Report to
The Vermont Legislature

Report on
Secure Residential Facility: Plan for Siting and Design

In Accordance with Act No. 26:
An act relating to capital construction and State bonding.

Submitted to: Representative Johnson, Chair, House Appropriations
Representative Emmons, Chair, House Corrections and Institutions
Representative Pugh, Chair, House Human Services
Senator Ayer, Chair, Senate Health and Welfare
Senator Kitchel, Chair, Senate Appropriations
Senator Flory, Chair, Senate Institutions

Submitted by: **Hal Cohen**
Secretary

Prepared by: **Frank Reed**
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Report Date: **February 22nd, 2016**

VERMONT
AGENCY OF HUMAN SERVICES

I. Legislative Charges for Secure Residential Facility:

Act 79 (2012):
"Sec. 10. SECURE RESIDENTIAL RECOVERY PROGRAM
(a) The commissioner of mental health is authorized to establish and oversee a secure seven-bed residential facility owned and operated by the state for individuals no longer requiring acute inpatient care, but who remain in need of treatment within a secure setting for an extended period of time. The program shall be the least restrictive and most integrated setting for each of the individual residents. (b) The opening of the facility described in subsection (a) of this section is contingent upon the passage of necessary statutory amendments authorizing judicial orders for commitment to such a facility, which shall parallel or be included in 18 V.S.A. § 7620 (related to applications for continuation of involuntary treatment), and shall include the same level of statutory protections for the legal rights of the residents as provided for individuals at inpatient facilities."

Act 178 (2014):
"the Commissioner of Buildings and General Services, in consultation with the Commissioners of Mental Health and Corrections, shall develop a proposal to establish a permanent secure residential facility no later than January 15, 2015."

Act 26 (2015):
"Sec. 30. SECURE RESIDENTIAL FACILITY; PLAN FOR SITING AND DESIGN
(a) The Secretary of Human Services shall conduct an examination of the needs of the Agency of Human Services for siting and designing a secure residential facility. The examination shall analyze the operating costs for the facility, including the staffing, size of the facility, the quality of care supported by the structure, and the broadest options available for the management and ownership of the facility."

II. Background to Date:

The current temporary secure residential recovery program, the Middlesex Therapeutic Community Residence ("MTCR") in Middlesex, Vermont, opened in June 2013 with capacity to serve 7 residents. Since opening, the facility has served 29 residents. In the two and a half years of operation, the facility has discharged 22 individuals and has an average length of stay (LOS) of 5 months. The process for referral into the facility is managed by the Department of Mental Health ("DMH") care management team in coordination with the higher level of care facilities, most frequently inpatient treatment settings. There is an average of one referral identified each month for potential admission to the MTCR. The program serves individuals with mental illness who no longer require inpatient acute psychiatric hospitalization, but their care requires a secure (locked) setting, as well as individuals who are no longer severely symptomatic but must remain in a secure environment until resolution of judicial process. Given the facility's licensing as a Therapeutic Community Residence (TCR) and space limitations, the program does not serve individuals who require emergency involuntary procedures (i.e. seclusion and restraint).

The development and purpose of the Secure Residential Recovery ("SRR") Program was originally conceptualized as part of the Vermont Futures Project, which sought to design and develop an array of investments in essential community capacities and reconfigure the Vermont State Hospital into a new system of inpatient, rehabilitation, and residential services for adults. As part of this new system, the SRR program was designed to serve individuals who would otherwise remain at the Vermont State Hospital due to a high risk of self-harm or neglect, or pose a danger to others. Individuals served by this program do not require inpatient acute psychiatric services, but their care needs exceed local community resources. Some of these individuals are suicidal with a high risk of self-harm. Other individuals manifest a high incidence of aggressive behaviors and are dangerous to others but are not in an acute psychotic crisis. Another smaller group includes those who are no longer clinically severely symptomatic, but must remain in a secure environment for prolonged periods of time awaiting resolution of a judicial process.

Given that the MTCR is a temporary facility with a planned closure in 2018, DMH has been working with state and community partners to assess the need for a permanent SRR Facility. In January 2015, DMH and the Department of Building and General Services ("BGS") submitted a proposal to the House Committee on Corrections and Institutions for the permanent replacement of the MTCR. DMH recommended the creation of a 14-bed, involuntary, secure (locked) residential facility located within the state of Vermont on lands to be acquired for construction or renovation. As proposed, the program would require a waiver of current TCR standards to include the potential need for and use of brief involuntary interventions with residents served. Residents of the facility would include those people who remain in acute care settings due to a high risk of self-harm, or neglect, or pose a danger to themselves or others. They would be individuals who do not require inpatient acute psychiatric services, but whose care needs exceed local community program resources. The cost to develop the program, excluding land acquisition costs, was estimated to be approximately $12 million, with a projected annual operating cost of $5.1 million using Global Commitment funding with some private pay. A copy of the report is included in the attachments of this report.

Based on that report and subsequent discussions between the Agency of Human Services (AHS) and the legislature regarding other high-need populations being served by other AHS departments (e.g. Department of Corrections and the Department of Disability, Aging and Independent Living) that may require secure residential treatment, the legislature subsequently directed the Secretary of AHS to "conduct an examination of the needs of the Agency of Human Services for siting and designing a secure residential facility. The examination shall analyze the operating costs for the facility, including the staffing, size of the facility, the quality of care supported by the structure, and the broadest options available for the management and ownership of the facility" (Act 26). As part of that examination, AHS has been asked to assess how the development of an SRR Facility may address or overlap with the needs of individuals who are currently being served by other departments but have similar needs for secure residential treatment. These individuals include a Department of Corrections ("DOC") offender population that may be eligible for release and/or medical furlough to treatment services, DOC offenders with significant serious functional impairment who would meet the criteria for orders of non-hospitalization, and elderly offenders who are eligible for long-term care services, but given offense history are challenged to be admitted to extended care nursing facilities.

The following status update provides a summary of planning and analysis completed to date and recommendations for a continuing planning process.

III. Plan for Siting and Design

Secure Residential Facility Request for Information ("RFI")

As part of Vermont's planning for the siting and design of a permanent SRR Facility, AHS posted an RFI in the fall of 2015 seeking input from interested parties who wished to provide information, recommendations and/or conceptual proposals regarding the planning, development, operations and/or management of the new SRR Facility. Specifically, the RFI requested information on the types of roles interested parties would like to play in the design, development and/or operation of the new SRR Facility and conceptual proposals or initial recommendations regarding the siting and location of the facility, the size and capacity of the facility, estimates of operating costs for the facility, the quality of care supported by the structure, and potential options available for the management and ownership of the facility.

RFI responses were received from two architectural firms, one developer, one long-term care corporation, and three service provider organizations. A summary of the responses is as follows:

***Anmahian Winton Architects** (Architecture firm)*

- Proposal to provide full architecture and engineering design services for the new SRR facility, including:
    - Planning and preliminary design, including site test fits
    - Interaction with AHS/DMH community and key stakeholders for the project
    - Preparation of materials required for Local, State, & Department approvals
    - Documents for construction permitting
    - Development of design and construction documents
    - Construction administration.

Architecture+/Black River Design/Engelberth Construction (Architecture, Design and Property Development Firms)

- Proposal to provide architectural and engineering design services
- Provides initial analyses regarding size, capacity, siting, design, ownership of the SRR Facility
- Has background working with Vermont on similar projects (e.g. Vermont Psychiatric Care Hospital; initial design/planning for the SRR Facility).

Brattleboro Retreat/Collaborative Solutions/Second Spring (Inpatient and residential treatment providers)

- Proposal to develop and own the SRR Facility on Retreat Campus; would be operated by Collaborative Solutions

Genesis Healthcare (Post-acute care mental health and substance use service provider in MA)

- Interest in identification and development of an appropriate physical plant setting for the SRR Facility, as well as operation of the program
- Identified potential site at former Rutland manor Residential Care Building.

Hundred Acre Homestead (Therapeutic Community Residence in Worchester, VT)

- Interest in "any role mutually agreed upon by State and Hundred Acre Homestead", including development and operation of the SRR Facility on their property.

Northeast Kingdom Human Services (Designated Agency)

- Proposal to create LLC (wholly owned subsidiary of NKHS) that would develop and operate social service campus in Essex County, which would include the SRR
- Already initiated significant planning with numerous stakeholder (board, town of Bloomfield, legislators, architect, landowner) and developed business/development plan
- Proposing to purchase Bloomfield Ridge Property in Essex County for siting of the SRR Facility; campus could be expanded to include small residential units for "graduates."

Pizzagali Properties (Property Management and Developer)

- Submitted several proposals for siting SRR:
    - Development on Northwest State Correctional Facility campus; need to be master-planned to avoid interfering with possible expansion of Northwestern State Correctional Facility
    - Acquisition/development of property in Meadowland Business Park, South Burlington
    - Development of SRR Facility on Pizzagali-owned property in St. Albans (Grice Brook Road)
- Could act in varying roles, including selling or leasing property and/or developer of property.

AHS is currently engaging in more detailed discussion regarding initial interests expressed in the RFI response and assessing the feasibility of different models for development and operation of the SRR Facility discussed in the RFI responses.

<u>Siting Considerations</u>

State Owned Lands

Given the potential for sharing existing facility infrastructure (e.g. heating) and services (e.g. food service), AHS asked BGS to assess two state-owned sites that may have enough property to site a new SRR Facility: Northwestern State Correctional Facility ("NWSCF") and Southern State Correctional Facility ("SSCF"). Criteria used to assess the two sites included lot size, physical characteristics, utilities, zoning/permitting, potential construction issues, and the quality of the program. The BGS analysis is as follows:

Site Consideration Fact Sheet			
Completed: November 19, 2015			
Criterion	Description/Questions	SSCF	NWSCF
Lot Size	Acreage	149.47 Acres; includes 101.51 A - SSCF, 31.93 A Industrial Park plus 16.03 A deer yard. SSCF area also includes 57 A deer yard. The fenced in area is approximately 17.88 acres.	161 Acres; w/ 32.6 acre prime ag conservation easement to the Town of St. Albans as well as a utility easement to Town for Sewage Treatment Plant
	Is the site capable of supporting development?	Planned for additional 150-beds	Plans show 500-bed & 700 bed build-out
	Adequate Circulation Space (Cars, Trucks, Parking, Loading)?	Included in planning	Included in planning
	Adequate for Buffers, Safety, & Security?	Yes, Question on separating MH Beds from DOC Beds?	Reduced on West side. Same ques re: Separation
Physical Characteristics	Flat, Rolling, or Steep Slopes?	Flat w/ Steep Slopes at perimeter	Generally flat and rolling.
	Are Soils Well Drained?	Yes	Not necessarily
	Ledge or Rock Outcroppings?	Limited w/in Industrial Park	Not aware of any
	Does Site lend itself to development?	Separation of MH vs DOC beds?	Separation of MH vs DOC beds?
	Does site support building configuration?	Unknown, but probably	Unknown, but probably
Utilities	Municipal Water and Sewer?	Sized & Allotted I believe	Water may need upgrade, but sewage definitely needs upgrade
	Electrical Service	Verify size	Verify size
	Natural Gas	No	No
	Telephone/CATV	Yes	Yes
	Storm water Utility?	No but on-site capable	No, but on-site capable
Zoning/ Permitting	Permitted or Conditional Use?	Permitted	Conditional I believe
	Special Zoning District?	Certain site restrictions	Special Correctional Facility Zone very restricted
	Special Restrictions?	Re-negotiate ability to serve w/ Town	Limiting expansion capabilities
	Conform with Local Plan	Yes	Questionable
	Land Use Permit Status?	Permitted for additional 150-beds	Will need an Amendment
Construction Issues	Impacts on existing Facilities?	Security concerns	Security concerns
	Special Logistical Issues?	Maintain Security of facility during construction	Maintain Security of facility during construction Infrastructure upgrades
	Scheduling Concerns?	None aware of	Infrastructure upgrades
Quality of Program	Integrated Facility?	MH vs DOC Beds?	Infrastructure & MH vs DOC
	Separate Facility supported by Existing Infrastructure?	Logistics of providing services to a separate building	Separate building self-supporting?

Additional considerations highlighted by BGS as part of the analysis of these sites included:

- Due to the nature of the SRR Facility, it would most likely need to have its own core services, recreation yard and security perimeter inside the confines of the existing facility footprint.
- For the SSCF site, access to the SRR Facility would most likely have to be from the adjacent property that is supposed to be a future industrial park.
- Populations would most likely need to be kept separated. Sharing of services with the inmate population would be a challenge.
- For the SSCF site, the SRR Facility would have to share the open area that is currently a ballfield and the future site of a 150 bed unit.
- Town support for the creation of a new secure treatment facility may be an issue.
- While sharing infrastructure may be possible at both facilities, BGS would need to verify the capacity of the heat plant at SSCF. The state would need to upgrade the heat plant at NWSCF, as well as verify the water service. The sewage treatment plant would require an upgrade.
- Regarding services, the food service at NWSCF would also need to be upgraded for this added capacity. The balance of available services would need to be addressed during the programming for the facility based on the mix of bed types as well as the service being considered.

While these two locations may represent potential cost savings based on existing state ownership, cost investments and infrastructure issues need further analysis if these are prioritized sites for consideration.

Non-State Owned Lands and Acquisition

AHS and BGS will also continue to explore the potential of the SRR Facility on non-state owned lands. As part of the Vermont State Hospital Futures Project, selection criteria has been established to provide a comprehensive and quantifiable evaluation of the multiple variations of the site options proposed for consideration to house the permanent SRR Facility to replace the current MTCR. These criteria will be used to compare the relative viability of each site to house the proposed facility. The ultimate site option selected will also need to consider the anticipated capital and operational costs estimated for each option, as well as the potential revenue stream to offset the operational costs to provide the most affordable and sustainable program to serve the State's needs over the long term. Accordingly, the quality of care that can be acquired for each of the options under consideration should also weigh heavily in the final decision.

Below is an itemized list of the criteria, along with specific questions to be considered when evaluating each variation and option:

1) Criterion 1 – Lot Size (Acreage_____):
   - Is the site capable of reasonably providing for the Building(s), Future Expansion, Outdoor Access?
   - Is there space to accommodate safe Vehicular (truck & auto) and Pedestrian Circulation, Roads, Parking, and Loading Facilities?

- Is there adequate frontage/Access for sight distances?
- Is the site large enough to provide for buffers, safety, and security?

2) Criterion 2 – Site Physical Characteristics:
   - Is the site flat, rolling, or does it have steep grades? (5% for parking; 10% for buildings)
   - Are the soils well drained?
   - Is there any rock or ledge outcroppings?
   - Does the site configuration lend itself to the proposed development?
   - Does the site support the optimum building configuration?

3) Criterion 3 – Utilities:
   - Is municipal water and sewer available?
   - Is there adequate electrical service?
   - Is Natural gas available?
   - Is telephone and cable television available?
   - Is there a storm water utility or provisions for municipal storm water disposal?

4) Criterion 4 – Zoning/Permitting:
   - Is this a permitted use?
   - Is this a conditional use?
   - Is the site within a special zoning district?
   - Are there special restrictions/requirements on the site?
   - Can the site be planned to conform with Planning/Zoning criteria?
   - Is there a current or will we require a State Land Use Permit?

5) Criterion 5 – Neighborhood:
   - Is the site located in an Institutional area?
   - Is the site located in a Residential area?
   - Is the site located in a Mixed-Use area?
   - Is this a rural, suburban or urban setting?
   - Are there view opportunities?

6) Criterion 6 – Construction Issues:
   - Are there existing buildings on site that need demolition?
   - Is this a new building or renovation?
   - Are there construction impacts on existing facilities?
   - Are there special logistical issues to address for construction?
   - Will these impacts and issues have scheduling implications?
   - Are there existing facilities that need to be replaced?

7) Criterion 7 – Quality of Program/Service:
   - Can the site accommodate a fully integrated facility?
   - Is integration possible for clinical and medical services?
   - Can the site accommodate integration of infrastructure and support services?
   - Is the site in close proximity to services if integration is not possible?

While siting of the permanent SRR is still to be determined, AHS and BGS continue to examine additional potential sites as they become identified.

Extension of Time for Closing MTCR

Preliminary communications with the Chair of the Middlesex Select Board regarding a request for an extension of the current time line with the Town of Middlesex have been positive. A formal request for a two-year extension has been submitted by the Secretary of the Agency of Human Services to the Middlesex Select Board Chair (see attached). Initial discussions have also indicated there may be interest in siting the permanent SRR Facility in Middlesex.

Population Mix/Planning Considerations

As described above, AHS Central Office has been working with DMH, DOC, and the Department of Disability, Aging and Independent Living ("DAIL") to identify potential populations to be served by the SRR program that would meet the greatest need across the AHS. A discussion of the current and potential population eligibility and mix is as follows:

Description of statutory eligibility

Act 160 of 2012 created a statutory definition of the SRR Program and gave authority to the Commissioner of DMH to oversee and seek to have patients receive treatment in secure residential recovery facilities. Act 160 defines the "Secure residential recovery facility" as a "residential facility, licensed as a therapeutic community residence (as defined in 33 V.S.A. § 7102(11)), for an individual who no longer requires acute inpatient care but who does remain in need of treatment within a secure setting for an extended period of time." Under current statute, individuals may only be admitted to the SRR Facility if they are currently receiving inpatient care, and the Commissioner files a court application for continued treatment that results in an order of non-hospitalization requiring the individual reside at the SRR facility. If the State seeks to admit individuals to the SRR Facility directly from the community or a correctional facility, changes in statutory eligibility will need to be sought.

Mental Health Population

As described in the AHS and BGS report to House Corrections and Institutions submitted in January 2015 (see attached), DMH has proposed that residents of the new SRR Facility include those people who remain in acute care settings due to a high risk of self-harm, neglect, or pose a danger to others. They would be individuals who do not require inpatient acute psychiatric services, but whose care needs exceed local community program resources. Some of these individuals are suicidal with a high risk of self-harm. Other individuals manifest a high incidence of aggressive behaviors and are dangerous to others. Another, smaller group would include those who are no longer clinically severely symptomatic, thus no longer requiring acute care, but who must remain in a secure environment for prolonged periods of time awaiting resolution of criminal proceedings.

Specific examples of the kind of behavior the facility would treat include:

- People with severe symptoms of mental illness such as delusions of persecution which only partially respond to acute hospital-based treatment and are prone to act on those delusions by assaulting others;
- Individuals with mental illness whose mental status fluctuates with episodes of severe symptoms such as hallucinations in which assaultive behavior or self-destructive urges are prominent, yet have prolonged periods of stability between these episodes;
- Individuals with a primary mental illness and cognitive impairments, who have a high frequency of assaultive behaviors.

It should be noted that violent behavior in and of itself would not be a sufficient criterion for admission to the proposed SRR Facility. Persons in acute psychotic crises (who might be assaultive) would be admitted directly to an acute psychiatric inpatient unit of a hospital. On the other hand, individuals who demonstrate dangerous behavior as a result of mental illness but are not in a psychiatric crisis and do not require the medical services of an inpatient care unit, would be eligible for the SRR.

DOC Inmate Population

AHS, DMH and DOC are working to assess the viability of using the permanent SRR program to also treat individuals who are involved in the correctional system. Discussions have focused on identifying a subset of inmates who meet all of the following criteria:

- Impaired due to a mental illness to the point that they lack the ability to meet the ordinary demands of life,
- Substantially impaired when it comes to functioning in a correctional environment,
- Eligible to be released from DOC custody, and
- Meet the legal criteria to be placed on an order of non-hospitalization.

Accordingly, there may be instances wherein, in the discretion of the Commissioners of the Departments of Mental Health and Corrections, placement of these individuals may serve important rehabilitative, therapeutic and re-integration objectives.

DOC reports that the most prevalent types of disorders among inmates that might be referred to the SRR Facility are as follows:

1) Schizophrenia Spectrum and other Psychotic Disorders: Individuals suffering from these disorders experience distressing symptoms in at least one of the following domains: delusions, hallucinations, disorganized thinking (speech), disorganized or abnormal motor behavior (including catatonia) and negative symptoms (e.g. diminished emotional expressions and avolition).
2) Bipolar Disorders: Individuals suffering from these disorders experience periods of mania characterized by elevated, expansive or irritable mood with increased activity. The individual may describe that they feel “on top of the world” and may exhibit inflated self-

esteem, decreased need for sleep, rapid and pressured speech, racing thoughts, distractibility and excessive goal directed thinking.

Details of the collaboration between the DOC and DMH resulting in the possible assignment of DOC populations who meet the criteria outlined above to short-term therapeutic stays at the SRR Facility have yet to be fully worked out. Among the factors to be addressed would be measures to safeguard the availability of Medicaid funding for treatment services provided by the SRR Program in serving this population.

Long-Term Care Eligible Population

AHS, DMH, DOC and DAIL have also examined expected service needs for elderly offenders who are eligible for long-term care services, but given offense history are challenged to be admitted to extended care nursing facilities. At this time, AHS does not feel this population would be appropriate for the SRR Facility, but DMH and DAIL have been meeting with potential providers to discuss specialized services for the DOC offender population that is eligible for release and long-term care services. To date, DMH and DAIL have:

- Met with the Vermont Veteran's Home Administrator to discuss the provision of specialized services for this population
- Met with Designated Agency Executive Directors to engage any local long-term care facilities who would consider a specialized care unit for this population. Follow up meetings regarding mental health services and long-term care oversight issues are being planned;
- Met with a long-term care corporation who was a respondent to DMH's RFI for SRR services to discuss long-term care eligible populations across various AHS departments who present with specialized service needs.

DMH and DAIL will also be engaging with the Vermont Health Care Association to solicit their support in the planning process.

<u>Program Characteristics</u>

As with the current SRR, the focus of care of the permanent SRR Facility would continue to be the provision of psychiatric rehabilitation services and psychosocial treatment delivered in a positive behavioral support framework to assist individuals to engage in their own recovery and develop the necessary skills to move to less intensive services, and, ultimately, independent living. Program interventions would focus on connecting with the resident using positive behavioral supports designed to facilitate the individual's growth in skills needed for a return to the community. The focus of programming would include:

- Behavioral analysis and development of individualized treatment plans;
- Treatment of underlying mental illness;
- Life skills development;
- Psych-social and psycho-educational programming focused on learning how to be safe and responsible citizens;

- Supporting and motivating residents (and their home communities) to engage in a recovery process;
- Discharge planning.

Program characteristics would also include the capacity to maintain a safe, secure environment regardless of the level of risk. The environment of care would permit separation of sub-groups so that all are safe and individuals with a history of traumatic experiences and victimization by others would not be further traumatized by contact with individuals prone to aggressive, assaultive behavior. Staff would be trained and credentialed to work with this population group.

As discussed previously, the proposed population to be served would include individuals who are at risk for exhibiting brief episodes of assaultive or self-injurious behavior, and thus the permanent SRR Facility would require a waiver of current TCR standards to include the potential need for and use of brief emergency involuntary interventions with residents served.

Financial Sustainability Considerations

AHS has examined a number of issues related to funding and financial sustainability of a permanent SRR Program. The temporary SRR facility in Middlesex is currently supported using Medicaid Global Commitment funds, and AHS is seeking to develop a program that can be supported using this same funding stream. As such, a number of factors must be taken into consideration.

Vermont currently relies on the flexibility it has under the Global Commitment managed care model to pay for services that are demonstrated to be cost effective alternatives to traditionally-covered services. These include services provided in an Institution for Mental Disease (IMD). Federal law provides that Federal Financial Participation (FFP) is not available for individuals between the ages of 21 and 65 who are residents of IMDs, which is a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing care and treatment of individuals with mental diseases.

Vermont currently relies on the flexibility it has under the Global Commitment managed care model to pay for services that are demonstrated to be cost effective alternatives to traditionally-covered services. Using this authority, program payments are included in the base for purposes of calculating the annual, actuarially-determined per-member per-month (PMPM) limits.

Vermont, under the above flexibility of the Global Commitment Demonstration, reimburses three facilities (licensed as Therapeutic Community Residences) for substance abuse treatment services. All three facilities operate more than 16 beds and are engaged in providing treatment for mental disease (which includes treatment for substance use and addiction for purposes of defining IMDs).

As part of the planning process for building the 25-bed Vermont Psychiatric Care Hospital (VPCH), in 2012 Vermont sought clarification from the Center for Medicaid and Medicare Services (CMS) regarding our authority to access Medicaid funding to support the new facility. In response to this request, CMS indicated that costs of services for individuals between

the ages of 21 and 65 residing in an IMD would not be included in the calculating the annual PMPM limits and that Vermont has authority under the Demonstration to fund IMD services by using its "managed care savings." However, on May 26, 2015, CMS issued proposed revisions in regulations for Medicaid Managed Care plans that would allow for capitation payments to plans for persons receiving certain services in an IMD for less than 15 days per month.

While Vermont has asserted its authority under the managed care model to pay for Therapeutic Community Residence services for several years, the 2012 guidance received from CMS in response to Vermont's inquiry suggests that managed care savings should be used to pay for all IMD services. Vermont has opted to continue to pay these facilities as cost effective alternatives while categorizing similar hospital-based payments as managed care investments.

Under either of these options, FFP is available under the current Section 1115 demonstration model to support these services. Starting in CY '17, we will be operating under a new Agreement. We have just started negotiations with CMS and it is yet to be determined what changes in the current program may result, although it should be noted that we have requested a no-change extension. Should CMS propose specific actions regarding IMDs, we might reasonably propose something that aligns more closely with the 2015 proposed Medicaid Managed Care regulations. These regulations allow for up to 15 days payment eligible for FFP before we would have to turn to Managed Care Investment funds to receive FFP.

It is important to note that while Vermont's ability to support VPCH using its "managed care savings" (also referred to as MCO Investment) has benefitted the state in a number of ways, AHS is seeking to avoid funding the permanent SRR facility as an MCO Investment.

The State's Global Commitment waiver is capped by the PMPM limit. Any savings within the PMPM limit can be used for MCO Investments. To minimize the risk of not having enough savings to cover the MCO Investments, the State has tried to keep MCO Investments at 5-7% of total Global Commitment (GC) costs. In SFY'15, MCO Investment spending was at 8.79% of total GC costs, therefore above our target. Developing additional programming that would require MCO Investment funding would increase the percentage and risk of not having enough savings to cover the MCO Investments.

Management

Development of a state-run facility versus a collaborative initiative with interested providers, such as the initiatives for inpatient care following Act 79 with Rutland Regional Medical Center and the Brattleboro Retreat, still needs to be formulated and analyzed for long-term cost considerations.

Preliminary Recommendations

AHS has met with BGS representatives and included DOC, DAIL, and DCF participants in the preceding months with regard to potential populations to be served, compatibility of programming potentials, siting potentials, and funding mechanisms to be considered.

Presently, it appears most feasible for the development of a SRR facility that maximizes occupancy up to 16 beds that could address the needs of individuals who have mental illness and treatment needs for this setting drawing from eligible inpatients ready for transition from a hospital and eligible individuals from DOC into this level of care.

Under this proposed program, individuals would be under the care and custody of the DMH Commissioner and treatment programming would maximize opportunities for traditional Medicaid participation and minimize Global Commitment MCO Investment funding.

These preliminary recommendations continue to mirror the initial proposal put forward by both DMH and BGS in January 2015 with regard to projected construction costs and annualized operating costs. Acquisition costs as siting considerations are finalized and management costs, depending on state-run versus a public-private partnership configuration, still needs to be evaluated. It is recommended that a Request for Proposals be developed, identifying major programmatic components, further exploration of public-private partnership efficiencies, and with requirements for more detailed cost projections in order to determine overall cost benefits for both quality and service delivery to the population to be served. State Fiscal Year '18 budget development should then include requests for identified resources that will be necessary to initiate *Certificate of Need* or *Certificate of Approval* requirements and the project development and management coordination necessary to oversee the establishment of a permanent secure residential program.

Attachments:

Proposal for Secure Residential Facility [Act 179, Sec. 35: Appropriations Act, Sec E 314.2]: Submitted to House Corrections and Institutions January 2015

AHS Letter to Peter Hood, Chair, Middlesex Select Board

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MEMORANDUM

TO: Representative Alice Emmons, Chair
House Corrections & Institutions Committee

FROM: Paul Dupre, Commissioner
Department of Mental Health

Michael Obuchowski, Commissioner
Department of Buildings and General Services

DATE: January 12, 2015

SUBJECT: Permanent Replacement for the Secure Residential Program

Pursuant to the Level 1 Psychiatric Care Evaluation required by the Fiscal Year fiscal year 2014 Appropriations Act, Sec. E.314.2, the Commissioner of Buildings and General Services, in consultation with the Commissioners Mental Health and Corrections, shall develop a proposal to establish a permanent secure residential facility no later than January 15, 2015.

Please find attached a copy of the Project Brief and the projected costs for the permanent replacement of the temporary Middlesex Therapeutic Community Residence (Secure Residential Program) in Middlesex.

Please let us know if you have any questions regarding the information contained within the report brief or require additional information.

Thank you.

C: Secretary Cohen, Agency of Human Services
Committee Members

Brief - 14 Bed Permanent Replacement

Secure Residential Recovery Treatment Facility

What is the current need

The current temporary secure residential recovery program, the Middlesex Therapeutic Community Residence (MTCR) in Middlesex, Vermont opened in June, 2013 with capacity to serve 7 residents. Since opening, the facility has served 24 residents with an average length of stay (LOS) of 4.5 months. The facility has admitted 22 individuals and seen 15 discharges over the past one and a half years of operation. The process for referral into the facility is managed by the DMH care management team in coordination with higher level of care facilities, most frequently inpatient treatment settings. There is an average of 3-5 referrals identified each month for potential admission to the MTCR.

As part of Act 79 passed in 2012, the DMH was given authority to develop an additional 7 Intensive Residential Recovery beds in the northwestern portion of the state. At the time, funding for these additional beds as part of the overall system of care was not appropriated to DMH. Subsequent to passage of this legislation, DMH on an ongoing basis has been evaluating the capacity of inpatient, crisis, and Intensive Residential Recovery (IRR) beds available and/or coming on line in the various regions of the state since the closure of the former Vermont State Hospital. During this time, the most challenging dispositions from inpatient care are those individuals who no longer require inpatient treatment services, but who may remain either emotionally or behaviorally dysregulated and in need of supervision within a secure (locked) treatment setting prior to return to the community. These individuals, while relatively small in numbers overall, account for a significant number of either Level I or other involuntary patient treatment days, resulting in longer lengths of stay in the finite number of inpatient beds, at the highest level of care.

The inability to manage timely transfer to less acute levels of care results in unnecessary delays in accessing the most acute inpatient beds from the community, corrections, and emergency department settings.

At the time of program development, the DMH determined that it would not seek a waiver of existing requirements for Therapeutic Community Residences, with regard to the potential use of emergency involuntary procedures, from the Division of Licensing and Protection for residents admitted to the program. Efforts to provide alternative spaces to minimize the need for such emergency procedures through planning for adequate programmatic space, resident room configurations, and access to the outdoors were prioritized, as well as, a stronger emphasis on a recovery-oriented residential environment. As such, the current MTCR Program does not have the physical space to safely manage individuals who may require periodic emergency involuntary procedures during the course of admission to the program. This programmatic limitation has been a significant consideration in the referral process and readiness of individuals who might otherwise have been served in this level of care.

What is proposed recommendation

Consistent with Act 79 mental health services transformation and development of a comprehensive continuum of care, the DMH proposes to repurpose the 7 remaining IRR beds identified in Act 79 into secure residential recovery beds. In combination with the 7 existing beds in the MTCR, the additional compliment of like beds will better address the care system's ongoing need for this level of care in the continuum of existing bed capacity. The proposed facility would be a newly constructed or renovated

14-bed, involuntary, secure (locked) residential facility located within the state of Vermont on lands to be acquired for this specific construction or renovation. The program would be a permanent replacement facility for the MTCR and continue to serve individuals who are not ready for discharge to the community, but who no longer require acute inpatient psychiatric care. Residents in this facility would not be in active crisis. The focus of care would continue to be provision of psychiatric rehabilitation services and psychosocial treatment delivered in a positive behavioral support framework to assist individuals to engage in their own recovery and develop the necessary skills to move to less intensive services and, ultimately, independent living. The permanent replacement program will require a waiver of current TCR standards to include the potential need for and use of brief emergency involuntary interventions with residents served.

Who this facility would serve

Residents of the facility would include those people who remain in acute care settings due to a high risk of self-harm, or neglect, or pose a danger to others. They would be individuals who do not require inpatient acute psychiatric services, but whose care needs exceed local community program resources. Some of these individuals are suicidal with a high risk of self harm. Other individuals manifest a high incidence of aggressive behaviors and are dangerous to others. Another, smaller, group would include those who are no longer clinically severely symptomatic, thus no longer requiring acute care, but who must remain in a secure environment for prolonged periods of time awaiting resolution of a criminal proceeding.

Specific examples of the kinds of behavior the facility would treat include:

- people with severe symptoms of mental illness such as delusions of persecution which only partially respond to acute hospital-based treatment and are prone to act on those delusions by assaulting others;
- individuals with mental illness whose mental status fluctuates with episodes of severe symptoms such as hallucinations in which assaultive behavior **or** self destructive urges are prominent, yet have prolonged periods of stability between these episodes;
- individuals with a primary mental illness and cognitive impairments, who have a high frequency of assaultive behaviors.

How many people would be served and for how long

Initially the facility would open with the transfer of the current 7 residents admitted to the MTCR. Up to 7 additional individuals who are currently in acute care settings would be admitted in the weeks and months following the opening of the facility, to its full capacity at 14 beds. As currently operating, this facility will continue to have capacity to be a longer term residential treatment program. It is anticipated that the length of stay could be approximately 3 months to 2 years or more. As individual progress and recovery is attained and as community program beds, capable of providing the next level of care for the population served become available, it is expected that the length of stay for the secure residential facility would shorten. Unlike the current MTCR, the permanent replacement facility would have the capacity to respond to emergency situations utilizing emergency involuntary interventions if needed to stabilize individual resident assaultive behavior. Currently, assaultive behaviors warranting such intervention, require residents to be transferred to other care settings, most often emergency department services and/or psychiatric inpatient care settings until the behavioral crisis has passed and the individual's care needs can be managed in less acute levels of care. The proposed permanent secure residential program would be able to manage such brief episodes of resident behavior, rather than potentially unnecessary transfers to higher levels of care settings and requiring assessment outside of the program.

How the program would fit within the mental health system

Initially, only inpatients in acute care hospitals who meet the criteria for the secure residential facility would be served by the program. Individuals from the secure residential facility could transfer to other community residential care services within the existing continuum of care, such as intensive residential recovery programs. *It should be noted that violent behavior in and of itself is not a sufficient criterion for admission to the proposed secure residential facility. Persons in acute psychotic crises (who might be assaultive) would be admitted directly to an acute inpatient unit of a general medical hospital. On the other hand, individuals who demonstrate dangerous behavior as a result of mental illness but are not in a psychotic crisis and do not require the medical services of an inpatient acute care unit, would be eligible for the secure residential program.*

Program and services that would be provided

Program characteristics include the capacity to maintain a safe, secure environment regardless of the level of risk. The environment of care should permit separation of sub-groups so that all are safe and individuals with a history of abusive treatment by others are not further traumatized by contact with individuals prone to aggressive, assaultive behavior. Staff would be trained and credentialed to work with this population group. Program interventions would focus on connecting with the resident using positive behavioral supports designed to facilitate the individual's growth in skills needed for return to the community. The focus of programming would be:

- Behavioral analysis and development of individualized treatment plans
- Treatment of underlying mental illness
- Life skills development
- Psycho-social and psycho-educational programming focused on learning how to be safe and responsible citizens
- Supporting and motivating residents (and their home communities) to engage in a recovery process
- Discharge planning

Staffing required

Because of its residential treatment mission the staffing requirements of the 14 bed secure residential recovery facility differ significantly from those of an acute inpatient psychiatric unit. The current MTCR utilizes 32 staff positions who provide program and treatment services. Personnel include Registered Nurses, Mental Health Specialists, and Mental Health Recovery Specialists, a Program Director, a behavioral Psychologist, a Social Worker, and a half-time Psychiatrist. Additional resident capacity would proportionately increase the number of Mental Health Specialists and Mental Health Recovery Specialists and hours of psychiatry oversight needed.

Accreditation and certification

The current MTCR is licensed by the State of Vermont, Department of Aging and Independent Living, Licensing and Protection Division, as a Therapeutic Community Residential (TCR) Program. Licensing for the 14 bed program would be the same. Capacity to provide emergency involuntary interventions will require a waiver of the current TCR licensing requirements. Other forms of program accreditation may be sought through nationally recognized accrediting organizations and would be identified as permanent program development and planning occurs.

Estimated cost

The estimated cost of this project, excluding land acquisition costs, would be approximately $12M. Attached please find the preliminary program for the development of this facility as well as the project cost estimate calculations. The total capital cost with debt service spread over 20 years is estimated to be $16.2M. The projected average annual operating costs would be approximately $5.1M.

Potential revenue sources for operating costs

Given the requirement to adequately fund the community system of care, the 14 bed residential program (at least initially) would be funded primarily through Global Commitment (Medicaid), with some private pay.

Time frame for planning and implementation of permanent facility

A time line for planning and implementation will be developed in the upcoming year subsequent to this initial report, as well as, any other activities as directed by statutory requirements that may be outlined in this upcoming legislative session. Planning activities currently rely on any unspent planning funds; $50K allocated in the 2013-2014 legislative session to BGS, and may require additional planning dollars in the FY 16 appropriation in order to achieve project milestones going forward. In the upcoming year, DMH will also be analyzing Certificate of Need (CON) Application requirements for the changes proposed in the program and this report as well.

THERAPUETIC COMMUNITY RESIDENTIAL FACILITY											
Program Comparison (Previous 15-bed vs 14-bed)											
	Mental Health - Adult Primary Unit	**2008 Program**			**2010 SD Allocation**			**2014 Program (14-Beds)**			
Ref		**No. of Spaces**	**NSF/ Space**	**Total NSF**	**No. of Spaces**	**NSF/ Space**	**Total NSF**	**No. of Spaces**	**NSF/ Space**	**Total NSF**	
	Unit Space	***Cluster A (7 Beds)***			***Cluster A (4 Beds)***			***Cluster A (7 Beds)***			
1	Patient Room, Private	6	120	720	3	135	405	6	120	720	
2	Patient Room, Private, Medical	1	200	200	1	178	178	1	200	200	
3	Toilet/Shower, Patient	6	50	300	3	38	114	1	50	50	
4	Toilet/Shower/Tub, Patient HC	1	80	80	1	58	58	1	120	120	
5	Activity/Recreation	1	200	200	0	200	0	0	200	0	
6	Living Room	0	160	0	1	152	152	1	160	160	
	Dining Room							10	30	300	Added Dining Room on each unit
7	Kitchenette	1	60	60	1	100	100	1	100	100	
8	Quiet Sitting Room	1	160	160	1	95	95	2	100	200	
	Subtotal			***1,720***			***1,102***			***1,850***	

	Unit Space	***Cluster B (8 Beds)***			***Cluster B (5 Beds)***			***Cluster B (7 Beds)***			
1	Patient Room, Private	7	120	840	4	139	556	6	120	720	
2	Patient Room, Private, Medical	1	200	200	1	204	204	1	200	200	
3	Toilet/Shower, Patient	7	50	350	4	37	148	1	50	50	
4	Toilet/Shower/Tub, Patient HC	1	80	80	1	64	64	1	120	120	
5	Activity/Recreation	1	200	200	0	200	0	0	200	0	
6	Living Room	0	160	0	1	177	177	1	160	160	
	Dining Room							10	30	300	Added Dining Room on each unit
7	Kitchenette	1	60	60	1	104	104	1	100	100	
8	Quiet Sitting Room	1	160	160	1	99	99	2	100	200	
	Subtotal			***1,890***			***1,352***			***1,850***	

	Unit Space	***Cluster C (0 Beds)***			***Cluster C (6 Beds)***			***Cluster C (0 Beds)***			
1	Patient Room, Private	0	120	0	4	136	544	0	136	0	
2	Patient Room, Private, Medical	0	200	0	2	178	356	0	178	0	
3	Toilet/Shower, Patient	0	50	0	4	36	144	0	36	0	
4	Toilet/Shower, Patient HC	0	80	0	2	67	134	0	67	0	
5	Activity/Recreation	0	200	0	0	200	0	0	200	0	
6	Living Room	0	160	0	1	183	183	0	183	0	
7	Kitchenette	0	60	0	1	93	93	0	93	0	
8	Quiet Sitting Room	0	160	0	2	100	200	0	100	0	
	Subtotal			***0***			***1,654***			***0***	

	Team Care and Support										
1	Exam Room	1	120	120	1	128	128	1	120	120	Also serves as psychiatry space when on site
2	Charting and Records Storage	1	300	300	1	152	152	1	200	200	Probably does not need to exceed 200 for facility size
3	Team Conference/Report Room	1	360	360	1	343	343	1	360	360	
4	Medication Room	1	100	100	1	98	98	1	100	100	
5	Tub Room	1	120	120	1	113	113	0	120	0	Included on Units

6	Clean Utility	1	100	100	1	98	98	1	100	100	
7	Soiled Utility	1	100	100	1	101	101	1	100	100	
8	Storage, Patient Clothing	1	80	80	1	79	79	1	80	80	
9	Storage, Equipment	1	80	80	1	129	129	0	80	0	Include in General Storage
10	Housekeeping /Cleaning Supply Stor	1	120	120	1	128	128	1	120	120	
11	Staff Lockers/Team Room	1	160	160	1	157	157	1	100	100	Could be reduced as conference/report room already exists.
12	Toilet, Staff	1	60	60	1	61	61	1	60	60	
	Subtotal			***1,700***			***1,587***			***1,340***	

Dining and Residential Activities

1	Dining Room	1	375	375	1	620	620	0	375	0	Added Dining Room on each unit
2	Kitchen	1	750	750	1	301	301	1	750	750	
3	General Storage	1	750	750	1	254	254	1	750	750	
	Seclusion Suite										
4	- Seclusion Room	1	100	100	2	98	196	1	100	100	
5	- Restraint Room	0	100	0	0	100	0	1	100	100	Include this capacity
6	- Ante Room	1	100	100	1	132	132	1	100	100	
7	- Toilet Room	1	60	60	1	48	48	1	60	60	
8	- Restraints Closet	1	20	20	0	20	0	1	20	20	Include this storage area
9	Toilet, Patient	1	60	60	2	38	76	1	60	60	
10	Patient Laundry	1	160	160	1	137	137	1	160	160	
11	Comfort Room	0	120	0	1	99	99	0	100	0	Delete
12	Toilet, Visitor	1	60	60	1	65	65	1	60	60	
	Subtotal			***2,435***			***1,928***			***2,160***	

Therapy and Work Area

1	Exercise/Fitness	1	225	225	1	306	306	1	225	225	
2	Entrance Vestibule	1	80	80	2	118	236	1	80	80	
3	Multi-Purpose Activity (Noisy)	1	400	400	1	451	451	1	400	400	
4	Multi-Purpose Activity (Quiet)	0	225	0	1	451	451	0	225	0	
5	Bi-Purpose: Group Therapy/Class Rm	1	225	225	1	361	361	1	225	225	
6	Comfort Room	1	120	120	1	97	97	1	120	120	
7	Interview/Consult Rooms	1	120	120	1	150	150	0	120	0	Delete
8	Bi-Purpose: Group Therapy/Library	1	225	225	1	304	304	0	225	0	Delete
9	Pastoral Parlor/Serenity Room	1	160	160	1	208	208	0	160	0	Delete
10	Volunteers	0	160	0	1	152	152	0	160	0	
11	Toilet, Visitor	1	60	60	0	60	0	1	60	60	
	Subtotal			***1,615***			***2,716***			***1,110***	

Clinical Team Cluster

1	Office, Nurse Manager/Admin Supervisc	1	120	120	1	120	120	0	120	0	Delete
2	Office, Program Manager	1	120	120	1	118	118	1	120	120	
3	Office, Psychiatrists	1	60	60	1	59	59	0	60	0	Delete
4	Office, Social Workers	1	100	100	1	101	101	1	160	160	Would increase for shared space with Nurse
5	Office, Quality Assurance	1	100	100	1	100	100	0	100	0	Delete
6	Workstation, Secretarial	1	64	64	1	79	79	1	64	64	

7	- Unit Mailboxes	1	5	5	1	6	6	1	5	5	
8	- Equipment/Files/Storage	1	100	100	1	127	127	1	100	100	
9	Office, AT/OT	1	150	150	1	145	145	0	150	0	Delete
10	Wrkstns, Rehab, MHW & Hoteling	2	40	80	2	39	78	1	40	40	Reduce to 1
11	Toilet, Staff	1	60	60	2	64	128	1	60	60	
	Subtotal			***959***			***1,061***			***549***	

Housekeeping Services

1	Storage Cleaning Supplies	0	150	0	1	150	150	includes area for flammable material; to be located in adjacent space in Materials Management. Stock in equipment storage rooms...not in Housekeeping Central.
2	Storage, Equipment	0	150	0	1	150	150	
3	Housekeeping Closets	0	60	0	1	60	60	Distributed throughout in addition to those programmed on patient unit and in dietary.
4	Washer/Dryer Room	0	100	0	1	100	100	Commercial equipment -Delete. This should be part of patient laundry. We would not be doing laundry for facility on site. No - BGS Use
	Subtotal			**0**			**460**	

Maintenance and Grounds

1	Office/Plan Room/Library	0	100	0	1	120	120	Delete No - BGS Use
2	Maintenance Shops	0	170	0	1	250	250	includes: key room, flammable materials storage room (150 sf), carpentry, plumbing, electrical, paint, metal working and welding. A clean and a dirty staging assembly area surrounded by work cages for benches and tools We do not need this capacity on site No - BGS Use
3	Grounds Equipment and Supplies	0	300	0	1	300	300	Out structure: a couple large riding mowers, a small backhoe, ditch witch etc. 3 bay garage outbuilding We do not need this level of equipment storage No - BGS Use
4	Workstation-Maintenance Workers	0	48	0	1	48	48	Shared by two
	Subtotal			**0**			**718**	

Total 15-bed Unit	10,319	11,400	14-bed 10,037
Number of Units	1	1	1
Total NSF	10,319	11,400	10,037
Department Total Net SF (NSF)	10,319	11,400	10,037
NSF to DGSF Multiplier	1.55	1.47	1.55
Departmental Gross SF (DGSF)	15,994	16,720	15,557
BGSF Multiplier	1.25	1.25	1.25
Building Gross SF (BGSF)	19,993	20,900	19,447
Number of Beds	15	15	14
DGSF	15,994	16,720	15,557
DGSF/Beds	1,066	1,115	1,111
BGSF	19,993	20,900	19,447
BGSF/Bed	1,333	1,393	1,389

DEPARTMENT OF BUILDINGS & GENERAL SERVICES

PROJECT COST ESTIMATE

Date: January 9, 2015

Dollars based on December 2014

Project Name: NEW 14-BED THERAPUETIC COMMUNITY RESIDENTIAL FACILITY

Location: To Be Determined

Construction Cost (19,500 gsf x 450/sf)	$8,775,000
A&E 8% x Construction (Fee Adjustable)	$702,000
Reimbursable 2% x Construction	$175,500
Administrative, Bonds, Art and Inspections 5% x Construction	$438,750
Contingency (5% - 10%) x Construction	$877,500
Special Items for Programming; Consultant Fees; Site Considerations; Fitup Costs, etc.	$438,750
Land Acquisition	To Be Determined
GRAND TOTAL	**$11,407,500**

Estimate based on Today's dollars

Energy conservation & use of renewable energy measures not evaluated in estimate

Engineer: Michael J. Kuhn

State of Vermont
Agency of Human Services
Office of the Secretary
208 Hurricane Lane, Suite 103
Williston, VT 05495
humanservices.vermont.gov

Hal Cohen, Secretary

[phone] 802-871-3009
[fax] 802-871-3001

Peter Hood, Chair
Middlesex Select Board
5 Church Street
Middlesex, VT 05602

Dear Mr. Hood,

As you may be aware, the Department of Mental Health proposed an expansion of the current 7-bed secure residential program in January, 2015 as part of permanent replacement planning for this facility. Subsequently, the Legislature requested that the Agency of Human Services conduct additional exploration of program size, operating costs, and program management during 2015. The AHS is reporting back to the Legislature this month on the progress made in planning and developing a permanent secure residential facility to replace the temporary facility located in Middlesex.

While I am prepared to provide a report of progress this month, I am not yet ready to make a final recommendation in all of the areas required for evaluation. During this current legislative session, AHS and the Department of Mental Health will be continuing to explore the most cost-effective siting and program management options for this permanent facility. The process for determining an accessible location and workforce, the population mix to be served, staffing levels, and the financial resources necessary to support the facility are all subject to legislative scrutiny prior to considering project approval. Additionally, the project will also require new certificate of need review and approval. Given these ongoing evaluation components to be resolved, a final recommendation and cost request will likely not be introduced until the beginning of the 2017 legislative session.

The Town of Middlesex has currently agreed to a closing date of January 1, 2018 for this facility. This timeline will be quite challenging given current status and review requirements prior to possible authorization by the Legislative. I am, therefore, seeking the approval of your Board to extend the closing date for this facility until January 1, 2020 to provide ample time for a permanent program to be developed as successor to this temporary facility. I believe that this request represents the outer most time frame to be anticipated and appreciate the flexibility and good will we have experienced in working with the Town of Middlesex. I am happy to provide additional information to your Board as needed. Thank you for your consideration. Please feel free to contact me with any questions.

Sincerely,

Hal Cohen, Secretary
Agency of Human Services

Cc: Justin Johnson, Secretary Agency of Administration
Frank Reed, Commissioner of Mental Health
Michael Obuchowski, Commissioner of Buildings and General Services