

**VERMONT STATE HOSPITAL FUTURES PROJECT  
VERMONT DEPARTMENT OF MENTAL HEALTH**

**Certificate of Need Implementation Report for Docket #06-013-H**

**Project Overview**

**Function of the Vermont State Hospital (VSH)**

VSH provides a statewide service for Vermonters who are severely mentally ill, virtually all of whom are there under conditions of involuntary commitment. The population served by VSH are the most acute admissions of the entire system, the most refractory in terms of achieving treatment progress, and, as a consequence, have comparatively longer lengths of stay when compared to patients served by Vermont's other psychiatric units. Currently only VSH administers non-emergency involuntary medication.

The Vermont State Hospital, (VSH), is licensed for 54 beds. During 2006 and 2007 the average daily census hovered around 50 – 52 patients. Following the opening of Second Spring in Williamstown in 2007, the average daily census has fallen. On March 25, the average census for the past 45 days was 44. The current operating budget is \$22M General Fund dollars. Over the past several years the Agency of Human Services has invested new resources to improve the existing program. Among these are upgraded capacity in Information Technology, contracted services in quality improvement and training and education, 60 new clinical & management positions and the development of a Treatment Mall in 2 locations providing over 20 hours per week of active treatment (skills development, groups, and individual treatment plans focused on recovery). These augmented resources followed in part as the consequence of an agreement with the Department of Justice to improve services at Vermont State Hospital

**Findings of March 2008 Department of Justice Site Evaluation**

At the March 2008 Department of Justice site visit, exit interview feedback indicated that the hospital was on target and had made substantial progress in most areas (physician clinical documentation, professional assessments, emergency involuntary procedures notification system, and education and training). The treatment planning process was described as “heading in the right direction” with more work needing to occur.

Although the hospital has made significant gains toward improved quality of care in compliance with the Department of Justice standards, the mission of VSH is not supported by the physical space of the building. There is virtually unanimous agreement that the physical facility should be closed. Determining the number and kind of services that should constitute the successor facilities is the object of this Certificate of Need planning process.

## **The Futures Plan is Designed to Transform the System of Care**

The Futures Plan calls for the continued transformation of the service system towards a consumer-directed, trauma-informed, and recovery-oriented system of mental health care. The core of the plan is proposed new investments in the essential community capacities, along with reconfiguration of the existing 54-bed inpatient capacity at the Vermont State Hospital into a new array of inpatient, rehabilitation, and residential facilities for adults. In FY 08 \$7.5M was proposed by the Administration and appropriated by the Legislature for an array of community services. These included: community residential recovery services, recovery housing support, peer services, inpatient diversion beds (crisis beds), alternative transportation services, and care management system development.

The fundamental goal is to support recovery for Vermonters with mental illnesses in the least restrictive and most integrated settings. To this end the Department of Mental Health was granted a Conceptual Certificate of Need in April 2007 to proceed with a comprehensive planning effort to define the successor facilities of the Vermont State Hospital.

### **Framework of the Futures Strategic Plan**

The following core recommendations follow from the Futures Strategic Plan that emerged from the planning process conducted during 2007.

1. In order to reduce reliance on involuntary inpatient services, Vermont should create new community residential, rehabilitative, and support services targeted to people with severe mental illness. All Vermonters at risk of psychiatric hospitalization potentially benefit from these services.
2. The long term care and rehabilitative functions currently performed at VSH could be better accomplished in non-hospital settings. For instance in smaller, residential rehabilitative programs. This could improve rehabilitative outcomes in a cost effective manner.
3. The remaining acute inpatient services at VSH should be integrated with existing acute care psychiatric inpatient programs operated by general medical centers. This requires new types of inpatient programming at general hospitals and therefore requires appropriate infrastructural supports for the psychiatric inpatient program(s).

### **Work Plan Progress**

**Benchmark Objective 1: Assess inpatient configurations based on feasibility analysis of multiple options—for both integrated and stand-alone facilities (CCON Conditions 13,15,17,18)** See related Benchmark Objective 5.

**Benchmark Objective Tasks: 1.1 –1.5**

The initial iteration of the four analytic Tasks 1.1 – 1.4 of this Objective were essentially completed at the time of the last Implementation Report (October 2007). DMH staff are now in the final stages of editing the Draft Inpatient Options Analysis. The completed report will be incorporated as an Appendix with the Certification of Need Application to proceed with the preferred configuration of options for VSH successor facilities.

As described in the October 2007 Implementation Report, the preferred configuration emerging from the Draft Inpatient Options Analysis was that of Model 5 –consisting of new construction of a 15 bed secure residential facility in Waterbury, and pending further analysis and agreements with potential partner hospitals, an expansion at RRMC, and possibly an expansion at FAHC. The underlying assumptions of this configuration assumed that lower inpatient bed capacity would be feasible with the development of additional community residential resources at successively staged levels of program intensity (Work Plan Objectives 10.1 – 10.6).

Policy implementation of the findings of the Draft Inpatient Options Analysis was understood to be dependent upon agreement between the Administration, the Legislature, and FAHC and RRMC, the potential partner hospitals. The November 2007 Report of the Legislative Consultants concurred with the draft findings of the Draft Inpatient Options Analysis (See Objective 2.6).

During the 2008 Legislative Session it was proposed that the women’s correctional facility be removed from the Dale Building on the Waterbury Campus, thereby creating the possibility that Dale could be renovated to become the location of the 15 bed secure residential treatment facility. Accordingly, a second iteration of planning involving the Model 5 configuration is currently in process. BGS has directed its consultants, Architecture+, to develop construction estimates for renovation of Dale. The current plan is to assess the relative merit of renovation of Dale vis-à-vis the renovation of Brooks Building or construction of a new 15 bed facility on the Waterbury Campus as the initial stage of the phased CON application.

This second iteration of planning to assess the feasibility of the Model 5 configuration includes exploration of the feasibility of enhanced inpatient psychiatric capacity with RRMC and FAHC. Issues requiring clarification to reach a framework for agreement include (in part) development of guiding principles, governance, overall program requirements, capital financing, operations financing ownership and dispute resolution.

NOTE: Given the possibility that the Dale Building may become a site option for the 15 bed secure residential facility, and that this decision awaits Legislative action, the CON application will likely occur during the fall of 2008.

**Benchmark Objective 2: Select Model & Site for CON Application (from 5 Models – 21 Sites)****Benchmark Objective Tasks 2.1 - 2.12.***2.1 Review findings of Inpatient Options Analysis Report.*

This task for the Secretary of AHS to review the findings of the Draft Inpatient Options Analysis Report has been completed. Additional review of the results of the second iteration of the planning process will occur as products are developed.

*2.2 Assess bed need for inpatient and residential services*

This task is in process.

With the opening of the Second Spring Community residential program in Williamstown the average daily census of VSH declined markedly. On March 25, the average census for the past 45 days was 44. This decline suggests that increased community residential resources would further lower the VSH census. The Futures Project envisions four levels of care needed to replace the current functions of the Vermont State Hospital; acute inpatient, secure recovery residential, staff intensive residential and recovery residential.

In an effort to better assess the number and kind of beds required in each category, DMH undertook, a retrospective survey during the winter of 2008 of VSH bed utilization for each level of patient functioning. The survey covered the three fiscal years of 2005, 2006 and 2007. Initial findings suggest that fewer than 50 inpatient acute care beds are needed provided there is in place an array of residential beds of differential intensity. The results of this study will be incorporated into the CON application as part of the supporting data for the preferred configuration model.

*2.3 Develop report of how other states' facilities & programs (including systems in place or planned) serve populations similar to those served by VSH (CCON Condition 16)*

This task has been completed.

Through in-depth interviews of commissioners and directors of state mental health authorities across all regions of the United States, the Vermont Department of Mental Health researched and analyzed issues associated with reconfiguration of state hospitals. The 21 states interviewed were identified by the National Association of State Mental Health Program Directors as states engaged in closing, building, reconfiguring or consolidating their state hospitals. Questions concerned the role of state hospitals in the system of care, the role of general hospitals, the interrelationship of the hospitals with community services, architectural trends and building plans, financial considerations, and mental health services for special populations.

Despite differences in size, economy, culture, and political tradition among the states surveyed, major trends emerged. States are closing state hospitals that are expensive to operate and unsuitable for the clinical mission. Fewer state hospital beds are used for acute psychiatric care as states develop financial arrangements with general hospitals to assume the acute inpatient psychiatric treatment role. States focus increasingly on long-term care using state hospitals or residential facilities that are not licensed as hospitals. A broader array of services is provided at the community level. Building plans incorporate the latest architectural standards for inpatient psychiatric facilities to create environments that will promote recovery. Overall, the number of state hospital beds is shrinking as virtually every new state hospital development project involves fewer new inpatient beds and greater investments in community resources.

The report of other states' experience will be incorporated as an appendix to the Certificate of Need Application.

*2.4 Assess revenue potential, long-range cost to state, capital construction & financing options, fiscal sustainability of mental health system as a whole (CCON Conditions 15 & 17)*

This task is in process. Initial assessments made as part of the work of the first iteration of the Draft Inpatient Options Analysis (Summary Report Submitted to the Mental Health Oversight Committee, November 2007) will require revision pending cost analysis of the latest options for configuration Model 5. In line with these assessments, and in the context of available resources, the Administration's FY09 proposed budget includes level funding for the care management system, community crisis bed/ step-down programming and an additional 6 – 10 beds for staff secure community residential intensive programming. Essentially level funding was proposed for Second Spring, Peer Respite Residential Support programming, transportation and housing.

*2.5 Obtain feedback from Transformation Council & other stakeholders on model / site trade-offs (CCON Condition 19). See Objective 3 below.*

The tasks of this objective have been met and are on-going.

The Transformation Council meets monthly, usually with 20 – 30 individuals in attendance. Since its inception the Council has provided policy input on the various planning processes and products of the Futures Project. See Objective 3 below for a more detailed description of agenda items. A list of Transformation Council Members is attached to this report.

The Consultation Group is an advisory body to the Futures Project staff. It is composed of consumers and family members and meets every 6 weeks. The group was established in December 2007 to provide direct consumer and family member feedback to the project planning staff on current work products. The content of the December and January meetings involved discussion of the needs of patients who would use the proposed 15 bed secure residential facility and the programming and spatial requirements that would be

required to support individual recovery. The draft concept proposal was subsequently revised to strengthen such needs as separating individuals who have experienced abuse from contact with other individuals who exhibit aggressive behavior. All discussions with the Consultation Group have touched on the theme of patient experience and what is required both programmatically and architecturally to reduce stigma and support recovery.

Recently the group has reviewed and discussed: (1) the pros and cons of new construction versus renovation for the proposed 15-bed Secure Recovery Residence, (2) reviewed the two proposals for a new community recovery residential program, and (3) commented on the preliminary design for new construction for an expanded inpatient psychiatric program at Rutland Regional Medical Center. The Consultation Group has also reviewed the preliminary floor plan for the Dale renovation, and two proposals to create a second 6 – 10 bed community secure residential program --- one that would involve renovation of Kirby House in Waterbury and a second that would require renovation of a farmhouse at the Brattleboro Retreat.

### *2.6 Integrate recommendations of Legislative Consultants*

This task has been completed.

Obtaining agreement among key stakeholders and Legislators is central to advancing planning for these successor programs. The initial findings of the Draft Inpatient Options Analysis were conveyed to the Administration and to the Legislative Consultants during the summer and fall 2008. The findings of the Consultants' November Report were consistent with the policy position of the Administration:

- The Consultant's Report concurred with the importance of strengthening the community system
- Agreed that there is need to close VSH
- Concurred with the effectiveness of creating new programs such as Second Spring in Williamstown
- Concurred with the policy of transferring delivery of acute, inpatient care to Vermont's general hospitals
- Agreed with the DMH recommendation to shorten the timeframes required for involuntary medication
- Agreed with the proposal that the State create and operate a secure residential treatment facility
- Were consistent with the proposal that the project be phased to spread capital commitments over time, and to ensure that the State does not overbuild inpatient resources at the expense of the community system of care.

There has been considerable support in the Legislature for proceeding with phased implementation of the Futures Project, beginning with the 15 bed secure residential component.

### *2.7 Review findings of other states' experience in serving populations similar to VSH*

*patients (CCON Condition s 15 & 16, Scope of Implementation Item 19)*

Note: This task is same as 2.3 above. Recommend this be dropped from the Work Plan.

*2.8 Review Futures Work Group recommendations & findings from Legislative Summer Corrections Study Group. Review findings of work group on the inpatient mental health treatment needs of the DOC inmate population. (CCON Condition 14)*

This task has been completed. Results of the work group on Department of Corrections inpatient bed needs will be incorporated into planning for the Certificate of Need Application.

*2.9 Review findings, reports with Transformation Council & other stakeholders; obtain feedback, and consult with Legislature. (See Objective 3 below)*

This task is on-going. See Tasks 2.5 and 2.6 above and Objective 3 below.

*2.10 Select configuration & sites for detailed analysis for CON Application.*

This task is in process.

BGS and DMH and their respective consultants are currently developing construction cost and financing estimates for the various proposed options for the 15 bed secure residential facility in Waterbury (including the Dale Building). Conversations are underway with RRMC and FAHC to determine feasibility of inpatient unit expansion at these hospitals. Should these efforts prove unfruitful, the State will develop alternative plans.

*2.11 Obtain BISHCA guidance re: sequencing of CON application.*

This task is on-going.

*2.12 Develop and submit CON Application*

At the writing of this report it is assumed that DMH will seek a Certificate of Need for the 15 bed secure residential facility in Waterbury. Depending on the outcome of conversations with RRMC the application may include augmented bed capacity and programming there for VSH level patients.

**Benchmark Objective 3: Assure mental health consumer & stakeholder participation (CCON Condition 19)**

Activities under this Objective are on-going.

### *3.1 Establish Transformation Council*

This task has been completed.

Beginning in September 2007 the Commissioner of Mental Health has conducted regular monthly meetings with the Transformation Council to review, discuss, and provide input on the various policy initiatives of the Futures Project. The composition of the Council includes advocates, providers, and clients and family members. Attendance generally numbers between 20 – 30 individuals. (See Membership List appended to this Report.) The following agenda items were discussed during meetings held over the fall and winter:

Peer Support Work Group Recommendations – development and progression of peer services in the system of care (The Council recommended DMH fund the proposal.)  
Provisions of Act 114 Involuntary Medication Law VSH Governing Body Staff Intensive Recovery Residential Program

- building the next levels of community residential recovery programming
- new construction vs renovation options for the 15 bed secure residential facility including renovation of Dale Building

Discussion of how to transition reluctant patients to community residential services  
Updates on legislation before the House and Senate for improved services for individuals having mental health and substance abuse to prevent incarceration, support transition back to the community

Involuntary medication - experience of the patient –role in treatment

Department of Justice Monitoring

Budgetary process – allocations for the Futures Project

Creating new acute inpatient capacity at Rutland Regional Medical Center

Development of a review process involving consumers & family members for proposals for the care management system

### *3.2 Post planning documents & meeting minutes on DMH website*

<http://healthvermont.gov/mh/update/mhupdate.aspx>

This task is on-going. See website.

### *3.3 Maintain active outreach to communities impacted by planning for, development of inpatient & community facility sites; convene work groups as needed for input to program planning processes.*

This task is on-going. Meetings have been held during the fall and winter in Rutland. RRMC has hosted two community forums and created an ongoing community advisory committee that meets regularly. It is anticipated that additional meetings will take place there and in Burlington as the next iteration of planning proceeds to select the final sites for VSH successor facilities.

*3.4 Provide updates to and solicit feedback from State Mental Health Adult Program Standing Co.*

This task is on-going.

This 6 member group meets monthly and receives regular updates on the Futures Project.

*3.5 Copy Interested Parties as required by BISHCA CON process*

This task is on-going.

Note: Other activities to enhance mental health consumer and stakeholder participation include the bi-weekly distribution of the Mental Health Update to a 400 member e-mail group. Meeting minutes and planning documents are regularly posted on the Department's website: <http://healthvermont.gov/mh/update/mhupdate.aspx>

**Benchmark Objective 4: Develop program design for new levels of care for VSH patients & DOC inmates needing acute inpatient care (with outside review). (CCON Scope #2,6,7,26, CCON Condition 14)**

*Benchmark tasks 4.1 – 4.4 (Work Group review reports, identify inpatient needs, update & refine descriptions of populations served)*

Tasks have been completed.

The Futures project is based on the premise that Department of Corrections inmates should have access to psychiatric hospitalization on par with that available to the general population; further, that the same standards of treatment should apply.

A Department of Mental Health work group met over the summer and fall of 2007 to review the issues of mental health services for Corrections clients and specifically the inpatient psychiatric bed needs of the DOC population. A clinical sub-group of the Work Group clarified VSH admissions criteria and applied it retrospectively for one year to DOC admissions to VSH. The Work Group found that twenty-four referrals were identified. The average length of stay was between 1 to 2 months. Assessment based on this data indicated 2-4 inpatient beds would be required to meet DOC inpatient needs. The report will be included as an appendix to the Certificate of Need Application and the findings incorporated in the Futures planning process.

*Benchmark Tasks 4.5 – 4.8*

Note: The time lines for achievement of these tasks will advance in conformity with revisions of the CON application date.

*4.5 Develop program goals & treatment methods sufficient to establish cost and operational parameters for CON Application.*

This task is in process and will be complete at time of CON Application

*4.6 Develop staffing model & plan sufficient to establish cost and operational parameters for CON Application (CCON Scope # 20, Condition 18)*

This task is in process and will be complete at time of CON Application

*4.7 Obtain outside review of program model for appropriateness for populations to be served, conformity with accreditation standards, cost effectiveness of service. (CCON Scope #7)*

This task will be addressed once particular sites (and host institutions) are identified.

*4.8 Refine architectural program of space requirements as needed (CCON Scope # 9, 10)*

This task is in process and will be complete at time of CON Application

*4.9 Review programming plans with Transformation Council, Adult Program Standing Committee, other stakeholders, Legislature, BISHCA.*

This task is on-going.

**Benchmark Objective 5: Develop architectural, site & construction plans for most feasible option(s) demonstrating conformity with relevant CON criteria. (CCON Conditions 15,17)**

*Benchmark Tasks 5.1 – 5.3 (Complete Architectural Program of Space, Identify Alternative Sites, Analyze Alternative Sites)*

(See Work Plan.) These tasks are addressed in the Draft Inpatient Options Analysis and will be incorporated as an appendix in the Certificate of Need Application. The remaining task activities under this Objective (5.4 – 5.10 for pre-CON planning; 5.11 through 5.16 for post CON activities) await agreement upon and selection of the final sites for the Certificate of Need Application. See Objectives 1 and 2 above.

**Benchmark Objective 6: Identify and plan to mitigate human services impacts of potential selected sites (CCON Specifications 14,29,32)**

*Tasks 6.1 – 6.4, 6.6, 6.7 (Identify VSH discharge patterns, consult local community, assess human service impacts of program, hold public meetings, consult with Transformation Council, other interested parties, develop & implement strategies to address impacts, etc. )*

These tasks await identification and final selection of inpatient sites of the preferred configuration. DMH will hold public meetings as indicated and develop and implement strategies to address impacts once it becomes clear where inpatient facilities will be located.

**Benchmark Objective 7: Develop long-range financing plan that reflects balance between inpatient services & community system of care. (CCON Scope #8,12,27; CCON Condition 15,17)**

*Benchmark Tasks 7.1 – 7.4* are completed for the initial Draft Inpatient Options Analysis sites. The second iteration of the planning process to develop capital cost estimates for additional sites under the Model 5 configuration is in process.

*Benchmark Tasks 7.5 – 7.8 (obtain consultation from BISHCA, develop draft operating financing plan, draft capital construction plan, develop 5 year financing plan, etc.)* are in process. Will be completed at time of Certificate of Need Application.

*Benchmark Task 7.9 (review with Stakeholders)* is on-going.

*Benchmark Task 7.10 (review draft financing plan at completion of design & documents preparation process, etc.)* awaits selection of final sites and completion of schematic design, design development and permitting planning documents.

The September 2007 Pacific Health Policy Group Final Report, *Follow-up Study on the Financial Sustainability of the Vermont Designated Agency Provider System for Mental Health, Developmental Disability and Substance Abuse Services*, found that caseload demand is increasing as is the intensity of service need. This is resulting in a rate of growth of demand that is outpacing the rate of growth in General Fund receipts. AHS and the Department are currently in the process of developing a strategic plan to ensure fiscal sustainability of the system as a whole. These contextual factors underline the clear risk of overbuilding expensive acute care beds and lend support to phased implementation of VSH successor programs.

The context of fiscal strategic planning has informed the discussions that have taken place between DMH, AHS, and JFO staff. It will be important to phase Futures implementation and do specific projects first. Each project – due to differing sites, licensing entity, revenue potential and capital development costs--- will require its own financing package. The advantage of this incremental approach is that it will permit the Department to reassess the relative bed need for inpatient and residential capacity. As the new community resources are developed, the Department will continue to monitor impact on the VSH census. Stabilization of the trend line (and further evaluation of bed needs in terms of specific requirements of various patient groups) will enhance long range financial planning to promote balance between inpatient and community services.

**Benchmark Objective 8: Develop partner agreements for planning, construction & facility operations (CCON Condition 17,18)**

Note: The timelines for the various tasks under this benchmark will be adjusted to conform with revised planning timelines for the CON application once the final configuration sites are identified.

*Benchmark Task 8.1 Obtain clarification from BISHCA re: CON standards for partner agreement.*

Task is on-going. Content currently informs discussion with potential hospital partners.

*Benchmark Tasks 8.2 – 8.5 (Potential partner agreements)*

Initial exploratory activities are underway by DMH legal staff to define the legal parameters of agreements between the Department and potential partners. Once the outcome of these discussions suggests that agreement has been reached, the Department will again seek guidance from BISHCA over the requirements for the CON Application.

*Benchmark Task 8.6 (Development of agreements for staffing, workforce development, etc.)*

This task will be addressed once the framework agreement between DMH and its potential partners has been achieved.

*Benchmark Task 8.7 (Consult Transformation Council, Adult Mental Health Program Standing Committee, Legislators, BISHCA)*

This task is on-going.

**Benchmark Objective 9: Develop workforce recruitment & retention plans to adequately & appropriately support new inpatient programs. (CCON Condition 18)**

Work on this Objective and tasks related to inpatient psychiatric services will begin once DMH completes agreements with potential partners. Work on these tasks as they relate to staffing the 15 bed secure residential, staff secure and community residential programs is in process. Time lines will be revised as specific sites are identified.

*Benchmark Task 9, 7 (Obtain input from VSEA, other players and stakeholders, etc.)* will be initiated around work-force development once program planning parameters are defined.

**Benchmark Objective 10.1 – 10.6: Develop community capacities (CCON Scope #15,16,17,18,24,25,29)**

*Benchmark Objective 10.1 Increase community residential recovery, and secure and non-secure levels of rehabilitation beds (23 beds):*

In process.

**Community residential recovery:** The Second Spring Program that opened in Williamstown in May 2007 has maintained an average census of 10 residents during the winter and is building to full capacity of 11 beds. The Department is currently working to develop additional community residential capacity. Two proposals are currently being evaluated to develop 6 – 10 staff secure community residential recovery beds.

One joint proposal by HCRS and Brattleboro Retreat offers a 6-10 bed renovation of a farmhouse on the campus of Brattleboro Retreat to provide staff secure recovery beds. In addition the package would include 4-6 acute inpatient beds designed to provide immediate emergency care for individuals of the residential program who may temporarily require a higher level of safety and could not otherwise be served by the Retreat.

The second proposal involves a project offered by Collaborative Solutions (Developer of Second Spring) for total renovation of Kirby House in Waterbury, a community care home currently serving 30 CRT clients. A unit of the renovated Kirby House would house the staff secure community residential program. In addition to the beds available at Kirby House, the latter proposal would seek to achieve efficiencies of scale through jointly shared administrative and clinical staff with Second Spring. An additional 2 staff-secure-beds at each site would also be available at Second Spring and at Chrysalis House in Waterbury. This would bring the total bed potential of this proposal to 10 staff-secure, 11 licensed Level III, and 26 existing community residential (renovated) beds at Kirby House.

The initial public review of these proposals was held on April 7. It is anticipated that the staff secure facility would be operational during the spring or summer of 2009. In combination with the state-run 15 bed secure residential facility planned for the Waterbury Campus of the State Office Complex, this would increase the number of community residential beds to 21 or 25.

*Benchmark Objective 10.2 Increase crisis stabilization beds (10 beds): program start-up for 4 beds (NEKHS - NCSS) plus 6 additional beds*

Program implementation is underway for 4 crisis beds --- 2 each with Northwest Counseling & Support Services and North East Kingdom Human Services. Plans for five or six additional crisis beds --- 3 in Burlington and 2 or 3 in Rutland--- are in development.

The Department has \$550,000 of FY 07 dollars available to develop up to six crisis beds. With the additional 4 crisis beds developed earlier in the year the total statewide crisis bed capacity by the end of 2008 will be 27.

As both the residential and the crisis beds come on-line, the Department will monitor their impact on VSH admissions and inpatient census.

Updating the Transformation Council and other stakeholder groups is on-going.

*Benchmark Objective 10.3 Develop Peer Services program plan*

In process.

The Peer Services Work Group issued its report over the winter to the Department and presented its recommendations to the Transformation Council. The group proposed an alternative peer services respite facility. The Transformation Council endorsed the recommendations and DMH has allocated \$230,000 for the project in its initial year. Currently a search is being conducted for a project director. It is expected that this position will be filled in June and that initial program and facilities plans will be drafted by Fall with initial program implementation during the late fall 2008.

*Benchmark Objective 10.4 Design Care Management System (CCON Scope #28)*

In process.

The Department issued an RFP during February 2008 for a contractor to assist with the design and development of a care management system to coordinate utilization and quality assurance and quality improvement for mental health services for VSH level clients across the continuum of care. The system would incorporate general hospital inpatient units, crisis stabilization / inpatient diversion beds, secure residential recovery, community residential recovery and other community residential programs serving mental health consumers.

Five proposals were reviewed on April 11. It is expected that the Commissioner of Mental Health will begin contract discussions with the successful bidder in the near future.

*Benchmark Objective 10.5 Increase housing resources (CCON Scope #17, 29)*

As reported in September planning tasks A,B,C have been completed (See Work Plan)

With input from the VSH Futures Housing Development work group, final recommendations of the VSH Futures Advisory Committee, and interested stakeholder participation, the Department of Mental Health completed distribution of the FY 08 recovery housing funds. One half of the total allocation of \$460,500.00 was distributed equally among the ten Designated Agencies. The remaining one half was distributed using Designated Agency hospital utilization rates for FY07. The current planned distribution considered existing housing resources available to mental health consumers, existing capacity and demand of programs, and ways to improve availability of housing for consumers. A summary of the contributors to the feedback process and recommended uses for funding is available at the Department of Mental Health website.

Task element “E” –Assess impact of additional housing on inpatient bed need & design is in process.

Task elements “F” --- identify need, create development fund plan --- is being coordinated by the AHS Housing Task Force (the state’s policy group charged with developing permanent supportive housing for people with disabilities). Through this process DMH allocated \$130,000 (of a total project cost of \$760,000) for rehabilitation of Hill House, a Transitional Housing Project in Addison County that serves chronically homeless individuals with histories of hospitalizations for mental illness and substance abuse. Hill House is scheduled to open in October 2008 with increased bed and staff capacity.

Updating of the Transformation Council, State Adult Mental Health Standing Committee and other stakeholders is ongoing.

*Benchmark Objective 10.6 Develop alternative transportation system*

Tasks A and B have been achieved. The alternative involuntary transportation pilot operated by HowardCenter and Washington County Mental Health began in September 2007. The pilot is in process.

**Material or Non-material Changes**

There are no material changes in this CON process. All activities described above that have been undertaken since the granting of the April Conceptual Certificate of Need are authorized under the scope of the approved planning activities.

**Attachments**

1. Architectural Planning Appropriations, Encumbrances and Expenditures – April 8, 2008
2. Membership List – Transformation Council
3. Invitee List – Consultation Group

VSH FUTURES PROJECT  
NEW INPATIENT FACILITIES TO REPLACE VSH  
APPROPRIATIONS, ENCUMBRANCES, AND EXPENDITURES  
APRIL 8, 2008

## Appropriations:

Act 43 of 2005 Legislative Session:	\$ 625,000	
Act 147 of 2006 Legislative Session:	\$1,000,000	
TOTAL APPROPRIATIONS:		\$1,625,000

## Encumbrances:

Architecture Plus:	\$355,000	
Fletcher Allen Health Care:	\$ 45,000	
Legislative Consultants:	\$100,000	
TOTAL ENCUMBRANCES:		\$500,000

BALANCE REMAINING:  
\$1,125,000

## Expenditures:

Architecture Plus:	\$298,874.60	
Fletcher Allen Health Care:	\$ 0.00	
Legislative Consultants:	\$ 52,873.81	
TOTAL EXPENDITURES:		\$351,748.41

BALANCE OF ENCUMBRANCES:

\$148,251.59

**Participants– Consultation Group\***

1. Larry Lewack
2. Linda Corey
3. Anne Donahue
4. Ken Liebertoff
5. Ed Paquin
6. Marie Luhr
7. Kitty Gallagher
8. David Gallagher
9. Jean New
10. Harvey Peck
11. Leah Matteson
12. Ann Moore
13. Roberta Downey
14. Marty Roberts
15. Morgan Brown
16. Xenia Williams
17. Steve Morgan
18. Joanna Cole
19. Ruth Grant

\* The individuals on this list were invited to participate. The meeting, however, is open to any and all consumers and family members who wish to participate. Note: The designation “participant” indicates individuals who expressed interest in the meetings and did attend meetings on one or more occasions, either in person or by teleconference call. “Participant” is a term the Department uses; an individual who wishes to be designated in some other manner should inform the staff of his or her preference.

Mental Health Transformation Council  
Membership

Corey, Linda

Dupre, Paul

Gallagher, David

Gallagher, Kitty

Graves, Stuart

Hartman, Michael

Lewack, Larry

Libertoff, Ken

Matteson, Leah

McMains, Bill MD

New, Jean

Olson, Jill

Paquin, Ed

Parrish, Sally

Peck, Harvey

Roberts, Marty

Rothenberg, Jeff

Rowe, Terry

Simpatico, Tom

Smith, Ron

Tanzman Beth

Waller, Marlys

Wargo, Lorraine

Staff:

Gregorek, Sarah

Rosenstreich, Judy