Report to
The Vermont Legislature

Report on AHS Major Facilities

In Accordance with Sec. 31 of Act 84 (H.519) of 2017
An Act Relating to Capital Construction and State Bonding

Submitted to: House Committees on Appropriations, Corrections and Institutions, Health Care, and Human Services, and the Senate Committees on Appropriations, Health and Welfare and Institutions

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VERMONT
AGENCY OF HUMAN SERVICES

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EXECUTIVE SUMMARY

The Agency of Human Services (AHS) views its facilities as resources which enable our services and help us achieve good outcomes. With the urgent and emergent issues facing our ability to deliver services, we felt we needed to begin with the end in mind. That only by understanding and modeling an inclusive multi-departmental facility plan could we properly identify our urgent first steps. It is the recommendation of AHS that Vermont works towards the creation of one large 925 bed facility by 2028.

It is important to look at Appendix A – Mental Health Facility Inventory. Our analysis brought to light that every High Acuity Mental Health facility has at least one critical risk to its ability to meet the intended mission. This is troubling in light of the compelling need to fix the emergency room mental health flow issues. Not only do we not have the facilities to provide necessary services, over the next five years our mental health facility system will degrade further.

There are lingering questions related to financing that require this report to outline multiple options to meet the needs of these specialized populations. Additionally, we may need to create temporary facilities until a more permanent solution can be financed and constructed. Without this planning exercise we would not be able to recommend a temporary forensic facility, as questions would immediately challenge the wisdom of temporary money.

The work surrounding this report will serve as the first step in creating a master facility plan, something that does not currently exist. We believe it is important to continue this work for all of our facilities, in cooperation with the Department of Buildings and General Services (BGS).

INTRODUCTION

Act 84 of 2017 required the Secretary of Human Services (AHS), in consultation with the Commissioner of Buildings and General Services (BGS), to develop a plan to support specific populations. This report is submitted in fulfillment of the requirement, and addresses the pressing facility needs of the following populations:

(1) individuals who no longer require hospitalization but who remain in need of long-term treatment in a secure residential facility setting;
(2) elders with significant psychiatric needs who meet criteria for skilled nursing facilities;
(3) elders with significant psychiatric and medical needs who do not meet criteria for skilled nursing facilities;
(4) children in need of residential treatment;
(5) juvenile delinquents in need of residential detention;
(6) offenders in correctional facilities; and
(7) any other at-risk individuals.

This report also includes a thorough examination of the existing facilities and the required maintenance, as well as if any should be closed. For a complete view of the current state of facilities, please see the charts in Appendix A and B.

AHS recommends that the State of Vermont take actions that lead to a future state with a 925 bed facility in the northwest area of Vermont. The facility would address the needs of a variety of populations, and the construction of such a facility would impact both the Departments of Corrections (DOC) and Mental Health (DMH). AHS also recommends inclusion for funding a replacement for Woodside Juvenile Rehabilitation Center in SFY'20 capital bill, following the 2016 feasibility study (pages 17-21 of this report).

This report was prepared with the assumption that the location of the new facility would be Franklin County to mitigate concerns regarding long distance transfers for offenders. All associated costs are based on Franklin County. The facility could be located in a different part of the state as long as it becomes one multipurpose complex to benefit from the efficiencies gained by shared administration and economy of scale. The design concept and timeline for a new complex that is contemplated in this report is meant to be flexible. If either the location or timeline changes, new cost estimates will need to be completed to reflect those decisions.

This report was built upon the requirement to address the pressing facility needs of very specific populations and it does not address all AHS facilities. The AHS team is willing to work to add information on transitional housing and the future of the Windsor facility.

Department of Corrections

The recommendation to build a 925 bed facility would include the following units and populations:

- 175 beds for female offenders
- 457 beds for male offenders (including out of state offenders)
- 120 beds for federal offenders
- 50 ADA compliant beds for aging/infirm male offenders
- 30 booking and receiving beds
- 50 forensic beds (Approximately 20 hospital level of care and 30 out-patient or residential level of care)
- 18 infirmary beds including 2 hospice and 3 quarantine beds
- Department for Children and Families (DCF): 25 beds for youthful offenders. This would be a contingency plan for Woodside, based on Medicaid financing.

This multipurpose facility could be built in stages, with one or two units coming online every two years until the complex is complete in 2028. This long-term vision would eliminate the need to place offenders out-of-state (see exception under Long Term Planning – Envisioning 2028). Significant savings could be achieved through the closure of Chittenden Regional Correctional Facility and Northwest State Correctional Facility and the related cost of deferred maintenance. Increasing federal offender beds will generate additional revenue. Northwest State Correctional facility would be closed. AHS and BGS would work with the community and law enforcement to determine the best use for the Chittenden Regional Correctional Facility.

The preliminary cost estimates between the status quo and a future with the multipurpose facility are as follows. More detailed information is included in Appendix C of the report.

	Status Quo – 20 Years Out (Total Costs)	New Complex – 20 Years Out (Total Costs)
New Campus – 880 Correction Beds		$819,699,012
CRCF	$385,482,600	$101,711,372
NWSCF	$541,240,462	$98,068,962
OOS	$290,788,448	$96,969,757
MVRCF	$302,985,341	$302,985,341
NECC	$448,003,147	$448,003,147
NSCF	$709,165,817	$709,165,817
SSCF	$677,203,758	$677,203,758
TOTAL	**$3,354,869,574**	**$3,253,807,166**

In the interim, AHS proposes other short and long-term solutions as follows:

Department of Mental Health

- Replace the Middlesex Therapeutic (temporary) Community Residence (7 beds) with a state owned (permanent) facility of up to 16 beds. AHS and BGS will be evaluating potential residential properties in central Vermont that meet the needs of this population that could potentially be rehabilitated or will locate property where a new facility could be built.
- Vermont Psychiatric Care Hospital (VPCH) – reduce the beds from 25 to 16 to qualify for Medicaid reimbursement OR come to an agreement with the Centers for Medicare and Medicaid Services on how to continue receiving federal Medicaid beyond the terms of the existing Global commitment to Health 1115 Demonstration Waiver. To retain 25 beds without Medicaid funding, the hospital will need to privatize (ownership transferred to UVMMC).
- Create additional psychiatric beds at a current designated hospital. The number of beds may be dependent on the Brattleboro Retreat and the potential phase down of Medicaid coverage for care delivered there.
- Geriatric psychiatry – contract for 10-12 nursing home beds and 10-12 residential care home beds at various locations across the state.
- Woodside – If Medicaid financing cannot be used, build a 15-bed youth correctional facility within the proposed multi-use facility and contract for youth psychiatric care. If Medicaid financing is approved, build a new, state owned, 25 bed facility.

UNDERSTANDING THE PROBLEM

In the 1950s and 1960s, the United States and Vermont experienced a policy shift from institutionalization to community care for psychiatric patients and children and adults with physical and intellectual disabilities. This deinstitutionalization resulted in the loss of long-term care facilities and psychiatric hospitals. The civil rights movement and grave concerns regarding the lack of oversight for psychiatric care led to an effort to increase community-based care options and decrease institutional care. Today, a severe shortage of inpatient care for individuals with mental illness is becoming a public health crisis, as the number of individuals struggling with psychiatric and substance abuse problems continue to rise.

According to the Bureau of Justice statistics, 14% of prisoners and 26% of inmates meet the criteria for serious psychological distress. In comparison, the same study found that only 5% of the general population would meet the same criteria.[1] Individuals who require mental health treatment are at higher risk for homelessness and incarceration. Exacerbating the problem is the inability of private mental health hospitals to draw federal funds, unless they are attached to a medical hospital or are 16 beds or less. A provision in the law prevents the federal government from paying for long-term psychiatric care in an institution, except under narrow circumstances (see Institutions for Mental Disease Exclusion). Between the inability to pay for care with Medicaid and the lack of availability of beds, many people who experience a serious mental health crisis end up in the hospital emergency department for long stays. The very busy and chaotic nature of the emergency department is not a good option for someone experiencing a crisis. Tremendous stress is placed on the patient, the hospital staff, and the law enforcement community (they must provide 1:1 supervision for safety purposes).

Another stress on the mental health system is what is referred to as geriatric psychiatry (geri-psych). Geriatric psychiatry, also known as geropsychiatry, psychogeriatrics or psychiatry of old age, is a subspeciality of psychiatry dealing with the study, prevention and treatment of mental disorders in humans with old age. That is an overly broad category as it encompasses older Vermonters who might clinically require nursing home level of care, but also those older Vermonters who don't meet that clinical level of need, but who still require psychiatric care.

Institutions for Mental Disease Exclusion

The Institutions for mental diseases (IMD) exclusion prohibits the use of federal Medicaid funding for care provided to patients aged 22-64 in mental health and substance use disorder residential treatment facilities larger than 16 beds.[2] The IMD exclusion has been part of the Medicaid program since Medicaid's enactment in 1965.

[1] http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5946
[2] 1905(a)(B) of the Social Security Act

What makes a facility an IMD?

As defined in 42 CFR 435.1010, "Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases."

The Centers for Medicare and Medicaid Services (CMS) guidelines used to evaluate if the overall character of a facility is that of an IMD are based on whether the facility:

1. Is licensed or accredited as a psychiatric facility;
2. Is under the jurisdiction of the State's mental health authority;
3. Specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs; or
4. Has more than 50 percent of all its patients admitted as a result of mental diseases.[3]

Therefore, CMS assesses the character of a facility and its designation as an IMD based on the facility's governance structure, staffing expertise, and patient population. The evaluation of patient population in particular is what makes an IMD easily distinguishable from a traditional hospital that may have more than 16 beds dedicated to mental diseases, but has an even greater number available for the treatment of physical conditions. For purposes of determining whether a facility is subject to the IMD exclusion, CMS defines the term "mental disease" to include diseases listed as mental disorders in the International Classification of Diseases (ICD), with the exception of developmental disabilities, senility, and organic brain syndrome. Because the ICD system classifies substance use disorders (SUD) as mental disorders, facilities primarily engaged in providing inpatient SUD treatment are considered IMDs under the law.

History of Paying for IMDs in Vermont

To date, Vermont has relied on 1115 waiver authority to reimburse for IMDs. Though the specific authority permitting Medicaid's payment for IMD services has evolved over two decades of waiver negotiation with CMS, the underlying rationale for allowing IMD payments under an 1115 demonstration has remained consistent: IMDs as a cost-effective alternative to general acute inpatient hospital services.

[3] CMS State Medicaid Manual 4390. Institutions for Mental Diseases.

In 1996, as part of its original 1115 Demonstration for the Vermont Health Access Plan (VHAP) Medicaid Expansion, Vermont received a waiver of the IMD exclusion that permitted Medicaid reimbursement of IMDs. Vermont, like several other states, used Disproportionate Share Hospital (DSH) funding as the payment mechanism to support the State Psychiatric Hospital.

In 1999, the 1115 Demonstration was amended to include the Community Rehabilitation and Treatment (CRT) program for adults who had a severe and persistent mental illness. This amendment changed the IMD reimbursement methodology from DSH to a capitated payment inclusive of funding for all inpatient psychiatric hospital services for the CRT program, including IMDs.

In 2004, Federal CMS policy changed to no longer permit IMD waivers under 1115 Demonstration authority; states with existing IMD waivers were given a schedule to phase out Medicaid reimbursement. Vermont's phase down schedule for IMD payments allowed for the continuation of Medicaid reimbursement for IMD services through 2004; reimbursement was limited to 50% of allowable expenditures in 2005; and IMD expenditure authority was completely phased out effective January 1, 2006.

When the former Vermont State Psychiatric Hospital lost its Medicare certification in 2005, CMS sought assurances that Medicaid funds would not be used to support it. Vermont removed funding for the State Hospital from the CRT capitation rates in 2005.

In 2005, Vermont received approval of the Global Commitment to Health Demonstration, which enabled Vermont to operate under a statewide, public managed care model. The Global Commitment Demonstration provided Vermont with additional flexibility regarding health care service financing, including the purchase of healthcare services not traditionally covered by Medicaid.

Since 2005, Vermont has used "in lieu of" authority under Global Commitment to reimburse for residential substance use disorder and inpatient psychiatric treatment at IMDs in lieu of more costly hospital-based care, provided that:

- Services are determined to be medically appropriate;
- Care is delivered by a licensed (and not Medicare de-certified) healthcare provider; and
- Coverage of the service achieves program objectives related to cost, quality, and/or access to care in the least restrictive, clinically appropriate setting possible.

In 2011, the former State Psychiatric Hospital was closed due to damage caused by Tropical Storm Irene. As part of the planning process for a replacement psychiatric hospital, Vermont sought clarification from CMS regarding its authority to access Medicaid funding to support a new facility categorized as an IMD. CMS indicated that IMD costs could not be included in annual Medicaid program costs, but that Vermont had authority under the Global Commitment Demonstration to fund IMD services using investment dollars. Since the Vermont Psychiatric

Care Hospital opened in 2015 as a 25 bed IMD, costs have been paid through Global Commitment investment dollars receiving federal match.

The 2017 extension of the Global Commitment Demonstration corresponded with new CMS regulations that tighten managed care rules around payment for IMDs. Vermont and CMS negotiated IMD expenditure authority using investment dollars that was time limited for the duration of the extension period (January 1, 2017-December 31, 2021). Vermont is the only state in the country that has expenditure authority, albeit time-limited, for IMDs specializing in mental health treatment, and is one of a growing number of state with expenditure authority for IMDs specializing in substance use disorders. The State plans to amend its Global Commitment Demonstration Waiver to receive IMD authority for substance use disorders beyond the current demonstration period, but is required to submit a phase-down plan to CMS in December 2018 for loss of federal financial participation for mental health services provided to individuals in IMDs starting in calendar year 2021 and concluding by the end of calendar year 2026.

Understanding Forensics

Mental illness is a major challenge for both national and state judicial systems. The Urban Institute estimated that in 2015, 56% of state prisoners, 45% of federal prisoners and 64% of jail inmates had a history of mental illness, according to the Urban Institute.[4] According to the bureau of Justice Statistics, 37% of prisoners and 44% of jail inmates had been told in the past by a mental health professional that they had a mental disorder.[5] Psychiatric care for those in various stages of the criminal justice system is commonly called forensic care.

Broadly speaking, there are four types of individuals in Vermont that we consider "forensic"[6]:

1. **Individuals who are awaiting a psychiatric evaluation as part of a trial**. These are individuals who have been accused of committing a crime and a concern has been raised about their ability to actively work with their attorney in their own defense and/or whether mental illness impacted their decision-making ability and ability to conform their behavior within the law at the time of the alleged crime. A court can issue an order for either an outpatient or inpatient competency/sanity evaluation. If an outpatient order is issued, the individual's location depends upon their conditions of release (i.e. can they make bail). If an inpatient order is issued, a psychiatrist will

[4] See "The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System: A Scan of Practice and Background Analysis." *The Urban Institute*. March 2015 http://webarchive.urban.org/UploadedPDF/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf

[5] https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf

[6] Please note that this report discusses different timelines to provide services to these various types of forensics. See page 27 for a discussion on the forensics the temporary facility could serve (inpatient level of care only) versus the long-term plan starting on page 3, which could potentially serve all types of forensics.

examine the individual to determine whether or not they meet criteria for a hospital level of care. If they do, they are admitted to an inpatient unit once a bed is open. If they do not meet criteria, their evaluation turns into an outpatient one and again their location depends upon their conditions of release.

2. **Individuals who have been found incompetent to stand trial**. As competency is a point in time evaluation, it can change. In many other states individuals accused of crimes who have been found incompetent are treated in forensic facilities so that they can regain competency. Vermont does not have a statutory mandate to do this. For more information, please see Section 5 of the Act 82 report which describes some best practices for a restoration of competency program and also discussion of a mandate to treat concept for Vermont.
3. **Individuals who were tried and found not guilty by reason of insanity**.
4. **Individuals serving a sentence in prison who develop the need for outpatient or inpatient psychiatric care on either a voluntary or involuntary basis**.

These different types of forensic individuals have a large impact on our designated mental health system. When an individual is ordered into a hospital for a competency/sanity evaluation, and meets criteria for hospitalization, they can often remain on that psychiatric hospital unit for several months. Forensic psychiatrists can disagree as to whether or not someone is competent and that results in a contested court hearing. If someone is found incompetent, but is refusing treatment, their stay is often quite prolonged as the state tries to use the current statutory criteria to provide that treatment. It is important to note that just because someone is incompetent to stand trial does not mean that the individual needs to be hospitalized – those are two very different assessments.

Under our current statutory system there is an inherent conflict between what the court perceives as its authority to order someone to remain hospitalized regardless of whether the hospital believes the person meets hospitalization criteria and what a hospital can legally do to retain its CMS certification and Joint Commission accreditation. Complying with these federal regulations and standards are the basis for being able to use federal funds to pay for these types of services and thus it is incredibly important that hospitals (including VPCH which is licensed, certified and accredited the same as any other hospital in this state) comply with these to bill Medicaid and Medicare. In addition, there are serious ethical and legal implications for hospitals (and the Department of Mental Health) should a criminal court order a hospital and DMH to hospitalize someone against their will in the highest level of mental health care available in this state when they do not meet that criteria. Moreover, if someone does not need to be in a bed but remains in the bed nonetheless, it means there is one less bed available for someone in an actual acute mental health crisis who really needs the bed but instead must wait, either in DOC or in an emergency department, until another becomes available.

Vermont must also consider the liability involved with the mixing of civilly committed individuals with forensic individuals. While mentally ill just like an individual civilly committed, some forensics also have an added criminogenic factor which could increase their risk of violence.

It is important to note that Act 78 of 2017is set to change current statute on July 1, 2019 to require DOC to provide inpatient treatment within 72 hours of being admitted to a correctional facility should an individual meet that level of care. Without an additional inpatient facility or access to this type of bed, the current system will be unable to meet this new requirement. Please see Appendix D for a summary of how some other states provide care to their forensic populations.

At any point in time there are “forensic” individuals in various places across the system: individuals awaiting inpatient or outpatient court ordered evaluations in the community, in DOC, in emergency departments, or on inpatient units; individuals in the community, in DOC, or on inpatient units found incompetent to stand trial; individuals found not guilty by reason of insanity still in need of either inpatient or outpatient treatment; and voluntary and involuntary inmates requiring outpatient or inpatient treatment. Forensics often have longer lengths of stay contributing to reduced flow within the inpatient system and can also contribute to higher acuity on units.

LONG TERM PLANNING – ENVISIONING 2028

AHS believes the best long-term solution is for the state to build a new facility with approximately 925 beds in the northwest area of Vermont. This would be about twice the capacity of the largest facility currently in the state. Two facilities (Chittenden Regional Correctional Facility and Northwest State Correctional Facility) would close (Windsor closed October 2017) and the out-of-state facility usage could also be reduced. There will always be some need for a small number of out-of-state beds, because corrections does not have a Maximum custody unit, although few inmates are in this category. The facilities selected for closure were identified based on their less than excellent Facility Condition Index (FCI) rating due to extensive deferred maintenance and on their needs for expansion. The northwest part of the state is desirable as it has more specialty care options.

A large-scale operation could help the state meet multiple objectives. There is the potential to create a forensics unit and a juvenile detention center (contingency plan if Woodside does not receive Medicaid funding, see pages 17-21 of this report) along with replacement beds for the closed correctional facilities. The state could double the capacity to house US Marshall beds and generate more revenue for the state. Operational costs would be reduced, and the new facility eliminates the need for significant maintenance costs, as well as returns inmates to Vermont from the out-of-state facility.

When the Department of Corrections Facility Study Report in Accordance with Act 160 was produced in January 2017, the Committee identified the following Pros and Cons for this option. It is not meant to be an exhaustive list:

PROS	CONS
• New facility with flexible space to meet the needs of a changing population (mental health, aging/one floor, potential for more infirmary and hospice beds) • The northwest part of the state has more specialty care options • Consolidation of operations (closing 3 facilities) • Out of state unit reduces to minimal number of offenders • Enough space to house US Marshal beds and generate revenue for the state • Possibly cost will be neutral or could create savings for the state • Modern facility set-up for security	• Siting could be difficult and local agreements could be costly to the state • Will still need some small out-of-state capacity (people doing life or maximum-security inmates) or people who need to be moved out of state • Impact to southern part of the state by locating more capacity in northern VT. • Longer transportation times for families and law enforcement • Economic loss to communities that lose a facility

and operations • Re-invest the deferred maintenance into other programs and projects • Opportunity to consider more vocational services to inmates • Consolidating high need medical people – eliminate redundant structures across the state • Economic gain to community that gains facility • Possible that all staff could shift to the new facility	

This option presents the State with the opportunity to reduce operations costs, while simultaneously constructing a new correctional facility and eliminating the significant maintenance costs at three current facilities, as well as return inmates to Vermont from the out-of-state facility.

As previously stated, the annual costs to operate the facilities that would be proposed for closing amounts to nearly $28.5 million. The scheduled and deferred maintenance costs of these facilities is currently projected to be $38.7 million over the next 20 years. Beyond these costs, there are also capital needs for these sites. This option targets the in-state facilities which have the highest per-capita costs, at an average of $75,000 per inmate annually. The reduction of the out-of-state contract will create General Fund savings which could be used to help finance the costs of this new facility (currently, the annual cost for the out-of-state contract is $7.6 million).

There are opportunities to increase state revenue and/or help fund this project. The United States Marshals Service has approached the Department and requested a minimum of an additional 60 federal detainer beds, for which they currently pay $130 per day. This equates to nearly $3 million in revenue that the state is not currently receiving due to a lack of available space.

The cost of this project is estimated between $141 million and $165 million.[7] This is based on the Department of Buildings and General Services (BGS) construction estimates of approximately $175,000 per correctional bed. There are a number of different financing

[7] **Cost estimates provided by BGS are preliminary in nature and are intended to provide a rough approximation only. If the Administration and Legislature approved the advancement of this project, BGS would conduct a feasibility study (or begin the design process) to determine the scope, project delivery schedule, and cost estimate.**

solutions. These include general obligation bonds, revenue bonds, lease-sublease/lease-purchase financing, and public/private combinations. There are various methods to combine several of the options listed above, but the most affordable model, and the one being used by most states and the federal government for projects of this scope, is a public private partnership (P3). There are entities, both local building firms and national private prison corporations, who have approached the State in recent years and expressed an interest in working toward this end. By utilizing a Real Estate Investment Trust (REIT), the project could be largely tax exempt, which incentivizes both competitive bidding from prospective vendors, as well as reduces the State's total costs for leasing the building. Under this concept, the lease payments from the State to the private vendor would be structured to qualify for tax-exempt treatment, thus giving the State the indirect benefit of tax exempt debt which would be reflected in lower rent payments than if conventional financing were obtained.

If a site can be identified that is on land currently owned by the State, this would significantly reduce the costs of this project. The land could then be leased to the private entity, who would be responsible for financing the design-build of the project and would then lease the building back to the State for a period of 25 years, for example. At that time, the term of the land lease would end. The State would continue to own the land, no longer subject to the land lease, and it would then also own the buildings.

While the tax-exempt lease would not be a direct debt obligation of the State, the State's involvement in the lease approach would require approval by the Governor and the General Assembly. Additionally, the State would be required to agree that it would annually appropriate the necessary rent payments and that it would not replace the facility financed by the debt. This would assure the lenders that there would be a continuing need for the facility and that annual appropriations would be made for this essential government service.

Finance costs of the new complex are borne by the build/finance firm. As a result, the facilities that are operational would not be at an added cost. Staff would be needed to operationalize the new complex. These staff would need to come from existing sites, so they would need to be moved to the new campus in very short succession to the new campus opening.

A project of this size will take considerable planning, and there will be some up-front costs. For instance, once a Request for Information (RFI) or a formal Request for Proposals (RFP) is issued by the State, there would likely be compensation costs (generally 8%) that are required by any vendor(s) working on the design services components of this project. These costs are typically refunded and included in the project costs if the project moves forward.

The objective would be to design a facility incorporating the latest concepts in correctional technology, labor saving building configurations and energy efficiency. New correctional technology and/or design will optimize security through open lines of sight, clear paths of travel, and flexibility in unit usage. The cost savings of operating a facility designed to these standards are expected to be substantial.

There is the potential for this building to be largely cost-neutral to the State. There is the additional revenue from the US Marshals, as well as savings from the current out-of-state facility. These two sources should equate to nearly $9 million, and do not factor the substantial aforementioned savings of staffing and operating a facility of this size. As an example, the largest current facility (Northern State) houses approximately 420 inmates and the per capita cost is near $50,000. With 220 inmates, Northwest State houses a little more than half of that population, though the per capita cost of this facility is over $70,000. If there is a 29% decrease in per capita cost between facilities with 220 and 420 inmates, it is likely that a facility housing 925 would achieve additional savings. A reduction in per capita costs of 15% would equate to an additional savings of nearly $2 million annually.

To move forward with a P3 option, private vendors, in consultation with the State, would retain an architectural firm with expertise in prison construction. This architect would work with the Department of Corrections to conceptually design a facility meeting the State's requirements. As an alternative, an initial step might be to retain a programming consultant to plan the State's facility needs and then the architect would take over. Either way, a conceptual design plan would result. Estimated construction and leasing costs would then be calculated.

This option closes two facilities (Chittenden Regional Correctional Facility, Northwest State Correctional Facility), in addition to the already closed Southeast State Correctional Facility). A review of other states that have closed a facility resulted in several ideas for future use, which are listed below. Each option would need further exploration as to its feasibility and associated costs to the state. This report assumes each closed facility would be mothballed by BGS as a first step.

- Sale of building/property
- Repurpose for other SOV use
- Reentry center for former prisoners
- Homeless Shelter
- Transitional work facility
- Transition to a hotel (Boston example)
- Rent to movie makers or other for-profit; Department of Tourism
- SESCF has tourism, historical, or recreational options
- Residential substance abuse treatment facilities

For more information, see Facility Study Report, In Accordance with Act 160, Sec. 30. Vermont State Correctional Facilities, January 19, 2017.

Individuals in Need of Treatment in a Secure Residential Setting

Background
During its 2004 session, the Vermont General Assembly set in motion a strategic planning process for the future of Vermont's public mental health system. The Future's Report was the

result in early 2005. A specific component of the envisioned continuum of care was a Secure Residential Facility and Program for individuals who no longer required hospitalization, but could not be immediately returned to a lower level of care in other community programs. Within a year and in accordance with state statues, a two-phase regulatory process of approval was initiated. The first approval hurdle, a Conceptual Certificate of Need (CCON) was submitted in 2006 and approved in the Spring of 2007 by regulators. This was followed by development of a concept brief, cost analysis, development planning, and stakeholder input in 2008 and 2009. A Certificate of Need (CON), the second regulatory requirement, was submitted in early 2010 and received regulatory approval in January 2011. This approval of construction of a 15-bed secure residential program in Waterbury also coincided with a gubernatorial administration change. The incoming administration paused further secure residential facility development and launched efforts to further examine the state's overall capacity and needs in the areas of inpatient and outpatient mental health services.

In the Fall of 2011, Tropical Storm Irene rendered the Vermont State Hospital (VSH) unusable for patient care and created the urgency necessary for a renewed legislative response. Act 79 resulted and a number of Emergency CON's (ECON) emerged to create temporary and permanent replacement capacity for individuals who had been served by the former VSH. One of the ECON's was the temporary Secure Residential facility in Middlesex that was approved in April 2012 and codified in Act 79. The temporary facility opened in Summer 2013 and in accordance with Act 178 (2014) developed a proposal for a permanent secure residential facility. The proposal in 2014 proposed the new facility to be a 14-bed facility. The Vermont General Assembly subsequently passed Act 26 (2015) requiring the Secretary of the Agency of Human Services (AHS) to further examine needs of multiple populations served by AHS. In late 2015, a Request for Information (RFI) followed assessment of populations who could be served by a secure residential program and responses to the RFI were received in early 2016, but did not culminate in a legislative appropriation to support further development.

Again, in late 2016 a gubernatorial change occurred. The General Assembly passed Act 82 (2017) requiring additional study on mental health system capacity and needs, as well as, cross-departmental collaboration on a number of legislatively required reports for shared populations served by AHS. These reports have been, or will be, submitted to Vermont legislators by January 2018.

Middlesex Therapeutic Community Residence (MTCR)
The seven-bed secure residential program, temporarily sited in Middlesex, was created from Act 79 in 2012. The intent of the legislature in creating MTCR was to create a step-down facility for those who were no longer in need of inpatient care, but continued to need intensive services involuntarily in a secure setting. In order to be placed at MTCR, an individual needs to be in the custody of the DMH Commissioner on an Order of Non-Hospitalization (ONH). While many individuals receive services in the community under an ONH, in order to be placed at MTCR the judge needs to specifically find that the clinically appropriate treatment for the patient's condition can only be provided safely in a secure residential recovery facility.

The MTCR was designed as a temporary facility, using Federal Emergency Management (FEMA) funds until a long-term residence could be completed/identified. The temporary facility is failing, and must be replaced or the state will have to reimburse FEMA. The state is at risk for a claw back of roughly $1.2 million and an inability to receive additional funds of up to $800,000 for the construction of the temporary facility and another $350,000-$450,000 for decommissioning the temporary facility in Middlesex. BGS and AHS will either be asking for a time waiver extension or to close out the existing Project Worksheet (PW) for construction of the facility and open another PW for decommissioning. We anticipate the extension to be for four years, until July 1, 2022.

The Department of Disabilities, Aging and Independent Living (DAIL) therapeutic community residential program licensing standards were modified to include a section dedicated to the secure "locked" program as outlined in Act 79 allowing it to be licensed. However, operating under these regulations does limit who MTCR can serve as the regulations do not allow for Emergency Involuntary Procedures (EIPs, or seclusion/restraint/emergency medication). There is a small, but important in terms of its impact, population of individuals who may stabilize to the point of no longer needing inpatient care but remain dysregulated enough that they may need occasional EIPs to assure their safety as well as the safety of others and staff. Because this is not a population that can be served currently at MTCR, it means that potentially there could be people on inpatient units that do not need to be there but because they cannot safety be maintained anywhere else, continue to occupy the beds. As discussed earlier under forensics, this could potentially cause both funding issues as well as reducing the flow within the system and causing an individual who really needs inpatient services to wait for an open bed while beds remain occupied by individuals who have nowhere else to go or whom the court does not believe can be safety maintained in an unsecure setting.

Even with these limitations, the population served by the program and the benefits to the individuals who have been served at MTCR remains in short supply and in demand. Additionally, since its opening in 2013, the secure residential program has achieved an impressive turnover rate of residents and in time frames much shorter than originally projected. However, it must be noted that the lower acuity of individuals who were admitted is a likely contributing factor for these shorter lengths of stay.

While it is always preferable for people to voluntarily receive treatment in the community, there will always exist a small number of individuals who are unable to do so and thus there is and will remain a need for a step-down level of care from inpatient hospitalization for individuals who continue to require a secure setting. DMH has outlined the continuing need for this type of facility and additional beds in previous reports to the legislation. When considering how to best replace MTCR, there are some key elements to consider:

1. Financing – MTCR currently relies upon FFP for its funding. The size, age, and treatment needs of potential future residents will determine if State General Fund (GF) will be required to finance the program.

2. Size – should the new facility be able to utilize FFP, the number of residential beds could not exceed 16 due to the Institution for Mental Disease (IMD) restriction.
3. Licensing – as explained above, currently MTCR is licensed by DAIL as a Therapeutic Community Residence. This prevents the ability of MTCR to use EIPs, and as such limits the individuals who can be served in the facility.
4. Staffing – Any expansion of program bed capacity would require the addition of staff to provide treatment services.
5. Projected Costs – Any expansion of program bed capacity would likely carry new cost. The size and eligibility for financing would dictate FFP availability and the magnitude of state share in the cost of the program.

Currently MTCR costs about $2.3 million a year to run.

Children in Need of Residential Treatment/Juvenile Delinquents in Need of Residential Detention

Woodside Juvenile Rehabilitation Center
Woodside is a 30-bed residential treatment facility serving youth ages 10 to 18 in the custody of the Commissioner of the Department for Children and Families (DCF) with a delinquency charge or adjudication. Youth receiving treatment at Woodside cannot be safely treated in less restrictive settings. Woodside is operated by DCF's Family Services Division. Youth placed at Woodside are in the custody of the Commissioner of DCF as a result of alleged delinquent behavior. Most youth receiving treatment at Woodside have exhibited aggressive and assaultive behaviors. The majority of youth in the program have traumatic abuse histories resulting in intensive clinical needs.

Consistent with the renovation feasibility study of Woodside submitted to the Vermont General Assembly in 2016, AHS and BGS recommend replacing the Woodside facility.[8] Replacement of the facility would allow the program to serve youth in a more appropriate therapeutic setting consistent with the programming and would also support Woodside's efforts to restore Medicaid funding for the program, which was lost in the fall of 2016. Replacement of the facility would also allow Woodside to serve more youth than it currently does and serve some youth in-state that are currently being served in out-of-state facilities.

The feasibility report concluded that the Woodside facility was woefully inadequate to meet the needs of its therapeutic programming. The feasibility study highlights the fact that Woodside was originally constructed as a juvenile correctional facility. Since its repurposing, however, the report notes that Woodside's mission is to heal youth, not in a jail, but in a secure, therapeutic environment that supports a return to society. The feasibility study also points out that the Woodside therapeutic model is better for youth, their families and society and is more cost effective than detention.

[8] http://bgs.vermont.gov/sites/bgs/files/files_WS_12.22.16_FeasibilityReport.pdf

In its review of the existing building, the report concludes that the main Woodside building was not suitable to reuse for a therapeutic treatment program, but that the gym could be integrated into a new structure. The report notes the following highlighted reasons:

- Woodside is situated in a 500-year floodplain. Because Woodside is designated as a "critical facility", it cannot be built in 100 or 500-year floodplains. The main building is 1.5 feet below flood elevation and given its structure type, there is no way to raise the floor. The flood plain issue alone is believed to be a primary reason to abandon the building.
- Any renovations would be major involving the replacement of most of the systems and could not be done with the program remaining on site. The cost of finding, permitting, and retrofitting a secure, temporary facility are extremely high.
- Renovating the existing building would be so extensive that the costs approach new construction.

Due to these findings, the recommendation is to build a new structure on the current property which would incorporate the use of the gym while the Woodside program continues to operate in the main structure. After construction, the main building would be demolished and converted into a recreation yard and parking lot. Below are the estimated construction costs to build a 25-bed and a 30-bed facility.

Program name	**Square Footage**	**Average $/SF**	**Average Sub-Total**	**High Sub-Total (x1.15)**
25 BED - CONSTRUCTION (HARD) COSTS				
Housing	10,096	$ 300	$ 3,028,800	
Intake and Medical	2,426	$ 300	$ 727,800	
Staff Support	1,827	$ 300	$ 548,100	
Building Support	1,416	$ 300	$ 424, 800	
Dining	2,016	$ 300	$ 604, 800	
Public Entry and Meeting Rooms	2,028	$ 250	$ 507, 000	
Visitation	569	$ 275	$ 156, 475	
Administration	1,947	$250	$ 486,750	
Counseling	1,657	$ 300	$ 497,100	
Education and Programming	3,526	$ 300	$ 1,057,800	
Core and Primary Circulation	6,070	$ 250	$ 1,517,500	
Existing Gym	5,952	$ 90	$ 535,680	

Sub- Total	39,530		$ 10,092,605	$ 11,606,496
Site Work (Civil and Building)- Phase 1 & 2	18% of bldg. Sub-total		$ 1,816,669	$2,089,169
Phase 2- Demolition and Disposal	18,500	$ 11	$ 203,500	$ 234,025
25 BED- TOTAL CONSTRUCTION BUDGET			**$12, 112,774**	**$13, 929,690**
		Avg $/SF	$ 306	$ 352
30 BED – CONSTRUCTION (HARD) COSTS				
Housing	12,235	$ 300	$ 3,670,500	
Intake and Medical	2,426	$ 300	$ 727,800	
Staff Support	1,827	$ 300	$ 548,100	
Building Support	1,416	$ 300	$ 424,800	
Dining	2,016	$ 300	$ 604,800	
Public Entry and Meeting Rooms	2,028	$ 250	$ 507,000	
Visitation	569	$ 275	$ 156,475	
Administration	1,947	$250	$ 486,750	
Counseling	2,558	$ 300	$ 767,400	
Education and Programming	4,771	$ 300	$ 1,431,300	
Core and Primary Circulation	8,562	$ 250	$ 2,140,500	
Existing Gym	5,952	$ 90	$ 535,680	
Sub- Total	**46,307**		$ 12,001,105	$ 13,801,271
Site Work (Civil and Building)- Phase 1 & 2	18% of bldg. Sub-total		$ 2,160,199	$ 2,484,229
Phase 2- Demolition and Disposal	18,500	$ 11	$ 203,500	$ 234,025
30 BED- TOTAL			**$ 14,364,804**	**$ 16,519,524**

CONSTRUCTION BUDGET				
		Avg $/SF	$ 310	$ 357

	# of admissions to Woodside by age and year							
	Age							
Year	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**
2015	0	2	7	11	18	23	40	42
2016	1	0	2	15	7	31	28	37
2017	1	1	3	7	6	28	28	15

	total # of admissions	% male vs. female
2015	143	80/20
2016	120	77/23
2017	89	80/20

Please note that there are some youth at the program with more than one admission. The numbers above represent the total number of admissions, not the total number of youth. Currently, the majority of youth at Woodside are placed there for short-term treatment, although long-term treatment is also an option.

In this report, it is important to reference the companion report on the State's use of out-of-state and in-state residential placements recently prepared by the Turn the Curve Advisory Committee and submitted to the Vermont General Assembly on November 9, 2017.[9] The Turn the Curve Advisory Committee was formed in 2015 to review the State's use of residential placements for treating children. Vermont has an obligation to support children in the least restrictive setting available. The Turn the Curve committee reinforced the State's commitment to create more community-based treatment options.

Consistent with this commitment, the number of youth placed at Woodside since 2015, as well as in other residential treatment programs in and out-of-state, has decreased. Because Woodside is the State's most secure setting, the fact that placements in the Woodside program have decreased is a positive outcome of the Turn the Curve work. Replacement of the

[9] https://legislature.vermont.gov/assets/Legislative-Reports/Combined-Act-85-E.317-Use-of-Residential-Care-Facilities-Report-11.13.17.pdf

Woodside facility would enhance the therapeutic programming and also create opportunities to serve more youth in-state in varying degrees of facility security, which does not exist now with the current building structure. The number of youth in DCF custody as a delinquent has been decreasing slightly over the last few years, with just less than 200 youth in 2012 to around 150 in state fiscal year 2016. Currently, the number of these youth served in out-of-state residential facilities is approximately 15 to 20 youth at any given time.

Staffing	Month/year	Dangerous Incidents	Physical Restraints	Seclusion	Mechanical Restraints
37 FTE	May 2015	152	17	110	4
September 2015 9 staff added (3 to the front desk and overnights, 6 direct care)					
46 FTE	May 2016	61	11	13	0
August 2016 3 Clinical staff added					
49 FTE	May 2017	18	1	0	0

Woodside recently faced federal funding challenges. Woodside's current annual budget is approximately $6.4 million. During the most recent negotiation of the State's Medicaid Global Commitment Waiver, the federal Centers for Medicare and Medicaid Services (CMS) determined that Woodside was ineligible for Medicaid funding due to the determination at that time that youth served in the program met the definition of "inmates of a public institution" and were, therefore, ineligible for Medicaid. The loss of Medicaid funding was effective October 1, 2016.

Representatives of DCF and the Agency of Human Services (AHS) reached out to CMS following this determination and participated in multiple conversations to explore possibilities to regain federal Medicaid financial participation to support the therapeutic programming at Woodside. In December 2017, following an in-person meeting in Baltimore with CMS representatives, a path forward was identified. AHS will add psychiatric residential treatment facility (PRTF) as an option under Vermont's Medicaid State Plan for providing in-patient psychiatric treatment services for individuals under 21 years of age benefit (the psych under 21 benefit). DCF will also apply to CMS for certification for Woodside as a PRTF.

In order to implement changes required by CMS for PRTF certification, legislative changes will be necessary to allow youth currently in the program who turn 18 years old to remain in the program if they choose and this level of treatment continues to be medically indicated. Under current state law, Woodside cannot serve youth beyond their 18th birthday. DCF will also need to adopt state regulations consistent with federal PRTF requirements.

Although there is much work to do to become certified as a PRTF, Woodside has been working towards that goal for some time and has many PRTF certification requirements already in place, including accreditation from the Commission on Accreditation of Rehabilitation Facilities. It is anticipated that Woodside will achieve PRTF certification in SFY19. A key component to serving

existing and anticipated future populations in a therapeutic PRTF is a new facility for Woodside's programming.

A new facility would also allow the State to increase its use of Woodside with flexible programming, including lower security spaces, which would allow Woodside to serve some youth who are currently being served out-of-state. If Medicaid financing is not secured, an alternative would be to build an entirely separate unit at the location being discussed for the 925-bed facility in northwest Vermont.

Other at Risk Populations
The Lund Home provides residential services for women with a substance use disorder and/or mental health diagnosis who are pregnant or parenting a child under six years old. Lund's residential treatment program is licensed for 26 beds. The Lund Home is the only residential program in the State where women can receive treatment while living with their young children together in the program. The average length of stay for women in the program is six months. The Lund Home has been identified by CMS as an IMD. The Lund Home is privately owned and operated by a non-profit organization, but is funded primarily through state funds. DCF contracts and pays for the 26 licensed beds in the program. More than 75 percent of the women referred to the Lund Home have an open case with the Family Services Division of DCF. DCF's Reach Up program is the primary DCF funding source for the program. In state fiscal year 2016, 46 women were served by the Lund Home. In state fiscal year 2017, Lund served 57 women. In state fiscal year 2017, a little more than 30 percent of the women in the program also had a connection with the Department of Corrections.

Elders with Significant Psychiatric Needs

There are a number of options, in various stages of development, to potentially address the needs of older individuals with Psychiatric and complex needs in Vermont.

Individuals with Psychiatric and Complex Needs at Nursing Home Level of Care - Pilot for People with Complex Needs:
DAIL, DMH and the Division of Rate Setting (DRS) have been working for over a year with the Centers for Living and Rehabilitation (CLR) in Bennington to develop a complex needs unit for individuals who meet nursing home level of care but who are unable to step down from higher levels of care (inpatient psychiatric beds, emergency rooms, hospitals) due to complex needs. Often, these complex needs represent a combination of psychiatric, behavioral and medical needs and nursing homes in Vermont are reluctant to admit individuals due to the risk of CMS regulatory citations, the threat of disruption to residents who have chosen to make the facility their home, the risk of physical harm to other residents and/or staff, physical settings that are not conducive to supporting someone with behavioral issues or psychiatric concerns, and an inability to appropriately staff at a level which would enable them to address and de-escalate potentially threatening situations. The lack of psychiatrists and behavioral consultation to

support care plans in nursing facilities is also a significant barrier and presents an obstacle to quality of care.

Based on those risk factors, we have found that the private, nursing home industry has been unable to assist in ensuring that Vermonters move from higher levels of care into more appropriate settings. CLR stepped forward and volunteered to work with DAIL and DMH to convert an existing, separate 10-12 bed unit into a model to address the very needs articulated above. The unit will require an enhanced rate to address the required staffing needs and clinical considerations.

To-date, we have identified an existing rate option within our current regulations (Methods, Standards, and Principles for Establishing Medicaid Payment Rates for Long-Term Care Facilities, section 14.2) that is designed to facilitate the movement of nursing home eligible individuals from Level 1 beds or VPCH. We worked to finalize that rate option within the regulations; the option existed but criteria and the amounts had never been set. The resulting rate gives us a broad range of incentive payments that can be added to the existing rate for any facility to ensure that adequate staffing and supports will be in place. This rate needs to be certified quarterly by DAIL and DMH and is individual in nature which means it could fluctuate.

Our intent is to use this rate structure as a starting place to get the CLR option off the ground. In the long term we need to develop a more strategic and targeted rate structure to support this unit. It will require legislation and we may need to create a unique structure outside of current regulations to ensure that the safeguards currently built into our rates (occupancy levels, caps) don't create any disincentives and destabilize this unit and the whole of CLR.

Having established a starting point for the rate, we are working through operational details with CLR now. Those details include but are not limited to:

- Eligibility
- State-wide access
- Level of staffing
- Criteria for admittance and denial of admittance
- Relationship with the Designated Agency for behavioral supports and consultation
- Federal policy authority
- And many other details.

Our current best estimate of the annual costs for this unit are based on a $300/per day incentive, on top of the normal CLR rate of $269/day. Using a $600/day rate for 10 beds and assuming 100% occupancy, we have estimated the cost at $2.2 million annually. Assuming we can identify funding, our intent is to have this option on line in SFY 19.

Choices for Care Adult Family Care

One model that has already shown success is the Adult Family Care (AFC) Home service option under the Choices for Care (CFC) Program. AFC is a 24-hour home and community-based service option that provides participants with person-centered supports in a home environment that is safe, family oriented and designed to support autonomy and maximize independence and dignity. With AFC, the CFC participant is matched with a home provider who provides care and support to no more than two unrelated people in the provider's home. Providers are paid based on a tiered system that takes into consideration the needs of the individual. Because this model is so individualized, we have already seen a number of matches made in AFC for people with complex needs who were previously "stuck" in Level I psychiatric beds, emergency rooms and/or hospitals.

Individuals with Psychiatric and Complex Needs in Residential Care Homes

These older Vermonters present challenges in relation to housing and supports and services in the community. Although they fall into a global geriatric psychiatry bucket, they do not qualify for the level of care offered by a nursing facility/home. DAIL has identified a facility that currently operates as a licensed Level III Residential Care Home and is also enrolled as a Choices for Care Enhance Residential Care (ERC) facility. This means that the facility has the licensing to support individuals who are not nursing home level of care and who only receive community Medicaid (Assistive Community Care Services - ACCS) and to also support individuals who do meet nursing home level of care and are eligible to be served through both ACCS and CFC ERC. Nursing Home level of care, including ERC, is typically granted based on needed assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

Within ERC, there are different payment tiers that take into consideration the level of needs of individuals. We may be able to modify that further to include the complexity added to individual supports when a psychiatric issue is in play. One obstacle to serving people who are not nursing home level of care and who rely exclusively on ACCS is that the reimbursement rate for ACCS is very low and has not changed in several years. As such, it is inadequate to meet the needs of people with complex needs. Consideration could be given to increasing the ACCS rate and/or creating some sort of tier rate for ACCS similar to what is done with CFC ERC. DAIL plans to meet with the targeted facility to discuss the creation of several beds across their three facilities which would specifically target older individuals at this level of care and to determine what type of rate structure would be necessary to support those beds.

Individuals with Psychiatric and Complex Needs in Community

Older Vermonters with psychiatric issues also require access to outpatient care. This outpatient care should be targeted specifically at the unique needs and issues facing older Vermonters, to include the issue of medication management and mismanagement – a direct correlation to the issue of opioid use and addiction in older Vermonters. Currently we have eight Elder Care Clinicians at six of the designated agencies through an agreement with our Area Agencies on Aging (AAA) network. Most of these positions are not full time and five counties are without Elder Care coverage due to difficulties in recruiting licensed clinical social workers.

Statewide, the clinicians provide clinical treatment to approximately 400 homebound older Vermonters with a range of diagnoses from depression and anxiety to adjustment disorder and dementia. Many of these individuals manifest co-occurring physical and behavioral conditions. With treatment, clients report decreased symptoms and increased quality of life outcomes – leading to healthier individuals, fewer hospitalizations and decreased health care costs. The AAAs report that this treatment is often the critical component in keeping participants from institutional placement.

Elder Care Clinicians are currently funded with $235,423. While an increase in this investment could increase capacity across the state, changes in federal policy to enable Medicare billing for psychiatric and substance abuse care for older Vermonters would also help expand access.

PLANNING FOR TODAY

FORENSIC PSYCHIATRY – OPTION A

This proposal would create a temporary 12-bed forensic unit in an already existing correctional facility. While this facility would reflect hospital level of care, it is important to note that not all of the forensic populations described earlier in this report would be served in this facility. Specifically, this temporary unit would not be able to accommodate anyone needing a lesser level of care than hospitalization (i.e. residential or outpatient).

In order to transform a correctional facility unit into a forensic unit, renovations would be required. Depending on the unit, BGS estimates that capital construction costs would be roughly $3 million. DMH estimates that the ongoing operations costs for the 12-bed facility would be approximately $6.5 million. This cost model assumes that Medicaid cannot be billed for services and provides for the correctional security staff to support the operation.

Population

As this would be a hospital level of care, it is important to note that not all of the forensic populations described earlier in this report would be served in this facility. Specifically, this temporary unit would not be able to accommodate anyone needing a lesser level of care than hospitalization (i.e. residential or outpatient).

Other Considerations:

- Would the new facility be licensed? Title 18 allows the Commissioner of Mental Health to designate facilities for placement (which would allow those under DMH custody to be placed in the unit), but DAIL and/or VDH licensing requirements and other relevant regulations must also be considered depending on how the new facility is to be operated.
- The assumption is that Medicaid and Medicare funding will not be available for this population.
- An expedited Certificate of Needs (CON) would need to be applied for and approved. This could take between six months and a year to complete.

REPLACING MIDDLESEX THERAPEUTIC COMMUNITY RESIDENCE – Option B

AHS is exploring the potential to purchase property that could replace the temporary Middlesex facility and at the same time, expand its bed capacity.

EXPLORE PRIVATE OWNERSHIP OF VPCH – Option C

Unless something changes, AHS will need to find an alternative way to fund the Vermont Psychiatric Care Hospital when IMD expenditure authority ends in 2026. One option is to consider UVMMC assuming ownership of VPCH. If the facility becomes part of a hospital system, the facility becomes Medicaid eligible.

BUILD A 16 BED STATE HOSPITAL – Option D
If the multipurpose 925 bed facility is not built (which would have included 50 psychiatric beds of both hospital (20) and non-hospital (30) level beds, the mental health system will continue to be strained and additional beds will be needed. Construction of a 16-bed state facility would take pressure off the system and 16 beds meets the requirement for the IMD exclusion.

CONTRACT WITH NURSING HOMES FOR GERIATRIC PSYCHIATRY BEDS – Option E
Department for Disabilities, Aging and Independent Living is working to develop both capacity and an enhanced rate of reimbursement in nursing homes to meet the needs of older individuals with psychiatric needs. The hope is to have this option available for SFY '19.

INCREASE CAPACITY OF PSYCHIATRIC BEDS AT PARTICIPATING HOSPITALS – Option F
Explore possibilities to increase capacity of inpatient psychiatric beds with all Designated Hospitals in order to expand access to both general psychiatric beds as well as Level 1 beds. With the addition of temporary forensic beds in a correctional facility, the pressure would be reduced on the VPCH. If capacity could be increased at a designated hospital such as UVMMC, the problem of patients with long wait times in Emergency departments could be greatly improved.

RELATED REPORTS

- Act 85 Sec. 31. – The use of out-of-state and in-state residential placements including Woodside (November 2017).
- Act 78, Sec. 7. – How best to provide mental health treatment to inmates and detainees housed in a correctional facility. (January 18, 2018).
- Act 78, Sec. 9. – DOC, in consultation with DMH will develop a plan to create or establish access to a forensic mental health center (January 18, 2018).
- Act 85. E.300.15 – Recommendations on defining, treating and providing the appropriate venue for people with traumatic brain injury (September 15, 2018).
- appropriations for activities to reuse the Southeast State Correctional Facility located in Windsor, Vermont
- Act 85 Sec. E.335.1 Southeast State Correctional Facility -develop a plan for secure transitional housing for inmates preparing to reenter the community.
- Act 82 – Section 4 (6), (7) and (8) address the need for forensic, geri-psych and inpatient needs.

APPENDIX A

Agency of Human Services - Mental Health Facility Inventory															
Facility Name	**Facility Type or Capability (Secure Residential, Residential, Hospital, Nursing Home)**	**Area of Specialty or Services Provided**	**Population/ Eligibility Group**	**Facility Ownership Model (Owned, Leased, For Placement)**	**Facility Location (Physical Address)**	**Funding Sources (State General Funds, State Special Funds, Federal, Federal Medicaid, Grant)**	**Annual Operating Budget (FY17 actuals)**	**Facility Condition Assessment (excellent, moderate or poor)**	**Cost per bed**	**Facility Recommendation**	**Current census**	**Capacity**	**Facility Value (Estimated cost of replacement)**	**Deferred Maintenance**	**Staffing for Operations**
Vermont Psychiatric Care Hospital (VPCH)	Hospital	Mental Health	Adult Involuntary	State of Vermont Owned	350 Fisher Rd Berlin, VT	Federal Medicaid - Investment	$21,781,327	Excellent	$ 871,253		25	25 beds	24,000,000		177
Middlesex Therapeutic Community Residence (MTCR)	Intensive Residential/Secure	Mental Health	SPM/CRT eligible/court ordered	State of Vermont Owned-Temporary	1076 US Rt 2 Middlesex, VT	Federal Medicaid - Program	$2,351,781	Moderate/poor - facility is failing and was only designed to be temporary	$ 335,969	Relocate	7	7 beds			31
Woodside Juvenile Rehabilitation Center	Residential	Mental Health	Ages 10-17	State of Vermont Owned	26 Woodside Drive East Colchester, VT	General fund but moving to Federal Medicaid - Program	$5,794,394	Moderate	$ 193,146	Replace as recommended by the feasibility study	15	30 beds	$20,000,000	$3,000,000	50
Brattleboro Retreat - Level 1 Beds	Residential	Mental Health	Adults	Brattleboro Retreat	Brattleboro, VT	Federal Medicaid	$6,285,072		$ 448,934		14	14 Beds			

Key:
= Critical risk

APPENDIX B

Agency of Human Services - Correctional Facility Inventory													
Facility Name	**Population/ Eligibility Group**	**Facility Ownership Model (Owned, Leased)**	**Facility Location (Physical Address)**	**Funding Sources (State General Funds, State Special Funds, Federal, Federal Medicaid, Grant)**	**Annual Operating Budget (FY17 actuals)**	**Annual Operating Budget (FY19 estimated)**	**Year Built**	**Cost per bed**	**Facility Recommendation**	**Capacity**	**Facility Value (Estimated cost of replacement)**	**Deferred Maintenance**	**Staffing for Operations**
CRCF Chittenden Regional	Women's facility	State of Vermont - Owned	7 Farrell St. - S. Burlington	General fund	$ 8,395,312	$ 9,080,369	Buit 1973	$73,652	CLOSE	127 beds	$19,359,450	$7,973,426	100
MVRCF - Marble Valley Regional	General population	State of Vermont - Owned	167 State St. - Rutland	General fund	$ 6,463,720	$ 6,991,160	Built 1979	$70,580		130 beds	$15,486,600	$784,920	61
NERCF Complex - North East Regional	General population	State of Vermont - Owned	1270 US Rt 5 - St. Johnsbury	General fund	$ 9,755,583	$ 10,551,639	Built 1981	$73,398		215 beds	$15,829,050	$680,808	96
NSCF - Northern State	Risk reduction programming, Vocation, General population	State of Vermont - Owned	2559 Glen Rd. - Newport	General fund	$ 12,726,568	$ 13,765,056	Built 1994	$53,717		420 beds	$50,973,000	$4,661,559	124
NWSCF - North West State	Sex offender programming, Federal/State detentioners	State of Vermont - Owned	3649 Lower Newton Rd. - St. Albans	General fund	$ 11,403,372	$ 12,333,887	Built 1969	$70,614	CLOSE	247 beds	$32,768,850	$12,520,921	115
SESCF - South East State	Work camp/Re-entry planning for persons needing housing	State of Vermont - Owned	546 State Farm Rd. - Windsor	CLOSED			Built 1935			100 beds	$22,060,800		0
SSCF - Southern State	Aging, infirm, mental health, close custody population	State of Vermont - Owned	700 Charlestown Rd. - Springfield	General fund	$ 14,242,297	$ 15,404,468	Built 2003	$66,145		374 beds	$76,956,550	$975,639	136

Key:
= At Risk

Note: The operating costs listed above only include the base facility operating costs. This is only a part of the costs that are used to derive the cost per bed, but not inclusive of programming, medical, and other costs.

APPENDIX C: Summary - DOC Correctional Facility Cost Projections through FY2038, Status Quo versus New Campus

Old/Status Quo	Total Costs (FY18-FY22)	Total Costs (FY23-FY27)	Total Costs (FY28-FY37)	Total Costs over next 20 years
CRCF	68,809,355	87,356,831	229,316,413	385,482,600
NWSCF	98,068,962	124,200,779	318,970,722	541,240,462
OOS	48,593,479	62,018,961	180,176,009	290,788,448
MVRCF	55,031,822	67,022,945	180,930,573	302,985,341
NECC	81,474,610	98,687,778	267,840,760	448,003,147
NSCF	130,702,801	159,805,777	418,657,239	709,165,817
SSCF	121,650,977	148,545,485	407,007,295	677,203,758
Total	604,332,007	747,638,556	2,002,899,011	3,354,869,574

New	Total Costs (FY18-FY22)	Total Costs (FY23-FY27)	Total Costs (FY28-FY37)	Total Costs over next 20 years
New Campus - 880 Corrections Beds	-	148,341,790	671,357,222	819,699,012
CRCF	68,809,355	32,902,017	-	101,711,372
NWSCF	98,068,962	-	-	98,068,962
OOS	48,593,479	48,376,278	-	96,969,757
MVRCF	55,031,822	67,022,945	180,930,573	302,985,341
NECC	81,474,610	98,687,778	267,840,760	448,003,147
NSCF	130,702,801	159,805,777	418,657,239	709,165,817
SSCF	121,650,977	148,545,485	407,007,295	677,203,758
Total	604,332,007	703,682,069	1,945,793,090	3,253,807,166

Operating Costs	FY28	FY33	FY37	Total Costs over next 20 years
New Campus - 880 Corrections Beds	48,359,730	63,638,105	74,447,582	1,041,110,572
CRCF (Status Quo)	18,028,005	21,933,824	25,659,472	362,669,420
NWSCF (Status Quo)	25,111,234	30,551,656	35,741,116	505,162,774
OOS (Status Quo)	14,324,817	18,282,500	22,222,493	290,788,448
Total (Status Quo)	57,464,056	70,767,980	83,623,081	1,158,620,643
New Campus Operating Savings	9,104,326	7,129,875	9,175,499	117,510,070

Note - 20-year New Campus cost includes CRCF, NWSCF, and OOS costs through the completion of this project.

Assumptions:
Phased build approach - would reduce other department costs over several years. New Campus would need staff, so NWSCF could be closed first and federal beds could also be added to the new ste. This would be followed with the closure of CRCF, then reduction of OOS beds.
4% annual inflator, which factors staff cost of living adjustments, operational cost increases, and other inflationary items.
OOS population has an Average Daily Population of 261 beds over this time period.
OOS per diem cost inflation set at 5% annually (this is subject to demand, so may be much higher).
Design and total size of facility impact staffing ratio - New campus assumes total inmates to staff at 3.37:1.
Staffing need at New Campus estimated at 261. Building design will impact this and much more analysis will be necessary, which may dramatically change the total staffing need (any number at or above 215 staff would mean that no department jobs would be eliminated).
3.37:1 ratio is based on increased capacity for vocation, and all specialty populations housed within (includes forensics).
Additional federal bed revenue will be approximately $2.9 million annually and will be used to offset facility lease costs.
Approximately 651 inmates would be moved from CRCF, MVRCF, and OOS to the New Campus, and an additional 60 more federal detainees. The remaining 160+ correctional beds would be filled by consolidating specialized units statewide to create efficiencies. There would likely be significant savings at the remaining facilities (health services staff would be concentrated in one place to address the aging/infirm, inmates in the infirmary, and a correctional forensic population housed there as well).

New Campus Cost Estimates - BGS and Public Private Partnership (P3) Comparison

Preliminary Facility Cost Estimates		
Please note that no estimates have yet been quoted		
	Build Cost - per bed	925 Bed Facility
BGS estimate *	$ 175,000	$ 161,875,000
P3 pricing	$ 150,000	$ 138,750,000
year	Kansas DOC (2400 beds)	VT - estimated
1	$ 14,900,000	$ 5,744,692
2	$ 15,189,060	$ 5,856,139
3	$ 15,483,728	$ 5,969,748
4	$ 15,784,112	$ 6,085,561
5	$ 16,090,324	$ 6,203,621
6	$ 16,402,476	$ 6,323,971
7	$ 16,720,684	$ 6,446,656
8	$ 17,045,065	$ 6,571,721
9	$ 17,375,740	$ 6,699,213
10	$ 17,712,829	$ 6,829,177
11	$ 18,056,458	$ 6,961,663
12	$ 18,406,753	$ 7,096,720
13	$ 18,763,844	$ 7,234,396
14	$ 19,127,863	$ 7,374,743
15	$ 19,498,943	$ 7,517,813
16	$ 19,877,223	$ 7,663,659
17	$ 20,262,841	$ 7,812,334
18	$ 20,655,940	$ 7,963,893
19	$ 21,056,665	$ 8,118,393
20	$ 21,465,165	$ 8,275,889
Total	$ 359,875,714	$ 138,750,000
Kansas DOC cost per bed		$ 149,948.21
VT Facility size relative to size of Kansas DOC project		38.55%
* Cost estimates provided by BGS are preliminary in nature and are intended to provide a rough approximation only. If the Administration and Legislature approved the advancement of this project, BGS would conduct a feasibility study (or begin the design process) to determine the scope, project delivery schedule, and cost estimate.		

APPENDIX D

The following is a summary of how different states manage their forensic populations. AHS was unable to gather information on all states currently. There is also more information that would be helpful, especially in those states that have both DMH and DOC run facilities, as far as how it is determined which facility a person would be admitted to.

Maine is looking to open a new forensic "step-down" facility for those who are stuck in their hospitals as not criminally responsible or incompetent to stand trial but no longer require hospital level of care. They are exploring this in order for the state to regain federal certification and funding.

New Hampshire has a Secure Psychiatric Unit (SPU)at the state prison in Concord. They have come under fire from advocates and the Department of Justice because they also admit civilly committed persons who are "too violent" for their psychiatric hospitals and have no criminal justice involvement. The advocates also feel that the SPU is not a hospital level of care which is what these individuals require. The unit is designed to house those who are found not guilty by reason of insanity or not competent to stand trial, as well as those serving time.

Alaska houses forensic patients who have been found not competent or not guilty by reason of insanity in a separate wing of their only state hospital. Alaska also has an acute psychiatric unit (hospital level of care) for inmates with acute psychiatric needs.

Arkansas has a similar system as Alaska with evaluation patients going to the state hospital forensic unit, while inmates with acute psychiatric needs are treated within their DOC.

Delaware uses its only state hospital with a separate forensic unit to house evaluation patients and those found not competent, etc. This unit also works closely with the mental health court, drug court diversion, Veterans court, and trauma informed Probation. Delaware's DOC houses inmates in need of mental health services in segregated, restricted housing units.

Idaho mixes civilly committed people with some forensic people (evaluation status) at their state hospital, without a separate unit. Idaho's DOC also runs a 12-bed psychiatric unit for inmates who require acute psychiatric care.

Montana state law specifically forbids their DOC from operating a mental health facility.

New Mexico has a 72-bed forensic unit in their only State Hospital and it houses those who are facing felony charges and have been deemed incompetent. The NM DOC runs the Mental Health Treatment Center, a 104-bed facility that serves inmates in the correctional system. This includes the Acute Care Unit (which provides hospital level of care) the Treatment Restrict Unit, and the Chronic Care Unit.

North Dakota has a psychiatric hospital that shares the grounds with a correctional facility. 65 of the 140 beds are designated for forensics. North Dakota also runs a 24-bed inmate forensic unit for inmates with serious mental illness.

Rhode Island does not mix civil and forensic patients. RI's Department of Behavioral Health runs the only forensic facility.

South Dakota has both a DOC run forensic unit as well as a DMH run state hospital that was originally meant for only civilly committed patients.

Utah uses a combination of both DMH and DOC run facilities. The DMH run facilities are for those deemed incompetent and undergoing restoration, those deemed not guilty by reason of insanity, and transfers from prisons who require mental health stabilization. The DOC run forensic facilities serves as a temporary stabilization facility for up to 168 inmates who pose a danger to themselves or others due to their mental illness.

West Virginia, in a similar fashion to New Mexico and Utah, has both DMH as well as DOC run facilities.

Forensic patients enter the system because of their involvement with the criminal justice system. Civil commitments are also admitted to psychiatric facilities as a result of a court order, but this procedure transpires in civil court and is based on a demonstrated developmental disability, mental illness, or substance abuse. Voluntary admissions are not court ordered. These determinations influence treatment and have implications for various populations and whether non-forensic patients can be housed with forensic patients.

At any given point in time, there are approximately 15-20 individuals with court involvement including: court ordered evaluations, individuals found incompetent to stand trial and voluntary and involuntary inmates requiring inpatient treatment. These individuals can contribute to acuity on the units, show up in emergency departments from court when beds are not available, and have long lengths of stays which contribute to reduced flow in the inpatient system.

The 30% decrease in the number of inpatient beds nationally has placed an increased strain on general hospitals and their emergency rooms, many of which are not equipped to handle psychiatric crises.