Dartmouth Health

Southwestern Vermont Medical Center

November 26, 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 fifth round of questions (005) dated September 25, 2024

Before providing answers to the fifth round of questions (005), it is worth noting that SVMC has already answered many of these questions or provided information as to why SVMC is unable to answer these questions.

SVMC is concerned that the protracted CON process has caused three detrimental impacts to Vermonters;

- The capital cost of the project has increased from $9.5M to $10M due to construction inflation (6%) over the year-long CON process[1]
- The per capita total cost of care has remained high rather than quickly launching SVMC's unit that is 40% less expensive for Vermonters and payers, including Vermont Medicaid[2]
- Adolescents in mental health crisis suffered an additional unnecessary year with constrained access to the care they deserve

With the submission of responses to these questions, SVMC hopes the process can proceed quickly to close the CON application, move through the public hearing, and obtain a swift CON determination by the Green Mountain Care Board.

Some of these questions (Q005) inquire about the overall demand for inpatient mental health care by Vermont's adolescents – specifically, whether the capacity at Brattleboro Retreat already meets the need, and whether an additional unit at SVMC is needed to serve unmet demand. The current state of capacity and statewide demand validates the findings of the original 2023 feasibility study conducted by SVMC in partnership with the Department of Mental Health. At the time of the feasibility study, the number of inpatient mental health beds at the Brattleboro Retreat was limited. The study indicated that more inpatient beds were needed to serve the adolescents waiting in emergency departments across the state. Due to several factors the feasibility study was unable to specify an exact number of beds needed to meet statewide demand. Since completion of the feasibility study, the Brattleboro Retreat has nearly

[1] Construction and data services firm Gordian indicates that construction costs are still inflating at 6%. See page 26 and 27 for more detailed calculation of the project escalation and explanation.
[2] See answer to question 12, page 21 for more detailed explanation

doubled their number of beds serving adolescents and those beds are consistently full. If the Brattleboro Retreat had not expanded its bed capacity and SVMC had been granted swift approval and built its unit, the beds at SVMC would be filled, thereby validating the feasibility study findings that more beds were needed. Today, SVMC uses the same data and argument to suggest that there remains unmet demand for inpatient mental healthcare by adolescents. Adolescents are still waiting in emergency departments across the state. The logic underpinning the feasibility study's finding that more beds are needed has been demonstrated to be correct and is still applicable today. Despite the expanded bed count at the Retreat, Vermont's adolescents need more inpatient mental health beds.

The feasibility study leveraged the per capita number of pediatric mental health beds in Massachusetts to estimate a possible lower limit of additional beds needed to serve Vermont's adolescents. The most recent Massachusetts mental health crisis report indicates that despite all available pediatrics beds across the state being open and staffed, there are still 71 adolescents in mental health crisis waiting in emergency departments in Massachusetts[3]. This observation further validates the SVMC/DMH feasibility study's findings and suggests that Vermont needs more inpatient mental health beds for adolescents than currently offered by the Brattleboro Retreat.

For a more detailed explanation of why it is impossible to specify the exact number of inpatient mental health beds needed to care for Vermont's adolescents please reread the detailed responses to question 3 of the second round of questions and question 1 of the fourth round of questions. For convenience and to demonstrate how several of the questions in this round (005) duplicates questions already asked, the previous questions and responses are provided in appendix 1.

SVMC reiterates; 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 changes in access to other mental health care resources (ex. outpatient counselling or mobile crisis programs). Thereby, **it is not possible to calculate the definitive number of additional beds needed above those currently available at the Brattleboro Retreat**. SVMC's plan to develop an inpatient mental unit for adolescents was in response to a request for proposals from the Vermont Department of the Mental Health. Adolescents in mental health crisis are still waiting in emergency departments. Patients and their families deserve a choice of provider. And establishing more than one inpatient mental health provider for adolescents would be beneficial for the state (service resilience, financial and operational comparison, sharing of quality care processes, etc.).

[3] Capturing a Crisis: Weekly Behavioral Health Boarding Reports - Massachusetts Health & Hospital Association. https://www.mhalink.org/bhboarding/

Many of the questions in this round (Q005) again request detailed information about the proposed unit's admission criteria and processes, its services, its collaboration with outpatient services across the state, or its discharge processes. Such operational details beyond the general framing of operations that we have previously supplied cannot be developed until the care team has been hired, which can only occur after the CON is approved. We have stated such in the responses to several previous questions. Although questions about operations appear to be sensible at first blush under the guise of ensuring that the new unit delivers quality care, probing the details of operations prior to their development seems unhelpful and beyond the certificate of need process. Inquiries of details of yet-to-be developed operations is a distraction from the points critical to this CON process;

- Vermont's adolescents need more access to inpatient mental health care as evidenced by the number of youth waiting a very long time in EDs across Vermont
- Vermont's adolescents and their families deserve a choice of providers
- The state would benefit from having more than a single institution serving the inpatient mental health needs of adolescents for resiliency, comparison, and sharing of best-practices.
- When provided the opportunity, SVMC has a strong track record of creating and managing operations that deliver high quality, high value care.

Lastly, SVMC's unit will be a better value for Vermont's than the Brattleboro Retreat. **The anticipated per diem rate at SVMC unit is 40% less expensive than that at the Retreat.** Launching SVMC's unit will save Vermonters money and reduce the per capital total cost of care.

Below are answers to the Q005 questions.

1. **The Feasibility Study assumed 14 inpatient beds for adolescents at the Retreat. The Retreat currently has 23 inpatient beds for adolescents that can flex to 27. Scenarios for more than 14 beds at the Retreat were not included in the feasibility study. Explain why different scenarios for the number of existing beds were not included in the feasibility study to determine the number of additional beds that may be needed at SVMC. Given the 23 beds at the Retreat, please work with the consultant to revise and specify the number of additional inpatient beds that are needed for Vermont adolescents.**

The feasibility study conducted in collaboration with the Vermont Department of Mental health has been finalized and the associated report completed. The report cannot be reopened or appended and SVMC's contract engagement with the consult to assist in the feasibility study has ended. Thereby it is not possible to have "the consultant revise and specify the number of additional inpatient beds that are needed for Vermont adolescents".

This question continues to inquire about three things that are nearly impossible to specify beyond the level SVMC has previously provided:

- Quantitatively state the overall demand for inpatient mental health care by Vermont's adolescents
- Whether the capacity at Brattleboro Retreat already meets the need, and
- Whether an additional unit at SVMC is needed to serve unmet demand.

With all due respect, SVMC reiterates that this question is impossible to answer with greater specificity than has already been provided.

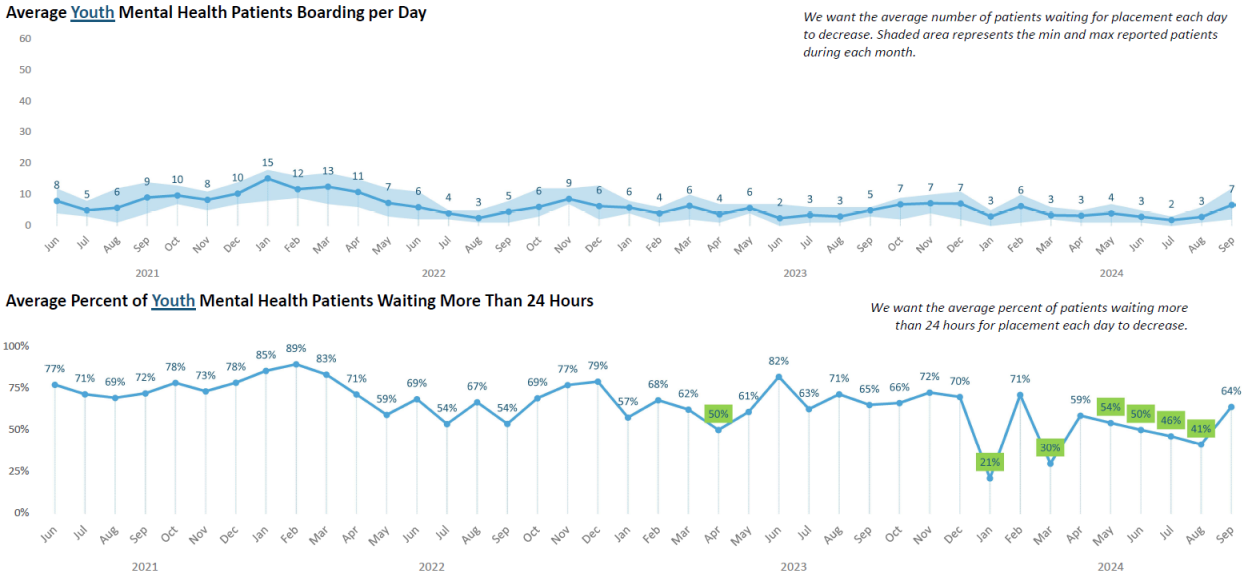
The response to question 3 of the third round of questions (Q003) and to question 1 of the fourth round of questions (Q004) go into great depth to explain why it is impossible to determine statewide demand for inpatient mental health care by Vermont's adolescents and whether the capacity at Brattleboro Retreat already meets the need. In an effort to ease access to these previous answers, the questions and responses are provided in Appendix 1, page 30.

In summary, it is impossible to quantitatively determine:

- The statewide demand for inpatient mental health care by Vermont's adolescents
- Whether the capacity at Brattleboro Retreat already meets the need, and
- Whether an additional unit at SVMC is needed to serve unmet demand.

Determining statewide demand is impossible because the data required to do so is unavailable. and because the demand is highly dynamic. Any change in the mental health treatment ecosystem (increase or decrease in outpatient counselling access (ex. retirement of a counselor), launch of a mobile crisis units, or establishment of a residential mental health service) may logically alter the demand. Thereby it is 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, 27, 30, 37, or 40 available beds. Although a top number of inpatient mental health beds needed to care for Vermont's adolescents does exits. The lack of data and dynamics of the system does not allow definitive determination relative to the beds present at the Retreat. With all due respect, please discontinue inquiring about whether the capacity at Brattleboro Retreat quantitatively meets demand. It is impossible to answer the question.

What is known is that youth are suffering as they wait in emergency departments for inpatient mental health care. The most recent report from the Vermont Association of Hospitals and Health Systems (VAHHS) shows an uptick in adolescents waiting with more than half (64%) waiting more than 24 hours.



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.

Also, SVMC has continually pressed that adolescents and their families deserve choices for their care. The SVMC unit would provide choice for Vermonters and be good for the state of the Vermont.

2. **In a table format, provide a full list of the mental health services and the physical health services that will be provided on-site at the unit. Explain in detail how available mental health and physical health services will be integrated, coordinated, and delivered during and after the inpatient stay.**

SVMC is unable to provide a "full list of mental health services and physical health services that will be provided on-site at the unit". The care provided to patients will be evidence-based, anchored in best-practices, and adjusted to the needs of the patient. Thereby providing a full list of service is not possible, a futile task, and not sensible. SVMC adolescent mental health unit will treat the range of mental health conditions typical of this population and allow treatment of patients with co-occurring medical conditions.

Perhaps the goal of this question is an attempt to leverage any list that might be provided to indicate that the Brattleboro Retreat already provides these service and the unit at SVMC is therefore not necessary. In the simplest terms, the vast majority of the services provided at SVMC's unit (both mental and medical) will be similar to, if not identical to, the care provided at the Brattleboro Retreat. The goal of SVMC's unit is to care for the inpatient mental health needs of Vermont's adolescents, the same population served by the Retreat. If both units are meeting the mental health care needs of the same population, then the units will likely deliver remarkably

similar services. Attempting to disqualify SVMC's unit because it does not deliver care different from the Retreat belies the goal of SVMC's unit to:

- Increase access to care
- Provide adolescents and families choice of provider
- Provide the state with a comparable financial and operational approaches between inpatient units, share of quality care processes across units, and ensure resiliency of access in the event of financial strain of natural disaster that compromises access at one of the providers.

The launch of SVMC's mental health unit for Vermont's adolescents would be good for Vermont, even if it delivers care that is similar to that delivered at the Brattleboro Retreat.

A portion of the response to question 10 of the second round of questions (Q002) attempted to address this and appears in Appendix 2, page 40.

The training and experience of the mental health clinical team will determine which services are provided on the unit. The specific services that SVMC will offer cannot be comprehensively listed ("full list") prior to the hiring of the clinical team. The clinical team will be hired after CON approval in accordance with normal advancement of similar CON projects and the timeline provided in the application.

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

- Depression
- Severe Anxiety
- Obsessive compulsive disorder
- Schizophrenia
- Suicidality
- Bipolar disorder
- Post-traumatic stress disorder
- Personality disorders

In general the mental health services will include;

- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Medication management
- Individual and group counseling
- Family counseling

The diagnosis and care needs of each patient will direct the treatment plan and the services provided.

The medical services for the adolescents on the inpatient mental health unit will be provided by SVMC's pediatricians and predominantly include care for routine medical conditions typical of adolescents;

- Diabetes
- Asthma management
- Wound care
- Urinary tract, ear, and eye infections with antibiotic prescribing
- Seizure disorders
- Other minor condition management

In addition to these routine services, SVMC has the capability to provide more intensive medical services to the adolescences including diagnostic imaging and laboratory services, and surgery. The individualized care plan developed by the clinical care team, including the pediatricians caring for the medical needs of the adolescents, will dictate the utilization of more intensive medical services.

SVMC is unaware of the medical capabilities and limitation of the Brattleboro Retreat. Similarly, SVMC is unaware of the specific medical conditions that create challenges for adolescent placement into inpatient mental health care as described by the Department of Health in the initial Request for Proposals (see Q002, question 11 for screen shot of the scope of services the requested unit will provide). Thereby it is unclear whether the medical services anticipated to be available to adolescents at SVMC's inpatient unit will differ from those at the Brattleboro Retreat or whether SVMC's unit will serve an unmet need for adolescents with mental and medical comorbidities. SVMC is willing to consider expanding the medical services associated with its mental health unit to better meet the unmet needs of Vermont's adolescents in accordance with more specific guidance from and in collaboration with the Department of Health after the CON is obtained and the unit is in operation.

Lastly adolescents will maintain their educational advancement through partnership with LearnWell, a nationally recognized educator for adolescent inpatient mental health units.

Again, SVMC anticipates that this description of planned services will not dissuade interested parties to this CON process, as what is described are not services markedly different from those already provided by the Brattleboro Retreat. The goal of SVMC's unit is to care for the inpatient mental health needs of Vermont's youth, and thereby the unit will likely deliver services remarkably similar to those provided at the Brattleboro Retreat that serves the same population. The purpose of this project is to address the following;

- Vermont's adolescents need more access to inpatient mental health care as evidenced by the number of youth waiting a very long time in EDs across Vermont
- Vermont's adolescents and their families deserve a choice of providers
- The state would benefit from having more than a single institution serving the inpatient mental health needs of adolescents for resiliency, comparison, and sharing of best-practices.

When provided the opportunity, SVMC has a strong track record of creating and managing operations that deliver high quality, high value care.

3. Provide the following information:

a. A complete list of all services (clinical, educational, non-clinical, etc.) to be provided;
b. The provider type (including level and FTE) delivering each service including certification/licensure;
c. The frequency of provision for each service;
d. The duration of each service;
e. Whether the service will be provided on or off-site (specify location if service is provided off-site);
f. Total staff required to appropriately staff the adolescent mental health unit and meet the co-occurring physical health needs of patients.

SVMC cannot provide a 'list of all services' that will be provided for the reasons indicated in the response to question 2 above (Q0005, #2) – the clinical team managing SVMC inpatient mental health unit will determine the services provided and the clinical team will not be hired until after the CON is approved (as is customary).

The initial CON application and several answers to previous questions provide a general description of the services that will be provided including;

- Mental health and psychiatric care (CBT/DBT, medication management, individual and group therapy, etc.)
- Medical care typical of that needed by adolescents
- Educational services through LearnWell
- Connectivity to family
- Connectivity to community
- Connectivity to outpatient counselors
- Space for support services such as from the Department for Children and Families, , the Agency for Human Services, the Vermont Alcohol and Drug Abuse Program, or other state agencies as appropriate for the adolescent.

Because it is impossible to provide a complete list of all services to be provided, and the care team has not yet been hired, it is doubly impossible to indicate the provider type and FTE level, including their certification and licensure, for each of the services that will be provided. Such detail is just not sensible to request or provide of a yet undeveloped unit.

Because it is impossible to provide a complete list of all services to be provided, and the care team has not yet been hired, it is doubly impossible to indicate the frequency and duration of each of the services that will be provided. Such detail is just not sensible to request or provide of a yet undeveloped unit. The therapeutic program will provide care 7 days per week.

All of the services to be provided by the unit will be provided on-site. No off-site services will be provided as part of the inpatient mental health unit.

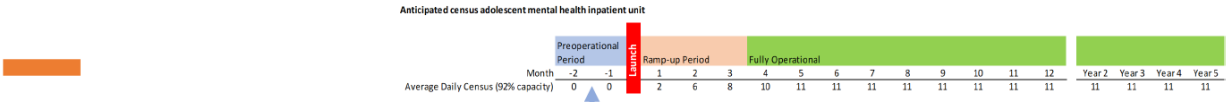
The staffing model for the unit was very carefully described in detail several times in the original application (pages 13 and Appendix 2- Feasibility study page 9, and Appendix 1 of the

Feasibility study, slides 21-23). These staffing models were carefully developed, scrutinized and sculpted by leadership at the Dartmouth Health Department of Psychiatry and the Vermont Department of Health. Efforts were made to ensure that sufficient specific staff were available to provide best-practice care for adolescents. When fully operational the number of staff during weekdays exceeds the number of patients (ratio of more than 1 to 1) highlighting the commitment to high-quality care.

Ratio of staff to patients (example 1.0 = 1 to 1, number greater than 1, reflects more staff than patients)

	Weekdays			Weekends		
	Day	Evening	Night	Day	Evening	Night
12 patients	1.2	0.7	0.3	0.8	0.6	0.3
8 patients	1.5	0.8	0.5	0.9	0.6	0.5

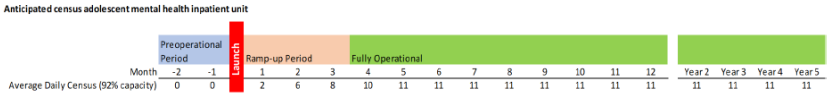
The three graphics below show the staffing model during the pre-operational, ramp-up and stable operational periods and we're extracted from the feasibility study which was included with the initial CON application.



Staffing Preoperational Period (2 months)

- The preoperational period will include the following efforts;
  - Establish care protocols
  - Finalize regulatory reviews
  - Orient staff and build cohesive team
  - Establish coordination with the LearnWell instructor
  - Establish relationships with Designated Agencies across VT
  - Coordinate with the Department of Mental Health's Care Management Team overseeing mental health admissions
- The efforts during the preoperational period will be coordinated by the Nurse Manager and Medical Director

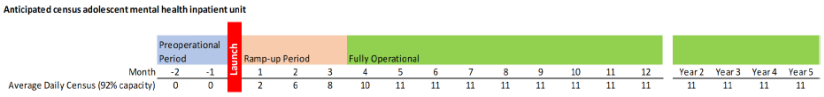
Number of people on the unit	Weekdays
Preoperational Period	**Day (8hrs)**
RN	1.00
Charge RN	0.00
Mental Health Technician (sitter)	0.00
Mental Health Counselor	1.00
Occupational Therapist	0.10
Unit Coord	0.10
Social Work	0.50
Nurse Manager	1.00
Providers	
APRN (DH Dept of Psychiatry)	1.00
MD Psychologist (DH Dept of Psychiatry	0.50
MD Psychiatrist (DH Dept of Psychiatry)	0.80
Mental Heath Medical Director (One of the persons that are MD Psychiatrist above)	0.20



Staffing Ramp-up Period (3 months)

- The providers required for 12 patients are required during the ramp-up period and to manage 8 patients
- During the ramp up period there will be;
  - 1 fewer RN
  - 1 fewer Mental Health Technician
- The number and complement of all other staff remain constant

8 patients or less- low staffing	Number of people on the unit Weekdays Day (8hrs)	Evening (8hrs)	Night (8hrs)	Weekends Day (8hrs)	Evening (8hrs)	Night (8hrs)
RN	1.00	1.00	1.00	1.00	1.00	1.00
Charge RN	1.00	1.00	1.00	1.00	1.00	1.00
Mental Health Technician (sitter)	2.00	2.00	2.00	2.00	2.00	2.00
Mental Health Counselor	2.00	2.00	0.00	1.00	1.00	0.00
Occupational Therapist	0.50	0.00	0.00	0.50	0.00	0.00
Unit Coord	1.00	0.00	0.00	0.00	0.00	0.00
Social Work	1.00	0.00	0.00	0.00	0.00	0.00
Nurse Manager	1.00	0.00	0.00	0.00	0.00	0.00
Providers						
APRN (DH Dept of Psychiatry)	1.00	0.00	0.00	1.00	0.00	0.00
MD Psychologist (DH Dept of Psychiatry	0.50	0.00	0.00	0.00	0.00	0.00
MD Psychiatrist (DH Dept of Psychiatry)	0.80	call	call	0.80	call	call
Mental Heath Medical Director (One of the persons that are MD Psychiatrist above)	0.20	0.00	0.00	0.00	0.00	0.00



Staffing Fully Operational

- Staff to match programming
- 2-3 RNs
- 2-3 Mental Health Technicians (sitters)
- 2-3 Mental Health Counselors
- Support staff
- Providers will be members of Dartmouth Hitchcock's Dept of Psychiatry
- Pediatric Psychiatrist and APRN
- Pediatric psychologist
- Some provider interaction may occur through telemedicine or through a purchased service

Greater than 8 patients- high staffing	Number of people on the unit Weekdays Day (8hrs)	Evening (8hrs)	Night (8hrs)	Weekends Day (8hrs)	Evening (8hrs)	Night (8hrs)
RN	2.00	2.00	1.00	2.00	2.00	1.00
Charge RN	1.00	1.00	1.00	1.00	1.00	1.00
Mental Health Technician (sitter)	3.00	3.00	2.00	3.00	3.00	2.00
Mental Health Counselor	2.00	2.00	0.00	1.00	1.00	0.00
Occupational Therapist	0.50	0.00	0.00	0.50	0.00	0.00
Unit Coord	1.00	0.00	0.00	0.00	0.00	0.00
Social Work	1.00	0.00	0.00	0.00	0.00	0.00
Nurse Manager	1.00	0.00	0.00	0.00	0.00	0.00
Providers						
APRN (DH Dept of Psychiatry)	1.00	0.00	0.00	1.00	0.00	0.00
MD Psychologist (DH Dept of Psychiatry	0.50	0.00	0.00	0.00	0.00	0.00
MD Psychiatrist (DH Dept of Psychiatry)	0.80	call	call	0.80	call	call
Mental Heath Medical Director (One of the persons that are MD Psychiatrist above)	0.20	0.00	0.00	0.00	0.00	0.00

The proposed number and compliment of providers was proposed by TaraVista Health Partners Consulting, reviewed and adjusted by SVMC nursing leadership, Dept of Psychiatry providers, and DMH staff

Note that these staffing models may be adapted if the recruited complement of provider and clinical staff differs from that expected. For example, mental health technicians may be swapped with LNA's with mental health training, or RNS might be swapped with staff with other certifications that better match that of other members of the team. Regardless, SVMC commits

to recruiting and retaining a talented team of clinicians that will deliver best practice high quality care for the adolescents. And SVMC has a strong track record of doing so.

SVMC encourages the reviewers to consult the feasibility study to better understand the staffing model and its considerable nuances.

4. **Regarding the primary mental health condition(s) and the co-occurring physical health condition(s) that adolescents seeking treatment at SVMC may have:**
    a. **Provide a more detailed explanation regarding the mental health conditions SVMC intends to admit and not to admit.**
    b. **Your application represents that only adolescents with "stable" physical health medical conditions will be admitted. Provide a clear definition of "stable physical health medical conditions" for adolescents presenting with co-occurring physical health conditions that SVMC will and will not admit and provide specific examples of each.**
    c. **Explain how and by whom the admissions decisions will be made.**
    d. **For patients who are not admitted, explain where SVMC will refer those adolescents and their families for care.**

Response 4a. The training and experience of the mental health clinical team, along with the unit's current milieu, will determine which patients are admitted and which are not appropriate for admission. The specific mental health conditions that SVMC intends to admit cannot be provided prior to the hiring of the clinical team. The clinical team will be hired after CON approval in accordance with normal advancement of similar CON projects and the timeline provided in the application.

A portion of the response to question 10 of the second round of questions (Q002) attempted to address question 4a appears in appendix 3, page 41.

In summary it is not possible to provide a more detailed list of specific mental health conditions that will be admitted to the unit and which conditions will not be admitted to the unit until after the clinical team is assembled.

Response 4b. SVMC appreciates that chronic medical conditions are associated with increased rates of mental health conditions[4]. Moreover, there is a strong association between poor chronic disease control and psychiatric comorbidities that is bidirectional: mental health problems may affect chronic disease self-management, while living with a chronic condition may increase the emotional burden experienced and increase prominence of a mental health condition. Thereby SVMC's inpatient mental health unit for adolescents will need to also co-manage the medical conditions of the adolescents receiving mental health therapy.

[4] Brady AM, Deighton J, Stansfeld S. Psychiatric outcomes associated with chronic illness in adolescence: a systematic review. J Adolesc 2017;59:112–23.

However, the clinical team of SVMC's inpatient mental health unit for adolescents will not be capable of providing acute medical care commensurate with an emergency department. Adolescents with acute, unstable medical conditions must have their medical needs stabilized at an emergency department prior to being admitted to any inpatient mental health unit. This process is identical to that employed for traditional medical patients being admitted to any inpatient medical unit- the acute medical conditions are always stabilized in the emergency department prior to admission to an inpatient medical unit.

SVMC does not have a predetermined definition of "stable physical health medical condition". The stability of a patient's medical condition and their appropriateness for admission to SVMC's inpatient mental health unit will be determined by the emergency department from which the patient is referred for psychiatric admission. If the emergency physician indicates that the acute medical condition of the adolescent has been stabilized and SVMC's pediatricians can provide ongoing care management of the medical condition, then the patient will be admitted[5].

The clinical capabilities of SVMC's team and the milieu of existing patients will dictate the stable medical conditions of new patients being admitted to the inpatient unit. SVMC's pediatric clinical team can manage a wide array of medical conditions including:

- Diabetes
- Asthma
- Wound care
- Urinary tract, ear, and eye infections
- Chon's disease and gastrointestinal disorders
- Some cancers
- Kidney disease needing hemodialysis
- Seizure disorders
- Other chronic diseases

SVMC's pediatric team is well verse in managing stable medical conditions after an acute care episode requiring an emergency department visits because they traditionally conduct follow-up outpatient visits on medical patients after an emergency department visit or medical inpatient admission.

SVMC's inpatient mental health unit should not admit adolescents requiring a level of care consistent with an inpatient intensive care unit (ICU) (ex. requires a ventilator) as the pediatric clinical team is unskilled at ICU care. Under some circumstances, SVMC's inpatient mental health unit will consider admission of adolescents requiring an inpatient level of medical care.

In addition to providing the medical services described above, SVMC has the capability to provide more intensive medical care to adolescents including diagnostic imaging, laboratory services, physical and occupational therapy, and surgery. The individualized care plan

[5] Admission will consider whether the mental health care team has the skill and capacity to care for the patient's mental health conditions and the unit's milieu is appropriate for the admission.

developed by the clinical care team, including the pediatricians caring for the medical needs of the adolescents, will dictate the utilization of more intensive medical services.

SVMC is unaware of the specific medical capabilities of the Brattleboro Retreat. Nor is SVMC aware of the specific medical conditions that create current challenges for adolescent placement into inpatient mental health care as described by the Department of Health in the initial Request for Proposals (see Q002, question 11 for screen shot of the scope of services to be provided by the requested unit). Thereby it is unclear whether it is necessary for the medical services available to adolescents at SVMC's inpatient unit to differ from those at the Brattleboro Retreat and whether there is an unmet demand by adolescents with mental and special medical comorbidities. SVMC is willing to consider expanding the medical services associated with its mental health unit to better meet the unmet needs of Vermont's adolescents in accordance with more specific guidance from and in collaboration with the Department of Health.

Response 4c. Admission decisions to SVMC's mental health unit for adolescents will be made by the provider and nurse designee on the unit.

The current process for admission to the Brattleboro Retreat from SVMC's Emergency Department begins with a crisis clinician from the local designated agency completing an assessment of the patient to determine whether the patient meets criteria for inpatient psychiatric level of care and if the patient is medically appropriate for that treatment. If inpatient mental healthcare is deemed necessary, the crisis clinician submits to the Brattleboro Retreat a referral including the patient demographics, mental health presentation and medical clearance. After review of the admission request, the Brattleboro Retreat grants admission or the patient is placed on a wait-list for future accommodation[6]. To finalize the admission the local designated agency crisis clinician, an emergency department physician, and the physician at the Brattleboro Retreat discuss the case. Once the patient is officially accepted, the emergency department nurse and the nurse at the Brattleboro Retreat discuss the patient and transportation to the Brattleboro Retreat is arranged.

SVMC anticipates a similar, yet streamlined, process to facilitate adolescent admission to the inpatient mental health unit at SVMC. The admission process will be designed by the clinical team once hired. The team will design the admission process to be efficient and require the least disruption to the emergency department and designated agency clinicians attempting to place the patient.

Adolescents not immediately admitted to SVMC's unit will be put on a wait list for future consideration for admission. A process should be developed to coordinate the two lists of

[6] Note that patients on the Brattleboro Retreat wait list remain in SVMC's emergency department where the medical staff comfort the patient yet deliver very limited mental health services. Delivery of mental health services are beyond the scope practice for emergency department providers and staff. SVMC is not compensated for any care delivered to the patient after the time of the request for admission to the Brattleboro Retreat and prior to discharge 'of the patient from SVMC's emergency department, despite the patient often remaining in SVMC's emergency department for several days awaiting admission (see VAHHS data, more than 50% of adolescents wait longer than 24 hours for inpatient mental health placement).

adolescents waiting inpatient mental health care at SVMC and the Brattleboro Retreat thereby ensuring all adolescents receive the care they need and the inpatient resources are maximally leveraged. SVMC anticipates close collaboration with the Brattleboro Retreat on this and other initiatives.

Response 4d. Adolescents not admitted to SVMC's unit will have several choices for inpatient psychiatric admission. The first and most appropriate would be for the emergency department and designated agency clinicians managing the adolescents care to submit a referral to the Brattleboro Retreat in attempt to secure inpatient admission If a referral hasn't already been completed). The second option would be to seek admission to an inpatient unit in another state. The third option, which is the current typical option, is for the adolescent to remain in the emergency department until admission to SVMC's unit or the Brattleboro Retreat becomes available[7].

5. **Provide a program schedule of activities hour by hour and the level of provider(s) providing each service from 7:00 a.m. through 10:00 p.m. for both weekdays and weekends.**

It is not possible to provide a schedule of activities hour by hour, nor the level of providers delivering the service because the clinical team has not been hired. Once on board the clinical team will develop the programming for unit. The programming will align with best-practices for delivering inpatient mental health care to adolescents.

6. **Explain in detail how SVMC's program is the same and how it will differ from the inpatient adolescent program at the Retreat.**

The care provided by SVMC's inpatient mental health unit will not differ appreciably from that delivered at the Brattleboro Retreat. The goal of SVMC's unit is to care for the inpatient mental health needs of Vermont's youth. This goal is identical to that of the Brattleboro Retreat which strives to care for the same population and their same mental health needs. Thereby it makes logical sense that the two units, treating the same mental health needs of the same population will have remarkably similar programs of care.

The drive to develop an inpatient mental health unit at SVMC was to increase access to care, to provide choice for adolescents and families, and to provide resilience for the state. The goal was never to provide uniquely differentiated care at the two units.

[7] Not infrequently patients on the wait list for admission to the Brattleboro Retreat remain in SVMC's emergency department for such a protracted length of time that their immediate mental health crisis wains allowing discharge to the community. Also not infrequent these adolescents return to SVMC's emergency department in mental health crisis again in future weeks. Not ideal, this recursive pattern occurs until the adolescent receives the inpatient mental health care required by their condition.

In the simplest terms, the vast majority of the services provided at SVMC's unit (both mental and medical) will be similar to, if not identical to, the care provided at the Brattleboro Retreat because both programs will be addressing the same mental health needs of the same population.

7. **Statutory Criterion 9 requires an applicant to explain how the project will support equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care, as appropriate. Explain in detail how the project will meet this criterion and provide examples.**

SVMC attempted to answer this question in the original CON application. In brief, SVMC is dedicated to delivering high quality medical and mental health care in an equitable and holistic manner that aligns with the cultural sensitivities and health goals of the individual patient. Management of the SVMC's adolescent mental health unit in collaboration with Dartmouth Health's Department of Psychiatry will ensure the highest quality, best-practice care. SVMC will make every effort to ensure consistent statewide access to the unit's inpatient resources.

It is not possible to provide more specifics or examples, as the treatment plan for each adolescent will be tailored to their unique needs. The range of process and care details designed for and dedicated to the triple aim are too extensive to enumerate. SVMC has a long history of providing high-quality, high-value care in an equitable manner and fully expects the mental health unit to continue this commitment. As evidence, SVMC has received many awards indicating its commitment to high-quality, efficient care[8].

Towards this end, SVMC has several channels for patients and community members to provide feedback. SVMC welcomes feedback from patients, Vermont residents, the healthcare Advocate's office, and all other groups in an effort to adapt processes and care models to continue raise quality standards and deliver integrated holistic care that is affordable for Vermonters. SVMC welcomes the opportunity to enhance the reach of its high-quality, high value care by launching the inpatient mental health unit for adolescents.

[8] Select examples of recent awards include; consistent 4 or 5 star rating by CMS, 5-time Magnet nursing recognition, first in Vermont Lantern Award for emergency care.

8. **GMCB Rule 4.000 § 4.402(3) identifies factors that the Board may consider in determining whether a project will serve the public good. Explain in detail how the project will meet 4.402(3)(a), (b, if applicable) (c), (d), (e) and (f).**

GMCB Rule 4.000 § 4.402(3) states;

The Board may consider the following factors in determining whether a project will serve the public good under 18 V.S.A. § 9437(6):
(a) Whether the project will help meet the needs of medically underserved groups and the goals of universal access to health services.
(b) Whether the project will help facilitate the implementation of the Blueprint.
(c) Whether the applicant has demonstrated it has analyzed the impact of the project on the Vermont health care system and the project furthers effective integration and coordination of health care services.
(d) Whether the project is consistent with current health care reform initiatives, at the state and federal level.
(e) Except where circumstances support approval of an emergency Certificate of Need, whether the project was identified prospectively as needed at least two years prior to the time of filing in the hospital's four-year capital plan.
(f) Whether, and if so to what extent, the project will have an adverse impact on the ability of existing facilities to provide medically necessary services to all in need, regardless of ability to pay or location of residence.

SVMC's inpatient mental health unit for adolescents addresses each of these parameters. For clarity a separate response to each parameter is provided below.

(a) Whether the project will help meet the needs of medically underserved groups and the goals of universal access to health services.

SVMC's inpatient mental health unit for adolescents will not discriminate against any patients. Patients from medical underserved groups will have equal access to the mental health care provided by the unit. Admission to the unit will consider only the mental health needs of the patient and whether the unit has the proper skill mix of clinicians, capacity, and milieu (considering existing patients being treated) to provide an appropriate healing environment for the patient.

Once admitted to the unit, the care will be tailored to the patient's specific needs and adhere to best-practices regardless of whether the patient belongs to a medically underserved group.

(b) Whether the project will help facilitate the implementation of the Blueprint.

SVMC's inpatient mental health unit for adolescents will not directly facilitate the implementation of the Vermont Blueprint for Health (Blueprint). However, the unit will collaborate with several Blueprint programs to ensure connectivity across the continuum of care for patients. For example the unit will closely collaborate with Blueprint case managers of patient-centered

medical homes and hub and spoke practices to develop treatment plans aligned with previous care plans for patients, including medication assisted treatment for substance use disorder. The collaboration with Blueprint case managers will ensure appropriate discharge planning and effective hand-over of patients for continuation of care by the patient's primary care or hub/spoke practice. For patients without a primary care provider, efforts will be made to identify an appropriate primary care provider for the patient. Pregnant patients will be linked with the Blueprint's pregnancy intention initiative to facilitate prenatal care. The Blueprint's community health teams will be engaged for appropriate patients to ensure patients have wrap around services that support the patient's health and overall wellbeing.

(c) Whether the applicant has demonstrated it has analyzed the impact of the project on the Vermont health care system and the project furthers effective integration and coordination of health care services.

SVMC has carefully considered the impact of this project on Vermont's health care system. Patients with an unmanaged mental health comorbidity have higher than average utilization of medical services and higher than average total cost of care. SVMC's inpatient mental health unit for adolescents will increase access to high-quality mental health care, decrease unnecessary healthcare utilization, and decrease the total cost of care.

SVMC has considered the impact of this project on other providers within the medical health ecosystem. Providing additional inpatient mental health capacity will reduce boarding in emergency departments and add to the tools available for outpatient mental health counselors across the state.

SVMC has considered the impact of this project on other providers within the mental health ecosystem, in particular the impact to the Brattleboro Retreat (see answers to other questions within this document). Currently adolescents only have one choice for inpatient mental health care. SVMC's inpatient mental health unit for adolescents will provide youth and families choice and a lower cost option for care.

(d) Whether the project is consistent with current health care reform initiatives, at the state and federal level.

Health reform initiatives can be broadly classified as striving to achieve the triple aim of improved care quality/outcomes and enhanced patient experience, improving the health of the population, and decreasing the per capita total cost of care. This project delivers across these dimensions and is thereby consistent with the current health care reform initiatives at the state and federal level.

For example, increasing access to high-quality, lower-cost inpatient mental health care will encourage treatment for mental health conditions that when left uncared for lead to unnecessary medical utilization (e.g. emergency department visits) that drive up the total cost of care. The unit will also allow the state to compare financial and operational approaches between inpatient mental health units, share quality care processes across units, and ensure resiliency of access in the event of financial strain or natural disaster that compromises access at one of the units.

Launching SVMC's inpatient mental health unit for adolescents is good for Vermonters and good for the state.

(e) Except where circumstances support approval of an emergency Certificate of Need, whether the project was identified prospectively as needed at least two years prior to the time of filing in the hospital's four-year capital plan.

The need for an additional inpatient mental health unit for adolescents has been prospectively identified as evidenced by the Request for Proposals (RFP) from the Vermont Department of Mental Health issued 6/2/2022. Since that time SVMC has been working towards creating an inpatient mental health unit for adolescents. That journey has included completing a feasibility study together with the Department of Mental Health in May, 2023. Submitting the CON application in February, 2024, and responding to five rounds of questions about the CON over the course of the last 9 months.

(f) Whether, and if so to what extent, the project will have an adverse impact on the ability of existing facilities to provide medically necessary services to all in need, regardless of ability to pay or location of residence.

The launch of SVMC's inpatient mental health unit for adolescents will not adversely impact any existing facility's ability to provide necessary services to all in need, regardless of ability to pay or location of residence. On the contrary, the unit will increase access to lower cost care to Vermonters in need of necessary services thereby allowing people to maintain more of their healthcare dollars for utilization on other necessary services.

The Brattleboro Retreat has attempted to argue that launch of SVMC's mental health unit will cause financial strain on the Retreat ($10M loss), thereby limiting their ability to provide care, particularly to those that might require financial assistance. It is noteworthy however, that demand for inpatient mental health care by adolescents exceeds the capacity at the Brattleboro Retreat as evidenced by the VAHHS wait time data. Thus, launching SVMC's unit might not have as large of an impact on the volume of patients at the Retreat or the financial sustainability of the Retreat. Indeed if the unmet demand for inpatient mental health care by adolescents is 60% of the volume anticipated for SVMC's unit, then the savings to Vermonters would cause the project to be neutral to the per capita cost of care. See the answer to question 12 below for a more through description of why it would be financially beneficial to Vermonters to launch SVMC's unit.

9. **Based on financial Table 7B (Utilization Projections), explain in detail what the projected monthly and annual occupancy rates (expressed as a percent) will be and what the associated number of utilized beds (of the 12) is projected to be in year 1, 2 and 3 of operation.**

The CON application and feasibility study detail this information. The table below from the feasibility study illustrate the anticipated initial volumes.

Prelaunch, ramp-up, and fully operational volumes

Anticipated census adolescent mental health inpatient unit

	Preoperational Period		Launch	Ramp-up Period			Fully Operational								
Month	-2	-1		1	2	3	4	5	6	7	8	9	10	11	12
Average Daily Census (92% capacity)	0	0		2	6	8	10	11	11	11	11	11	11	11	11

Once fully operational, the average occupancy is projected to be 11, which would be a 91.67% occupancy rate. Bed utilization will be;

- Year 1 – 79.13%
- Year 2 – 91.67%
- Year 3 and beyond – 91.67%

10. **The Feasibility Study assumed a 15-day length of stay with 5% of patients having a long stay of 120 days. Based on financial Table 7B, provide a breakdown of the projected number/percent of adolescents that will likely have inpatient stays of 15 days, 30, 60, 90, 120 days in year 1, 2, and 3. Explain in detail any changes in anticipated programming and staffing based on shorter or longer length of stays, including educational requirements.**

The pro forma and financial model does not provide the level of detail requested, nor is it necessary. The current projections are based upon a 12 bed unit with 92% occupancy, or average daily census of 11 adolescents. These parameters set the capacity of the unit (approximately 4,000 patient days per year) and the reimbursement over a period of time (per diem rate * 11 patients * duration of time in days). The average length of stay does not influence the overall capacity of the unit nor its revenue. Thereby a detailed breakdown of the percent of patients with particular lengths of stay was not developed nor necessary.

The average length of stay (ALOS) does influence the number of individuals that are treated by the unit during a period of time. For example, 4000 patient days over a year, with an ALOS of 15 days equates to treating approximately 265 adolescents throughout a year. A shorter average length of stay of 12 days would allow 333 adolescents to be treated in a year, while a longer length of stay of 17 would decrease the number that could be treated in a year to 222 adolescents.

The ALOS of 15 days is an estimated average and some adolescents will stay longer, while others will stay shorter. It is possible to speculate at the distribution of lengths of stay around the average and calculate the number and percentage of adolescents in each of the buckets requested (30, 60, 90, and 120 days). However, this would be further speculation. The estimation of an ALOS of 15 days is at best a guess[9] and might not even be correct once the unit is operational. Further speculating at the percent of patients in each of the buckets (30, 60, 90, and 120 days) would compound uncertainty. Moreover, should the CON be granted if we speculate that a certain percentage of patients stay for 30 days, while the CON should not be granted if a different percentage is speculated?

What we estimate is that SVMC's inpatient mental health unit will likely treat approximately 250 adolescents with varying lengths of stay throughout a year.

The second part of the question, how the treatment program will be adapted for adolescents across the range of lengths of stay is a much more relevant question. Despite its relevancy, it is a difficult question to answer and should not determine whether a CON is granted for this project. Adolescents with a short length of stay (ex. under 7 days) should receive different programming than those with protracted lengths of stay (ex. longer than 120 days). However, the programming cannot and should not be prescriptive based upon the length of stay. Rather programming and treatment should be based upon the adolescent's diagnosis, treatment, response to treatment, the patient's baseline coping and resiliency skills, their support system, and a myriad of other factors. In short, each day the programming should be individually tailored to the patient's needs regardless of the number of days the adolescent has been on the unit.

SVMC feels strongly about maintaining the educational advancement of all adolescents on the unit. The approach was described in detail in the feasibility study and initial CON application. SVMC will contract with a regional firm, LearnWell, that specialized in education of adolescents on inpatient mental health units. Educational programming will be integrated into the therapeutic plan for all patients on day 1, or as soon as sensible for the adolescent based upon their condition. Connectivity with educational materials from the patient's home education institution or school is a key best practice closely adhered to by LearnWell. SVMC's goal is for the adolescent to maintain academic progress and rigor while in the healing environment of the inpatient unit.

[9] The letter from the Brattleboro Retreat dates August 14, 2024 indicates that the average length of stay for adolescents at the Retreat is 18 days. The average length of stay of 15 days for adolescents at SVMC unit is only an estimate derived from the average length of stay for adolescents in Massachusetts, per the TaraVista consultant that assisted with the feasibility study.

11. **Provide a detailed explanation of your discharge planning process, and the facilities, programs, and levels of care available in Vermont for adolescents to receive the appropriate level of care following discharge from SVMC.**

The clinicians on SVMC's inpatient mental health unit will develop close collaborative relationships with the outpatient and residential programs across the state of Vermont. The quality and strength of the inpatient care provided while the adolescent is on SVMC's unit cannot stand alone. Rather the treatment plan, coping and resiliency skills learned, and the renewed anchor of self-worth gained while the adolescent is in SVMC's inpatient mental health unit will only be effective if bolstered by aligned and coordinated care after discharge. However, SVMC cannot provide more details about the discharge planning processes nor the collaboration with different levels of care that will create and maintain the adolescents care plan until after the clinical team has been on boarded. The care team is needed to develop these partnerships in earnest, and the care team cannot be assimilated unit after the CON is approved.

12. **The Retreat estimates that once the SVMC program is in operation, the Retreat will experience annually at least a $10 million loss in net patient revenues. To meet Statutory Criterion 2, please explain in more detail:**
    a. **How SVMC's financial condition will sustain any financial burden likely to result from the completion of the project;.**
    b. **The financial implications for the Retreat, overall;**
    c. **The financial implications for the Retreat's adolescent inpatient program, specifically;**
        i. **Include in this explanation the impact on the Retreat's services, expenditures, and charges;**
        ii. **Explain whether the impact on the Retreat's services, expenditures, and charges is outweighed by the benefit of SVMC's project to the public.**

The Brattleboro Retreat's estimate of revenue loss is based in the following assumptions:

- The Retreat is serving all the Vermont adolescents that require inpatient mental health care
- Any patients treated at SVMC's unit (patient days) will detract from the volume at the Retreat (commensurate decrease in patient days)

The Table below shows those assumptions in both volume and financial impact.

		Year 1		Year 2 (and beyond)
Without SVMC project				
Brattleboro Retreat volume		6,578		6,578
Revenue	$	18,840,477	$	18,840,477
Revenue per patient day (per diem rate)	$	2,864	$	2,864
With SVMC project				
SVMC unit volume		3,466		4,015
Revenue	$	5,871,593	$	7,062,405
Revenue per patient day (per diem rate)	$	1,694	$	1,759
Percent less expensive per diem rate than Brattleboro Retreat		41%		39%
Savings to Vermont	$	4,054,457	$	4,437,217
Brattleboro Retreat initial volume		6,578		6,578
BR's anticipated reduction in volume (full amount of SVMC's volume)		3,466		4,015
BR's anticipated volume		3,112		2,563
BR's % reduction in volume		53%		61%
BR's anticipated revenue		8,914,427		7,340,855
BR's anticipated financial impact (loss of $)	$	9,926,050	$	11,499,622

In the document dated August 14, 2024, the Retreat anticipates a volume of 6,578 adolescent inpatient days annually and a revenue of $18.8M. This yields a calculated per diem rate of $2,864. SVMC anticipates its 12 bed unit to have a volume of 3,466 patient days in year 1 and 4,015 patient days in year 2 and beyond. The calculated per diem rate would be around $1,700, or 40% lower than that of the Retreat, thereby saving Vermonters more than $4M for the same care.

The Retreat estimated the financial impact of launching SVMC's unit by deducting the full amount of patient days anticipated at SVMC (4,366 and 4,015) from the expected volume at the Retreat. Thereby the Retreat would provide 3,112 days of care to adolescents in year 1 of the launch of SVMC's unit and only 2,563 days of care in years 2 and beyond. Because the Retreat is reimbursed on a per diem basis, the loss of patient days would result in a concomitant decrease in revenue more than $9M[10]. The impact of this loss in revenue on the financial sustainability of the Retreat is unclear because it is unclear how expenses might flex as patient volume decreases by 50%.

If instead 60% of the anticipated volume at SVMC unit is unmet volume currently not being treated at the Brattleboro Retreat[11], then the Brattleboro Retreat's volume would decrease

[10] The impact of this loss in revenue on the financial sustainability of the Retreat is unclear because it is unclear how expenses might flex as patient volume decreases by 50%.

[11] See introduction in this document, and response to question #1, for reason why the unmet demand for inpatient mental health care by Vermont's adolescents cannot be precisely calculated. Thereby the estimate of 60% unmet demand is for the purpose on illustrating how the calculations from Brattleboro Retreat are maximum high waterline estimates. If there is any unmet demand the estimated financial impact of SVMC's unit will be less than that reported by the Retreat in the August 14, 2024 letter.

considerably less. The resulting financial implications to the Retreat would be a loss of only $4-4.5M. The savings to Vermonters, obtained by receiving care at SVMC's less expensive unit, would nearly equal the financial loss observed by the Brattleboro Retreat. Thereby, if the Retreat was made whole for this loss (ex through a higher per diem rate for the remaining patients), the launch of SVMC's inpatient mental health unit would be neutral to the per capita cost of care (see table below).

With SVMC project

SVMC unit volume		3,466		4,015
Revenue	$	5,871,593	$	7,062,405
Revenue per patient day (per diem rate)	$	1,694	$	1,759
Percent less expensive per diem rate than Brattleboro Retreat		41%		39%
Savings to Vermont	$	4,054,457	$	4,437,217
Brattleboro Retreat initial volume		6,578		6,578
BR's anticipated reduction in volume (40% of SVMC's volume)		1,386		1,606
BR's anticipated volume		5,192		4,972
BR's % reduction in volume		21%		24%
BR's anticipated financial impact (loss of $)	$	3,969,733	$	4,599,849

It is worth noting that SVMC's unit will be a better value for Vermont's than the Brattleboro Retreat. **The anticipated per diem rate at SVMC unit is 40% less expensive than that at the Retreat.** Thereby launching SVMC's unit will save Vermonters money and reduce the per capital total cost of care.

With that as the backdrop, the following sections attempt to answer the specific questions posed.

Response to 12a- How SVMC will sustain the financial impact of the unit has been described in great detail in the feasibility study, the initial application, and in the response to several questions. In brief, the per diem rate for SVMC will be flexed annually to match the operating expenses of a projected future volume and thereby maintain financial sustainability of SVMC's inpatient mental health unit for adolescents. This approach was described in detail in the response to question #2 in the fourth round of questions (Q004) and appears in appendix 4, page 42.

The project will be financially neutral to SVMC and thereby there will be no financial strain (or gain) to SVMC.

Response to 12b- It is very difficult for SVMC to "explain in detail, the financial implications for the Retreat" of this project. Doing so is highly speculative and beyond the scope of any applicant for a CON project.

The financial implications to the Retreat overall are highly dependent upon the overall demand for inpatient mental health care across the state and how that demand is split between the two units. This impact has been described at the beginning of the answer to this question (Q005, #12). A more rigorous attempt at speculating the financial impact of this project on the Retreat's financial sustainability appears below in the answer to question 12b.

SVMC notes that the demand for inpatient mental health care will be impacted by any and all change in resources across the mental health care ecosystem. The launch of an outpatient mobile crisis unit in St Albans, or the retirement of a counselor in Middlebury might have substantial impact on the Retreat's financial sustainability. Yet those activities would not receive the level of regulatory scrutiny that the launch of SVMC's unit is undergoing. Because there is insufficient data, it is very difficult to definitively calculate the financial implications to the Retreat of the launch of SVMC's mental health unit. Meanwhile, it is very possible to determine that the launch of SVMC inpatient mental health unit for adolescents will:

- Increase access to high quality care
- Improve choice for adolescents in crisis and their families
- Decrease the total cost of care.

For these reasons SVMC has continued to request swift approval of this project.

Response to 12c- The financial implications of the launch of SMVC's unit on the Retreat adolescent inpatient program, specifically, is difficult to ascertain because SVMC is unaware of how the Retreat internally manages the financials of their individual departments. For example does the Retreat shift revenue from departments whose revenue is more than expenses (profitable units) to other departments whose revenue is insufficient to cover expenses (unprofitable units, mission driven units). Such shifting from profitable units to mission driven units is commonplace in medical service accounting at the department level. Is the adolescent unit a profitable department or an unprofitable unit? What are the fixed and variable costs of the unit? What are the volume thresholds that align with step changes in the variable expenses? Considerably more information from the Retreat would be required to effectively answer this question.

By way of an attempt to illustrate this complexity, the following assumptions could be made:

- Assume that the Brattleboro Retreat's inpatient adolescent unit is financially stand-alone
- Assume that the Brattleboro Retreat's inpatient adolescent unit is profitable
- Assume that demand for adolescent inpatient mental health care across the state is insufficient to fully support both units
- Assume that upon the launch of SVMC's unit, the Retreat's adolescent mental health unit volume decreases by 40%
- Assume that the per diem rate at the Retreat remains consistent

With those broad assumptions (not backed by data), the launch of SVMC's unit will cause a loss of revenue of the Retreat's unit. The Retreat would have at least two courses of action in response to less revenue (as would any healthcare institution);

1. Right size the adolescent unit (decrease expenses) to better match demand
2. Request more revenue – a change in the per diem rate

Without specific knowledge about the Retreat, SVMC anticipates that fixed expenses (e.g. need a pediatric psychologist regardless of the number of patients treated) would prevent a reduction in expenses (approach #1) of sufficient scale to mirror the revenue loss. Thereby the Retreat may need to ask for change in the per diem rate to make-up the lost revenue.

However, this example is highly speculative with lots of assumptions that are not based in data. Through this example, SVMC hopes to have effectively demonstrated that although the posed question seems like a logical, in reality SVMC is unable to answer this question with any level of precision without considerable additional speculation. The base assumptions above are speculation. Alteration of one or more of assumptions would yield a completely different outcome such that launching SVMC unit could have no impact on the Retreats adolescent unit. Again, this is a question that not possible for SVMC to answer.

13. **SVMC has conceded that recruiting and retaining staff to operate the adolescent mental health unit will be challenging. (Q001, 4). Explain in more detail how SVMC will successfully recruit for each of the positions listed in your response to questions 3 and 10, above.**

In this employment environment no institution can guarantee staff recruiting. However, SVMC in partnership with Dartmouth Health has scale and a robust multifaceted recruitment system that greatly enhances recruitment and retention of talented staff.

SVMC leverages Symplr, and it's nationally recognized recruiting tool, to post positions where healthcare talent looks for careers including through Healthcaresource linked job sites, Indeed, LinkedIn, and a cast of other job boards. The positons on SVMC's inpatient mental health unit for adolescents will also be posted on the Dartmouth Health career web site, which receives thousands of searches for positions per week. The scale of visualization of the open mental health positions offered by SVMC's will unprecedented and far beyond what other mental health institutions and designated agencies in Vermont can achieve.

Seeing the available positions by a very wide pool of candidates is only the first step. SVMC's five-time Magnet nursing recognition and consistent ranking by CMS as a 4 or 5 star hospital raises the interest of prospective candidates. SVMC's repetitive recognition as one of the best places to work in Vermont often provokes candidates to learn more and apply to positions at SVMC.

SVMC's talent management team seals the deal using nationally recognized best practices for recruiting. Leveraging SVMC's compensation and benefits package explainers and personalized recruiting processes, the talent management team has achieved unparalleled recruiting success. During the pandemic few if any traveler staff were needed at SVMC because of the processes and talents of SVMC's recruiting team. Currently SVMC retains very few traveler staff and maintains a best-in-class employee retention/turnover rate.

Two additional features further increase the probability of successful recruitment of talented staff to SVMC's inpatient mental health unit for adolescents. First, SVMC is positioned within easy driving distance of 1 million people in the Albany-Troy-Schenectady metro area known for its density of healthcare talent. Many of our current employees hale from the NY metro area. Second, SVMC has built a robust pipeline of RN, LPN, and MA training programs through the Vermont State University and VT Tech. Each year, SVMC trains and hires many new grads.

Early exploration has indicated strong interest by existing SVMC staff to work on the inpatient mental health unit for adolescents. Recruiting and retaining staff for SVMC's inpatient mental health unit for adolescents may be challenging. However, SVMC is well positioned for success and has confidence that the current proven approaches will deliver and retain the talent necessary.

Summary

SVMC is grateful for the questions from the Green Mountain Care Board, and 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 of the decision and the limited data to illuminate the path forward. The most important dimension to remember 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. SVMC's hope is that the answers to the questions above provide sufficient context for the decision to proceed.

It is worth noting that because of the protracted CON process, this project will cost Vermonters more money, approximately $500,000 more. The derivation of this additional $500,000 cost is explained in the following paragraphs. The timeline submitted with the CON application anticipated CON approval in June of 2024.

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

	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
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																				

The timeline also included ACT250 permitting, detailed design, development of construction documents, contractor bidding, and other preconstruction activities contemporaneously with the CON process. When SVMC sensed the CON process could be protracted, it paused advancement of the project until the CON was obtained.

Below illustrates the new estimated timeline. This timeline includes a best guess that January, 2025 is the soonest the CON might be approved. This guestimate accommodates the notice and holding of a public meeting as required by involvement of interested parties to the CON. Shifting the ACT250 and preconstruction work until after the CON is obtained moves the start of construction to October 2025, a year later than initially anticipated.

Time Line for Developing SVMC's Inpatient Adolescent Mental Health Unit
Update as of 10/23/2024

	2023			2024									2025												2026						
	SVMC FY2024												SVMC FY2025												SVMC FY2026						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
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																															

According to the construction and data services firm Gordian, construction costs are inflating still at a rate of 6%[12]. Thereby the $9.5M construction project has ballooned to over $10M. Since the state of Vermont is supplying the capital for the construction, SVMC and the state may need to negotiate for the additional taxpayer dollars to deliver the facility.

In addition to the requirement for additional capital funding, the protracted CON process has delayed Vermonters saving money. The care on SVMC's unit will be 41% less expensive than that at the Retreat. Delaying the project, has prevented the reduction in the per capita total cost of care.

Lastly, the protracted CON process has negatively impacted Vermont's adolescents in mental health crisis as they have suffered an additional unnecessary year with constrained access to the inpatient care they deserve.

These issues (more project costs, higher total cost of care, and real impact on patients) highlight the serious impact of repetitive courses of nearly identical CON questions. Again, SVMC

[12] Hospital construction costs increase | HFM Magazine Annual healthcare facilities construction cost update report.

appreciates the rigor of the CON process in an effort to ensure Vermonters get high quality, high value healthcare, however, repetitive cycles of detailed unanswerable questions does not contribute to the rigor of the CON process. SVMC hopes the process can proceed quickly to close the CON application, move through the public hearing, and obtain a swift determination of the CON.

James Trimarchi, Director Planning
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Appendix 1- Supplement to Question #1

Q002, question 3- response dated June 17, 2024

Question 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:

- 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;

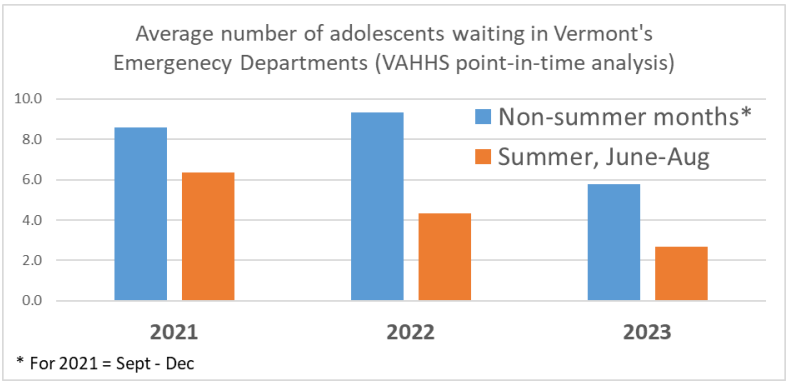
a. A population based analysis leveraged inpatient mental health beds per 100,000 youth in Massachusetts to estimate that Vermont needs 18 total inpatient mental health beds for adolescents. The current quoted adolescent bed capacity at the Brattleboro Retreat (23 beds, with ability to flex to 27) exceeds 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[13]. 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 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.

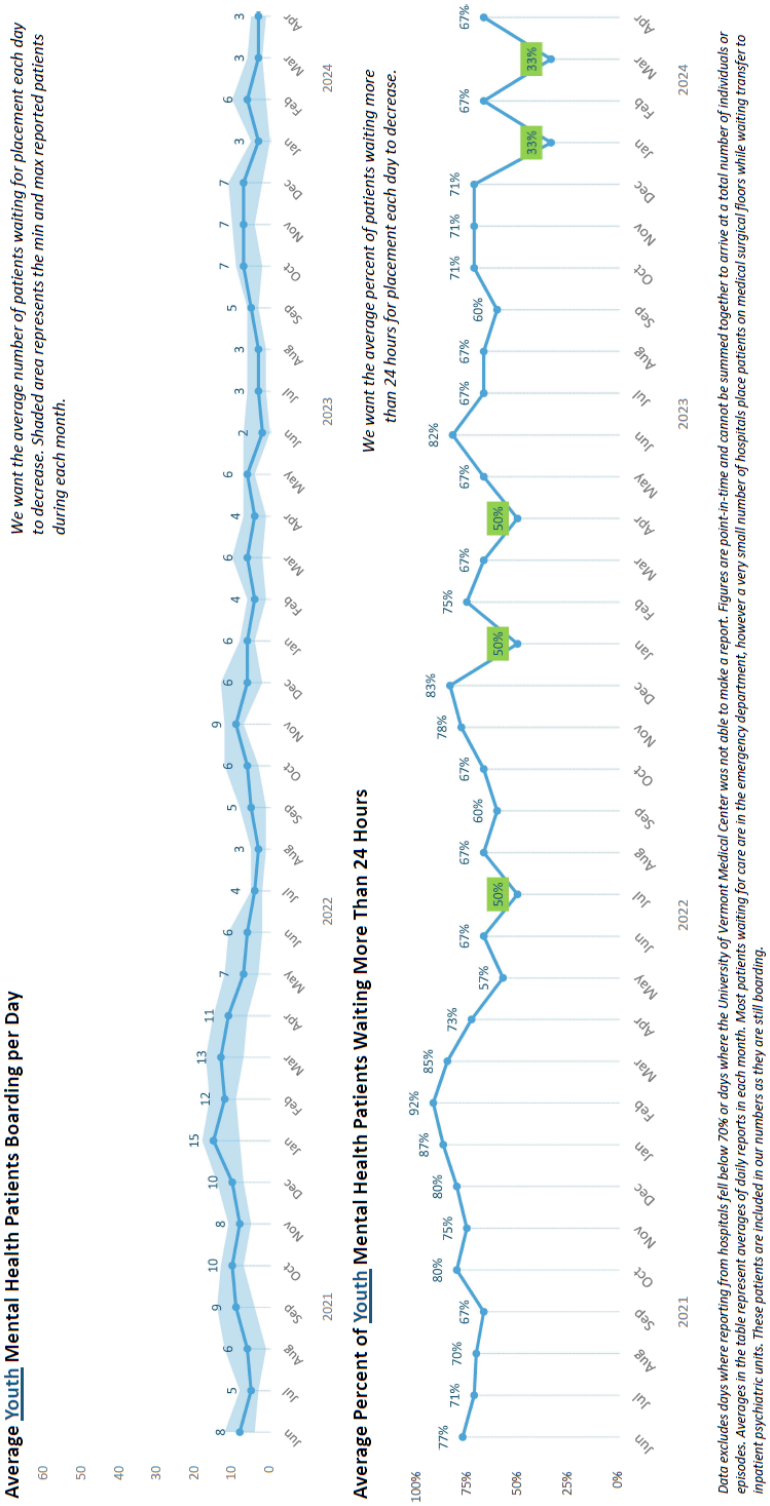


SVMC appreciates that this explanation can appear obtuse and frustrating and therefore offers an alternative qualitative perspective anchored in available facts. Adolescents across Vermont are waiting in emergency departments for excessive durations of time for inpatient mental health care. The most 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

[13] 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)

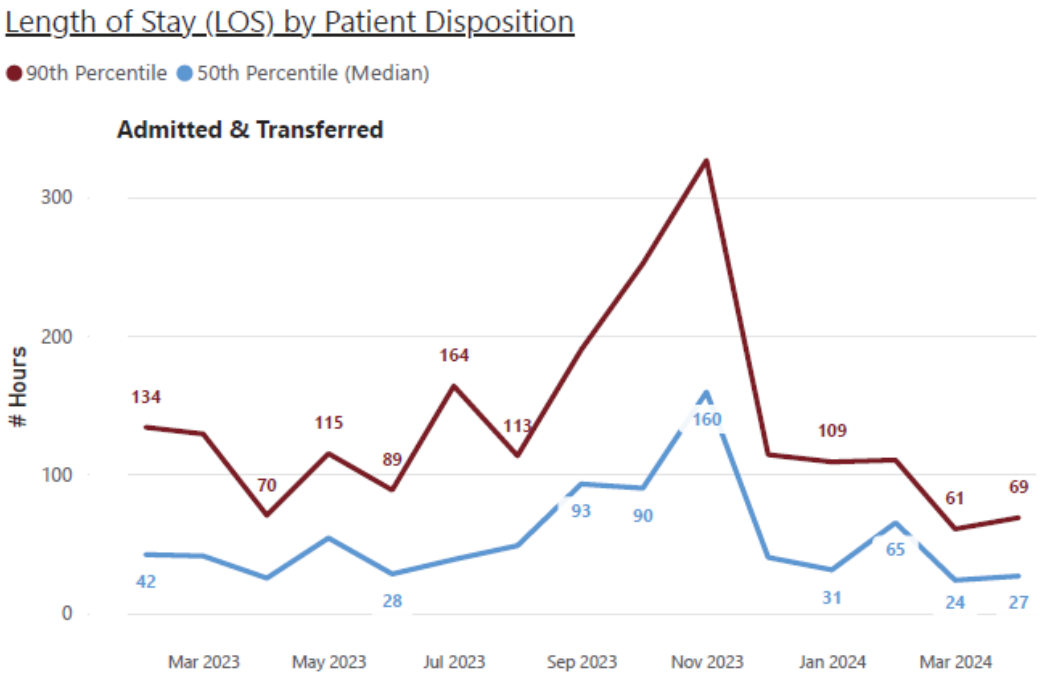
full report in appendix 2). The dark blue line in the top graph of the image below shows the average number of adolescents waiting gleaned from 6 to 8 point-in-time assessments throughout each month. The light blue shading shows the maximum and minimum number of adolescents waiting derived from point-in-time 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.

END Q002, question 3- response dated June 17, 2024

Q004, question 1- response dated August 21, 2024

Question 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.

END Q004, question 1- response dated August 21, 2024

Appendix 2- Supplement to Question #2

Portion of Q002, question 10- response dated June 17, 2024

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.

Appendix 3- Supplement to Question #4

Portion of Q002, question 10- response dated June 17, 2024

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.

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

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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.

Appendix 4- Supplement to Question #12

Q004, question 2- response dated August 21, 2024

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[14] 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 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

[14] 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.

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.