice of provider and the state would benefit from having multiple units as indicated at the beginning of this document (sections A & B).

13. Explain what SVMC or the State of Vermont has implemented in advance of this application to expand community-based services, improve discharge options, and reduce psychiatric inpatient hospital admissions.

Documenting all efforts by state agencies to improve the mental health care ecosystem across the entire state that have been implemented by state agencies and might reduce the need for future mental health inpatient admissions is beyond the scope of this CON application and far beyond the knowledge of SVMC. The Vermont Department of Mental Health might be better positioned to answer this question. It appears that this question is asking about the state wide strategy to build a comprehensive mental health care ecosystem that addresses adolescent mental health with a focus on providing prevention and care in the most unrestrictive environment. The proposed mental health unit at SVMC is only one small component of the strategy to bolster the entire continuum of mental health care and build resilience in the various service levels.

SVMC has taken several specific steps to reduce the future need for hospitalization of local adolescents in mental health crisis. Most notably, SVMC has partnered with United Counseling Service, the designated agency in Bennington County, to launch an intensive outpatient

program for youth, Hope House. This program grew out of PUCK, pediatric urgent care for kids, a well-recognized and lauded program that diverts children in need of mental health care away from SVMC's emergency department. At Hope House, youth and their families learn coping and resiliency skills that can mitigate mental health crisis. The age range managed by Hope House is currently younger than that which will be treated in the proposed inpatient unit. However, as those youth reach adolescents, the experience of Hope House will hopefully reduce their risk of mental health crisis and need for hospitalization. Hope House manages a small population of the children from Bennington County and only those in most immediate need. The proposed inpatient mental health unit at SVMC will serve adolescents from across the entire state. Therefore it is unclear whether Bennington's Hope House will substantially reduce future statewide demand for inpatient mental health care.

SVMC encourages any and all efforts to expand mental health care services for youth and adolescents across the state. The current continuum of care seems unbalanced against persistent and unabating demand for mental health care (See recent New York Times article that describes the youth epidemic in mental health, appendix 1).

14. For the adolescents waiting in EDs for placement, explain whether there is available data identifying the total number or percentage of adolescents awaiting placement monthly or annually and, of the total, the number of individuals who do not have co-occurring medical needs and could be provided appropriate psychiatric treatment in a residential treatment setting.

SVMC is unaware of data that documents the medical status (with/without medical comorbidities) of adolescents in mental health crisis that have received or were waiting for inpatient mental health care.

SVMC is unaware of data that identifies adolescents who have received inpatient mental health care that might have benefitted from residential psychiatric treatment.

15. In response to question 11 on page 15 of your response to Q002 dated June 17, 2024, you addressed the question with regard to serving adolescents with co-morbid medical conditions but you did not address the question with regard to adolescents with co-morbid developmental disabilities. Please explain in more detail how SVMC's new inpatient program will serve adolescents with co-morbid developmental disabilities.

To ensure the highest quality care, the conditions and comorbidities of adolescents accepted into SVMC's mental health unit will align with the capabilities of the clinical team. Conditions and comorbidities beyond the scope and skill of the clinical team will not be admitted to the unit. As indicated in Q002, the clinical team has not yet been recruited or on-boarded and will be developed while the unit is under construction. Without the clinical team, it is very difficult to definitively indicate which conditions and comorbidities will be admitted to SVMC unit and which will not be admitted.

It is likely the clinical team will be able to effectively care for some/many adolescents with co-morbid development disabilities. Adolescents with conditions that result in head-banging, chronic swallowing, or significant risk of injury to others will likely be beyond the scope and skill of the clinical team. However, the clinical team will likely be able to provide effective treatment for adolescents with some developmental disabilities such as intellectual disabilities or autism spectrum disorder.

The Department of Mental Health collaborates with organizations in Vermont assisting individuals with developmental disabilities (Developmental Disabilities Service Providers | Developmental Disabilities Services Division (vermont.gov)). This collaboration can inform appropriate inpatient placement of adolescents with developmental disabilities that are experiencing mental health crisis.

16. Explain in detail the specific "processes to maintain communication and connectivity with families" that SVMC is planning to implement.

The inpatient mental unit at SVMC with use the methods used today to maintain connectivity between medical patients and families including, in-person hospital visits, telephonic, and video chat. SVMC appreciates that the family connectivity needs of adolescents in mental health crisis are different that those of medical patients. During the construction phase of the project, the precise methods and protocols for this connectivity will be developed in collaboration with the Dartmouth Health Department of Psychiatry and informed by individuals with lived experience during the construct phase of the project. The unit will be fit with technology to allow 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.

The family connectivity with adolescents in mental health crisis cannot be precisely protocolized or specifically defined but must be individualized to the specific needs of the adolescent. Moreover, the frequency and intensity of the connectivity with family will likely evolve over the course of the individual adolescent's inpatient treatment. As such it is not possible to "Explain in detail the specific process to maintain" this communication- it will be individualized and ever changing.

SVMC recognizes the importance of communication between the adolescent and family. SVMC will collaborate with patients and families to develop methods that best support the mental health healing of the adolescent throughout the course of the inpatient care.

17. Explain whether SVMC will evaluate travel challenges for Vermont families and create a plan to provide additional support and assistance for families beyond establishing processes to maintain communication and connectivity with families.

Families with adolescents being treated at SVMC's inpatient mental health unit might experience travel and lodging challenges, particularly those families originating from distant communities in northern Vermont. Although the idea of providing support and assistance to families seems like a simple idea, there are three reasons why doing so might be challenging:

- Deciding who receives the support, and who does not, would be complicated and require a rigorous process or all families should be offered the same support
- Depending upon the scale of the support, the cost to the program, and to the state, could be substantial
- Providing support at a scale that actually assists families might have legal chalenges

For these reasons, SVMC recommends not pursuing providing direct support and assistance to families with adolescents being treated at SVMC's inpatient mental health unit. The operating budget submitted with the CON application did not include financial support for families. If providing family support is a state priority, an allowance for all families with adolescents in SVMC's unit would need to be built into the operating budget.

SVMC is willing to entertain other simple non-financial suggestions of ways to support families. Perhaps a volume-driven discounted rate for patient families could be established at a local hotel or eatery. SVMC cannot proceed with seeking such non-financial benefits until after the CON is approved. Below is a more thorough explanation of why forms of direct support or indirect support that has financial implications to SVMC would be challenging.

<u>Deciding which families receive support would be complicated</u>
No single criterion or set of criteria could be established that would cleanly identify the families who need support and those families that do not need support. For example, distance between the family's home and SVMC should not be used as a criterion, because a family living one mile closer to SVMC may not be eligible thereby creating an unfair situation. Moreover, a family living nearby SVMC with wheel-chair bound family members and limited transportation options might have more hardship visiting their child at SVMC than an able-bodied family with effective transportation from farther away. Rather than a single criterion, a suite of pre-established criteria could be established. However, for every criterion in the set there would be rational exceptions, thereby making the set of criteria ineffective.

An alternative approach to determine which families will receive support would be to establish a committee that would review requests from families. There are several problems with this approach. The effort of the committee would need to be funded. The decisions from the committee would likely be delayed by the review and deliberation process. Despite best efforts, the decisions may be influenced by inherent biases of committee members. And families with language barriers might have difficulty communicating a persuasive argument of their need for support. A committee to determine which families should receive support, and those that should not, is not a sensible solution.

Each family's situation is unique and the barriers are unique to them. Some of these barriers might be very personal. SVMC's process to determine which families will receive support could set-up a trauma inducing situation to either reveal very personal issues or not receive financial support.

Thereby, if SVMC is mandated to provide support to families, then SVMC recommends all families are made aware of the support and all families receive equitable support upon request without criteria or a review/approval process.

Cost of providing support to families could be significant
The overall cost of the program is dependent upon the amount of support given to each family. If the state required SVMC to provide $1,000 to each family to ease the financial burden created by inpatient admission of their child, then $267,000 in funds is needed to support the families of the 267 adolescents anticipated to be treated annually.

The operating budget submitted with the CON application did not include $267,000 in financial expense to support families nor the equivalent revenue. The proposed financial model is for the unit to be financially sustainable and budget neutral to SVMC. Thereby a mandate for SVMC to provide support to families, is a mandate for the state and insurance companies to provide $67 ($1,000 / 15 days length of stay) more in the per diem reimbursement rate. If providing family support is a state priority, the expense and revenue would need to be built into the operating budget and the reimbursement rate.

Providing support to families might not be legal
SVMC and the state would need to determine whether direct financial support to a patient's family does not run afoul with fraud and abuse laws or other regulatory statutes. Also parity across institutions would be required or families might elect one treatment institution over another based upon the magnitude of family support.

For these reasons, SVMC recommends not pursuing providing direct support and assistance to families with adolescents being treated at SVMC's inpatient mental health unit. SVMC is willing to provide family financial support, if it is deemed legal, if the operating budget and per diem reimbursement rate account for the added expense, and if all families have equal access to the support without criteria or a review/approval process. SVMC is willing to entertain other simple non-financial suggestions of ways to support families.

18. You have stated that SVMC's ED treated 98 adolescents (age 12-17) with a mental health primary diagnosis from October 1, 2023-April 30, 2024. Twenty-two percent of those adolescents were eventually transferred to an inpatient facility. Explain in detail whether those adolescent patients could have benefitted from crisis stabilization services or direct placement in a residential psychiatric treatment facility circumventing the need for inpatient treatment at a hospital.

Retrospectively determining if another care plan involving an alternative hypothetical care site might have been beneficial for a historic patient would require an extensive and expensive detailed chart review by a trained care professional. Although theoretically useful, conducing such a retrospective review of clinical decision making is beyond the scope of this CON application. Moreover, such a retrospective review of clinical decision making is likely to demonstrate that documentation in the chart is insufficient to provide a definitive determination of whether the patient would benefit from an alternative care plan involving an additional hypothetical resource. Clinical documentation is just not detailed enough to capture the nuances of most clinical decision making, especially around considerations of what could happen if hypothetical resources were available at the time of the decision. SVMC does appreciate the intent of this question, however, the approach requested is not possible nor practical.

Summary

SVMC is grateful for the questions from the Green Mountain Care Board, particularly those from the interested parties. The determination to launch an inpatient mental health unit is a challenging one given strong opinions on all sides and limited data. The most important dimension is to provide children and families with a choice of provider for receiving high quality care. SVMC appreciates the open CON process as it captures competing voices to inform critical decisions. Our hope is that the answers to these questions provides sufficient context for the decision to proceed.

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

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Appendices:

Appendix 1 – New York Times Article 8/8/2024

Appendix 1

The New York Times
The Morning
August 8, 2024

A national struggle

By Ellen Barry
I cover mental health.

It is no mystery why rates of anxiety and depression in the United States climbed in 2020, at the height of the pandemic. But then life began a slow return to normal. Why haven't rates of distress returned to normal, too?

Self-reported anxiety and depression have declined from the peak they reached in November 2020, when 42.6 percent of adults said they had symptoms, according to the Household Pulse Survey, a Census Bureau tool that measures well-being. Since then, that figure has declined to 20.7 percent. That's still double the 11 percent of Americans who said the same thing before the pandemic.

In today's newsletter, I'll explain why. Researchers say a big reason for this stubbornly elevated distress is young people, whose low mood was not linked to the pandemic.

A youth epidemic

The share of young adults reporting anxiety and depression had been rising for about a decade before Covid struck. That continued throughout the pandemic — and did not ease as quickly when vaccines became available.

This is likely because their symptoms were tied to problems other than the virus, like economic precarity, the housing crisis, social isolation and political turmoil, said Emma Adam, a psychologist at Northwestern. "There's so many things affecting adolescents and young adults that are about uncertainty with their future," Adam said. "And that hasn't changed."

Age, of course, tracks with income. Adam's team found that people between the ages of 18 and 39 were half as likely to live in their own home as their counterparts over 40. That means they were especially vulnerable to inflation, rent increases and job loss — just as they faced big decisions like whether to have children or own a home.

But it wasn't just about the economy. Researchers at Johns Hopkins found measurable declines in mood after the U.S. Supreme Court ruling that abolished the federal right to abortion. Women in states where abortion bans took effect had reported more anxiety and depression compared with counterparts in other states. There was no such difference for men.

Even though politics, law and the economy affect everyone, the young may pay more attention to social conditions, said Ludmila Nunes, who tracks research for the American Psychological Association. So they are both more exposed to the consequences and more aware of them. “These events affect them more than older people,” Nunes said. “So it’s normal that they are going to respond more.”

The older, the happier

The good news is, by some measures, distress is gradually declining. In November 2020, when vaccines were announced, “we see what almost looks like an exhale” among people in midlife or older, said Sarah Collier Villaume, another researcher at Northwestern.

There are various ways to measure mental distress, and not all of them reflect that exhale. The Behavioral Risk Factor Surveillance System, a national survey conducted by the C.D.C. that asks subjects how many days of poor mental health they experience per month, shows an unbroken upward trend. But that metric, too, shows that age boosts mental health.

While older people show declines in attention and memory, they seem to gain more control over their emotions. Some research suggests that older people learn to focus more on positive memories — or what one team of psychologists called “emotionally gratifying memory distortion” regarding the past.

Researchers at Boston College set out to test this hypothesis by surveying people between the ages of 18 and 80 about their memories from the early part of the pandemic. They found something paradoxical: The older their subjects were, the more positive memories they had of the pandemic, even though they were physically more at risk. This puts young people at a disadvantage when facing traumatic events. And if their stress was driven by economic and political uncertainty, rather than fear of illness, then there is no reason to expect it to recede.

Adam said her best guess is that older Americans would continue to recover faster than younger ones. “We can’t answer the fundamental question” of when, and if, Americans’ moods will return to a prepandemic norm, “except to predict very strongly that the age disparities will still be there,” she said.

Verification Under Oath

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	Answers to questions	)	
	Certificate of Need to	)	Docket No. GMCB-014-23con
	Inpatient Mental Health Unit	)	
	For Adolescents	)	

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

Robert Laba, being duly sworn, states on oath as follows:

1. My name is Robert Laba. I am the Chief Financial Officer and Vice President of Finance of Southwestern Vermont Medical Center. I have reviewed the answers to questions about the Certificate of Need Application for the project to create an inpatient mental health unit for adolescents.

2. Based on my personal knowledge and after diligent inquiry, I attest that the information contained in the answers to questions about the project to create an inpatient mental health unit for adolescents is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact.

3. My personal knowledge of the truth, accuracy and completeness of the information contained in the answers to questions about the project to create an inpatient mental health unit for adolescents is based upon either my actual knowledge of the subject information or upon information reasonably believed by me to be true and reliable and provided to me by the individuals identified below in paragraph 4. Each of these individuals has also certified that the information they have provided is true, accurate and complete, does not contain any untrue statement of a material fact and does not omit to state a material fact.

4. The following individuals have provided information or documents to me in connection with the answers to questions about the project to create an inpatient mental health unit for adolescents and each individual has certified, based either upon his or her actual knowledge of the subject information or, where specifically identified in such certification, based on information reasonably believed by the individual to be reliable, that the information or documents provided are true, accurate and complete, do not contain any untrue statement of a material fact, and do not omit to state a material fact:

   James Trimarchi, Director Planning

5. In the event that the information contained in the answers to questions about the project to create an inpatient mental health unit for adolescents becomes untrue, inaccurate or incomplete in any material respect, I acknowledge my obligation to notify the Green

Mountain Care Board and to supplement the answers to questions about the project to create an inpatient mental health unit for adolescents as soon as I know, or reasonably should know, that the information or document has become untrue, inaccurate or incomplete in any material respect.

[signature]

On 8/2/2024, Robert Laba appeared before me and swore to the truth, accuracy and completeness of the foregoing.

Notary public
My commission expires 1/31/2025

SEAL