COMMONWEALTH of VIRGINIA

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November 25, 2014

The Honorable Walter A. Stosch, Co-Chair
The Honorable Charles Colgan, Co-Chair
Senate Finance Committee
10th Floor, General Assembly Building
910 Capitol Street
Richmond, VA 23219

Dear Senator Stosch and Senator Colgan:

Pursuant Item 315.W. of the 2014 *Appropriation Act*, please find enclosed the *Report on Funding for Child Psychiatry and Children's Crisis Response Services.*

Staff at the department are available should you wish to discuss this report.

Sincerely,

Debra Ferguson, Ph.D.

Enc.

Cc: William A. Hazel, Jr., M.D.
Kathleen Drumwright
Joe Flores
Susan E. Massart
Daniel Herr
Donald Darr

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The Honorable S. Chris Jones, Chair
House Appropriations Committee
General Assembly Building
P.O. Box 406
Richmond, VA 23218

Dear Delegate Jones:

Pursuant Item 315.W. of the 2014 *Appropriation Act*, please find enclosed the *Report on Funding for Child Psychiatry and Children's Crisis Response Services.*

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DBHDS

Virginia Department of
Behavioral Health and
Developmental Services

Report on Funding for Child Psychiatry and Children's Crisis Response Services (Item 315.W., 2014 *Appropriation Act*)

to the Chairs of the
House Appropriations and Senate Finance Committees
of the General Assembly

October 01, 2014

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Child Psychiatry Services and Children's Crisis Response In Virginia

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Executive Summary

This report was developed in accordance with Item 315.W. of the 2013 *Appropriation Act* which addresses the management of the general fund appropriation for child psychiatry and children's crisis response services for children with mental health and behavioral disorders. Specifically, the language states:

> W. Out of this appropriation, $1,500,000 the first year and $3,650,000 the second year from the general fund shall be used to provide child psychiatry and children's crisis response services for children with mental health and behavioral disorders. These funds, divided among the health planning regions based on the current availability of the services, shall be used to hire or contract with child psychiatrists who can provide direct clinical services, including crisis response services, as well as training and consultation with other children's health care providers in the health planning region such as general practitioners, pediatricians, nurse practitioners, and community service boards staff, to increase their expertise in the prevention, diagnosis, and treatment of children with mental health disorders. Funds may also be used to create new or enhance existing community-based crisis response services in a health planning region, including mobile crisis teams and crisis stabilization services, with the goal of diverting children from inpatient psychiatric hospitalization to less restrictive services in or near their communities. The Department of Behavioral Health and Developmental Services shall report on the use and impact of this funding to the Chairmen of the House Appropriations and Senate Finance Committees beginning on October 1, 2013 and each year thereafter

This language was included in the current budget to address certain recommendations included in the 2011 report "A Plan for Community-Based Children's Behavioral Health Services in Virginia," (Report Document 267, Item 304.M.) by the Department of Behavioral Health and Developmental Services (DBHDS). That report described the comprehensive service array needed to meet the needs of children with behavioral health problems.

Included in that plan were the results of a survey of community services boards (CSBs) which indicated that, of all the services in the comprehensive service array, crisis response services including both mobile crisis and crisis stabilization were the least available services in the state.

At least part of the reason crisis response services are in short supply is because of the expense of such service models, which require highly trained clinicians who are available on a 24/7 basis to respond to crisis situations. Rural CSBs are particularly challenged in supporting these service models. For these reasons, a regional approach was proposed to allow the services to be shared across a health planning region.

Through a competitive Request for Applications in 2012, three regional proposals were selected from those submitted from all five health planning regions:

Region I – Horizon Behavioral Health is the lead CSB for the region
Region III - Mount Rogers is the lead CSB for the region
Region IV - Richmond Behavioral Health Authority is the lead CSB for the region

In fiscal year 2013, funding was appropriated so that all five health planning regions could develop regional crisis response services and regions II and V were added.

Region II- Arlington is the lead CSB for the region
Region V- Hampton-Newport News is the lead CSB for the Region

Overall, the regions achieved good outcomes in keeping children with their parents and attending school. They increased child psychiatry access, serving more children than the prior year through face-to-face visits, tele-psychiatry and consultation to pediatricians and primary care physicians.

I. Introduction and Background

This report was developed in accordance with Item 315.W. of the 2013 *Appropriation Act* which addresses the management of the general fund appropriation for child psychiatry and children's crisis response services for children with mental health and behavioral disorders. Specifically, the language states:

> W. Out of this appropriation, $1,500,000 the first year and $3,650,000 the second year from the general fund shall be used to provide child psychiatry and children's crisis response services for children with mental health and behavioral disorders. These funds, divided among the health planning regions based on the current availability of the services, shall be used to hire or contract with child psychiatrists who can provide direct clinical services, including crisis response services, as well as training and consultation with other children's health care providers in the health planning region such as general practitioners, pediatricians, nurse practitioners, and community service boards staff, to increase their expertise in the prevention, diagnosis, and treatment of children with mental health disorders. Funds may also be used to create new or enhance existing community-based crisis response services in a health planning region, including mobile crisis teams and crisis stabilization services, with the goal of diverting children from inpatient psychiatric hospitalization to less restrictive services in or near their communities. The Department of Behavioral Health and Developmental Services shall report on the use and impact of this funding to the Chairmen of the House Appropriations and Senate Finance Committees beginning on October 1, 2013 and each year thereafter

In its 2011 report to the General Assembly, Item 304.M. "A Plan for Community-Based Children's Behavioral Health Services in Virginia," the Department of Behavioral Health and Developmental Services (DBHDS) described the comprehensive service array needed to meet the needs of children with behavioral health problems. A survey of community services boards (CSBs) indicated that, of all the services in the comprehensive service array, crisis response services including mobile crisis services and crisis stabilization services were the least available services in the state. These services are in short supply due at least in part to the expense of such service models which require highly trained clinicians available on a 24/7 basis to respond to crisis situations. Rural CSBs are particularly challenged in supporting these service models. For these reasons, a regional approach was proposed to allow the services to be shared across a health planning region.

Child psychiatry is an integral part of all crisis response services, and it was also one of the highest-rated needed services in the survey for the 304.M Plan. The 2014 Session of the General Assembly considered many budget amendments that were intended to increase access to the services highlighted in the 304.M plan, including child psychiatry and crisis response services. Additionally, the positive impact on children's services in the three funded regions that had begun in 2013 was considered.

Item 315.W. provides $1.5 million the first year and $3.65 million the second year from the General Fund for regional funding for child psychiatry and children's crisis response services. The language allocates funding to health planning regions based on the availability of services with a report on the use and impact of funding due annually beginning in 2014.

II. Request for Applications and Selection Process

When the funding became effective on July 1, 2012, DBHDS issued a competitive Request for Applications for regional proposals that included the following key requirement. The two regions that were not funded in FY2013 were asked to respond to the same requirements:

- Funding must be used for community-based services for children who would otherwise need publicly-funded inpatient or residential services.
- The goal should be to divert children from these services to less restrictive services, and to keep children with, or as close to, their families as possible.
- The target population for the services are children through age 17 who:
  (i) have a mental health problem, and
  (ii) may have co-occurring mental health and substance abuse problems,
  (iii) may be in contact with the juvenile justice or courts systems,
  (iv) may require emergency services, or
  (v) may require long term community mental health and other supports.

All services must include a child psychiatrist and crisis response services should include:

1. *Mobile crisis response teams* – clinical team that goes to homes, schools and other community locations to help keep a child at home. Mobile teams are dispatched within 2 hours of a call to the CSB and are available 24 hours, 7 days a week. CSB emergency services may refer children and families to the mobile crisis team
2. *Crisis stabilization units* – short-term 6-bed or less units with 24/7 bed-based care to divert children from inpatient and residential care
3. *Combinations* of mobile crisis teams and crisis stabilization units

Five proposals were received, one from each Virginia Health Planning Region, and three proposals were selected in Fiscal Year 2013: Region I, Region III and Region IV. Two more regions: Region II and V were awarded funding in Fiscal Year 2014. This report describes the services provided from July 1, 2013 through June 30, 2014.

III. Description of Regional Programs

The following are summaries provided by each region of their services.

Region I (Horizon is the lead CSB for the region)

Out of eight CSBs in Region I, five did not have access to child psychiatry prior to the award of this funding. Through this regional partnership, a child psychiatrist is providing consultation to primary care physicians and pediatric practices on children's mental health needs. Tele-psychiatry is available for all CSBs in Region I that are in need of child psychiatry time. A mobile crisis response team will serve children in the Horizon Behavioral Health area. Horizon Behavioral Health, one of the CSBs with the most complete array of children's services, will partner with CSBs in Region I to provide consultation in the development of programs to decrease utilization of inpatient hospitals and to develop mobile crisis teams in other parts of the region.

Priority needs, challenges and solutions for FY2014 in Region I included:

- Recruitment of the second child psychiatrist has been a challenge. The region has filled the second position with temporary psychiatrists; unfortunately, this solution is more costly.

- Additional telepsychiatry equipment to expand accessibility is a priority need. The region was granted additional one time funds to purchase telepsychiatry equipment for Horizon, Northwestern, Rappahannock/Rapidan, and Region Ten, in order to increase telepsychiatry/psychiatry/consultation time across Region I.
- Crisis Dollars for Indigent Children. Horizon has provided crisis and emergency services for indigent children through the Region I project. Horizon expended all dollars by April 1, 2014. None of these children's services were discontinued, resulting in a deficit. An additional $50,000 in one time funds were awarded to complete services from May-June, 2014 for indigent children that Horizon was currently serving at a loss.

Crisis Activity:

Horizon's current proposal provides for child face-to-face psychiatry/telepsychiatry and Consultation to the following CSBs and private providers:

Telepsychiatry and Consultation:

- Rappahannock Area (3 sites)
- Rockbridge (Bath County)
- Harrisonburg/Rockingham (Harrisonburg)
- Northwestern
- Rappahannock/Rapidan (Culpepper)
- Region Ten (Greene County)

Face-to-Face Psychiatry / Consultation:

- Horizon
    - Amherst
    - Centra Child Obesity Clinic
    - Lynchburg Family
    - Three Private intensive in-home providers
    - Richeson Drive Pediatrics
- Rappahannock/Rapidan
- Region Ten
    - Nelson
    - Blue Ridge
- Rockbridge

Two FTE RN Case Managers Job Responsibilities include:

- Opens chart – completes state paperwork requirements
- Liaison to multiple CSBs receiving Tele-psychiatry services
- Expansion of RN responsibilities for CSBs across Region I (as outlined above):
    - Paperwork: Releases, consents
    - Vital signs and nursing assessment (enters BMI – Body Mass Index)
    - Height, weight
    - Educational services to parents and children
- Liaison to pharmacies across Region I
    - Preauthorization paperwork
- Maintain Doctors' Schedules
- Provide Nursing Case Management for up to 20 Private Provider/IIH Cases

Looking Ahead: FY2015

Strategies for FY 2015 in Region I include:
1) Additional mobile crisis teams for two CSBs to expand accessibility;
2) Crisis funding for indigent children for six CSBs. An additional $288,021 awarded in FY15 will increase child psychiatry access across the region. Expansion plans are based on needs requested by CSBs. These dollars will enable two teams to be established. The clinicians may work in tandem to address the needs of our children and families with the highest needs for crisis services. It is estimated that each team will serve at least 16 children the first year.

- **Additional Mobile Crisis Teams:** The goal is to continue to increase capacity of crisis services. Through additional funds, we will create two additional mobile crisis teams to serve two CSBs (To be identified).
- **Crisis Dollars for Indigent Children:** An additional $60,000 in one time funds was awarded for indigent care for the other six CSBs. These funds will be divided equally among the CSBs who agree to participate. This funding will be used to provide crisis services to children at risk of hospitalization or other out of home or school placement. These dollars will be used exclusively for children who have no other ability to pay. Crisis services are 1:1 services for children and/or families that can be provided in home, school, crisis stabilization milieu, or other community setting.

Region II (Arlington is the lead CSB for the region)
HPR II's regional crisis response program began services on June 13, 2014. The program, Children's Regional Crisis Response (also known as "CRCR" or "CR^2") is operated by the National Counseling Group, Inc. Management oversight of the program, including contract management, is provided by the Arlington CSB. A regional team meets at minimum monthly to monitor the rollout of the program, review outcomes, and implement strategies for success.
CRCR has two mobile-crisis teams available 24/7/365 to respond to crises experienced by young people up to age 17 and their families. One phone number is in place to reach the teams, and an intensive level of services is provided, with the goal of resolving the immediate crisis and maintaining the child in the community.
CRCR also provides urgent psychiatric assessment and medication, if needed, through tele-psychiatry. The program provides up to 30 days of services to ensure resolution of the crisis situation and to assist families with accessing ongoing services needed to maintain the child successfully in the community and reduce the risk of further crises.

Why a vendor?
Shortly after receiving funding, the region agreed that the most cost-effective approach for implementing the service was through a contracted vendor. The philosophy behind this decision was that there are providers in the community with the experience and the infrastructure in place to deliver this service, thereby using the funding more efficiently and effectively than building a new service at the Arlington CSB from the ground up.

This approach required developing a request for proposals, soliciting bids, reviewing bids, selecting a vendor and completing contracting procedures. This process, never fast in the best of circumstances, took longer than expected. The vendor was informed of their selection in mid-April 2014. They moved swiftly, with staff hired and a team leader in place by late May. The final hurdle—licensure—was cleared June 13, 2014.

Services provided thus far

The first client was served on June 20. Though the roll-out was delayed, once it was started the program was actively utilized, serving 40 clients in September 2014.

Rollout and marketing
Regional representatives agreed on a soft rollout for the program. This first phase involved informing emergency services departments in each of the region's CSBs about the program and how to contact it. CRCR staff also reached out directly to each emergency services program to set up face-to-face meetings, arrange shadowing opportunities, and help staff become familiar with this new service. Initial referrals to the program have come through the CSBs' emergency services departments.
The regional group has begun round two of the marketing plan: spreading the word throughout the region. This involves getting the program information into the hands of the full staff at each of the CSBs, to Department of Social Services staff, to each of the school departments, and to the justice system (police, school resource officers, court services units). The region is also developing a plan to directly market the program to parents, via community groups, online groups, government-access cable channels, etc. The region wants to ensure that this program is seen as a community resource, accessible by anyone experiencing a behavioral health crisis in their family.

Region III (Mount Rogers is the lead CSB for the region)
Region III, a large rural area in southwestern Virginia, has a severe shortage of child psychiatrists and crisis clinicians with specific expertise in children's services. Originally, the funding request focused on adding telepsychiatry and crisis clinicians to the 10 community services boards in Region III with the goal of stabilizing youth in crisis situations and determining wrap around services in the community. Funding was approved for 3 CSB's to hire crisis staff and the purchase of telepsychiatry services to be made available to the entire region. Mount Rogers Community Services Board (MRCSB) was designated as the lead for the region.

A Clinical Services Coordinator was designated to:
- coordinate telepsychiatry services and address any issues/concerns that arise
- assist CSB's in offering consultation services to local medical providers
- collaborate with CSB's receiving funds for crisis staff in order to report data to DBHDS

Connectivity and equipment varied greatly amongst the 10 CSB's. UVA's IT Department was heavily involved in testing all of the systems to ensure connectivity was compliant with telemedicine standards. As new sites were added or new equipment purchased, this same process was repeated.

Another hurdle involved contracting with UVA, which turned into a lengthy process. Aside from negotiating rates and hours, legal concerns were processed related to the consultation service to be provided. The Clinical Services Coordinator then completed trainings for existing staff, and those hired subsequent to the start of services, to orient the physicians to the goals and processes of the grant services as well as instructing them on use of the MRCSB Electronic Health Record.

As the Clinical Services Coordinator met with the CSB's, some reported seeing little need for the service due to their existing psychiatric services, limited equipment/bandwidth capability, and some expressed concern about use of telepsychiatry services in general. For those issues that CSBs requested assistance, the Coordinator was able to resolve the concerns. Scheduling certain CSBs for certain days addressed some limited access issues and opportunities to experience telemedicine services were provided. Six of the 10 CSB's ultimately utilized the telepsychiatry services.

New River Community Services discovered that utilizing their funds to create an Integrated Healthcare Liaison eliminated the need to utilize the service as they were more successful in collaborating with local medical providers. This new position focused on triaging children truly in need of psychiatric and/or crisis services and facilitating transitions from their psychiatrists to the local providers. Other CSB's discovered the benefit of using these services to prevent crises. Youth identified as urgently needing medication intervention, but not quite at the point of crises, participated in services as a means of avoiding the need for crisis services.

Several local providers were identified as good community partners with the CSB's. Although the Clinical Services Coordinator offered to assist CSB's in educating these partners about the consultation services offered via the grant, most CSB's preferred to take on this responsibility. Promotional materials were developed to assist CSB's in presenting services to these providers. As the Coordinator was able to meet with some providers and review the consultation services, the opportunity was well-received and twelve private providers registered to take part in the service.

Despite 12 private providers and all CSB's being given the opportunity to utilize consultation services, few consultation services have been provided. Consultations that were provided were described as "very helpful", but as feedback was sought related to the low usage, the following feedback was provided:

- Scheduling a consultation is challenging to work into medical provider schedules.
- Having the opportunity to connect via video conferencing and allow UVA to assess the patient at the time of the appointment would be ideal.
- A consultation does not meet the requirement of an evaluation for patients needing medications such as Risperdal.

The Clinical Services Coordinator has reviewed these issues with UVA and discussion is underway to determine if accommodations can be made to address the concerns.

Aside from telepsychiatry services, the CSBs who received funding for crisis staff each had a different approach for utilization. Mount Rogers Community Services Board developed the Positive Alternatives To Hospitalization (PATH) program and enlisted the funding to hire a Counselor/Program Manager to assist in assessment, service delivery, and oversight of the crisis intervention and mobile crisis stabilization program. New River Community Services developed an Integrated Healthcare Liaison position, detailed earlier in this summary. This position is housed in several local Health Departments and works closely with medical providers. Highlands Community Services Board hired a crisis counselor with youth experience and focus. This counselor also facilitates telepsychiatry appointments and transitions back to local providers. In the second year of the funding, Highlands also opened its Safety Zone program to provide center-based and mobile crisis stabilization services. All three approaches proved to be successful in reducing hospitalizations and the crisis stabilization programs hinge upon the availability of crisis funding services as without it, the requirement of a psychiatric evaluation within 72 hours of admission could not be met.

Region IV (Richmond Behavioral Health Authority is the lead CSB for the region)
Children in crisis who may be at risk for hospital or other long-term care can be stabilized in a 6-bed crisis stabilization unit under contract with a local provider. In addition, regional services have been expanded to include mobile crisis response to all CSBs in Region IV, except the far south side of the

region. Because of its distance, Southside Community Services Board will provide a mobile crisis team for its own locality.

The Region IV children's crisis response demonstration project completed its second fiscal year of program operations in June 2014 and, in this period, has undergone a number of programmatic shifts and changes as documented well in earlier reports. A primary focus of this last year has been the utilization of the residential crisis stabilization services provided by St. Joseph's Villa (SJV), the current status of which will be discussed in more detail below.

As of the end of FY14, Region IV maintained operations of a 6-bed CSU, capacity for ambulatory crisis stabilization services onsite at the CSU facility, capacity for mobile community-based services, and child psychiatry services delivered primarily via telemedicine.

Residential Crisis Stabilization Unit

For all of FY14, 135 children and adolescents were admitted to the CSU and received 1,073 bed days of service. A total of 148 residential admissions occurred during the year with 13 of those being readmissions. Compared with FY13, during which there were 92 admissions (86 children served), FY14 data indicates a 41% increase in CSU utilization. The average daily census for the entire year was 3.21; however, with the modification of 'direct access' protocols and the subsequent increased utilization, the average daily census for the last two quarters of the year rose to 3.59, and two of those months were at 4.0 or above.

Sixteen (16) children required a higher level of care at discharge from the CSU, two (2) of whom were subsequently admitted to CCCA. However, this means that 88% of children were discharged to a community setting: 112 of them (83%) returned to live with family and 125 of the children (92.5%) were attending school at discharge. Children admitted to the CSU continued to experience an average length of stay that hovers between six and seven days (6.36), consistent with one of the program's goals to stabilize the child quickly and return him/her to the community with identified supports in place.

Ambulatory Crisis Stabilization Services

For all of FY14, thirty-three (33) children participated in ambulatory crisis stabilization services, either onsite at SJV via "day programming" or in their home/community. Eight (8) of those children received this service as a stand-alone service; the remaining 25 children participated in the service as a step-down from a CSU admission. A total of 331 hours of ambulatory services were provided during the year. Overall, this represents an increase in utilization over last fiscal year. However, the utilization of the ambulatory component of this project has been low, as evidenced by only 33 of 137 children served (24%) accessing these services over the past twelve months.

The last six months of the reporting period coincided with significant reformatting and restructuring of the crisis stabilization services (residential and ambulatory) that came about as a result of intense review by the regional child crisis task force and was reflected in the revised contract between the region and SJV. SJV redirected resources to the 6-bed unit; ensured capacity for at least two children in its day program with expanded staffing patterns; modified the delivery of community-based mobile as primarily a step-down service; and firmed up psychiatry services (discussed more below).

The intense focus on boosting utilization of the program led to several recommendations earlier this year, including the approval for 'direct access' admissions for non-Region IV CSB enrolled children. While direct access referrals have been increasing over time, the majority of admissions continue to be CSB-linked children, as follows:

- 113 admissions from Region IV CSBs (72.4%);

- 41 'direct access' admissions of children living in Region IV but not served by CSBs at time of referral (26.3%); and,
- 2 admissions of children living outside Region IV and being served by their local CSB (1.3%).

As a required participant in the statewide bed registry, these services are more visible state-wide. As such, SJV and Region IV have outlined and communicated guidelines for accessing CSU and ambulatory services both within Region IV for non-CSB linked children and outside of Region IV for CSB-linked children only.

Child Psychiatry Services

All 135 children served by SJV had either a face-to-face (n=68) or telemedicine (n=67) contact with a project psychiatrist or nurse practitioner, and more than 152 hours of psychiatry were provided. Eleven (11) psychiatric consultations with an outpatient provider took place; this is an area that will continue to expand in the upcoming project year.

Procurement of child psychiatry services has been one of the more difficult tasks with this project, and challenges continued through this fiscal year. The vendor referenced in the mid-year report was not able to fulfill its contractual obligations to provide 15 hours of psychiatry services weekly, so SJV embarked on another search for a qualified and appropriate provider.

Despite this set-back, psychiatry services were made available to children admitted to the CSU and ambulatory services via temporary psychiatrists until another vendor was secured. Currently, an active contract with a telemedicine provider is in place, and a primary child psychiatrist has been interviewed, oriented to the program, and begun serving clients.

Emergency Crisis Response & Telepsychiatry – Southside CSB

Southside CSB (SCSB) continued to provide emergency crisis response to children and adolescents from its Mecklenburg, Brunswick and Halifax clinics through this period. During the fiscal year, SCSB served 39 youth experiencing a crisis situation and requiring intervention by the project-funded child services staff and quick linkage to the project psychiatrist. This represents a 59% increase in children served over FY13. Almost 100 hours of emergency crisis response and outpatient services were provided to these children. In addition, 22 of the children served received psychiatry services, for a total of over 25 hours of telemedicine provided.

The identified case manager provides crisis intervention, stabilization, and case management services at an intense level of care. Brief therapy is provided for up to 6 months, and aftercare is available. Once the child is stabilized, he or she is transferred to an outpatient clinician for weekly follow-up services.

During the fiscal year 2015, SCSB will be taking steps to notify other community partners about the availability of children' crisis assessments. Further, all clinicians will be trained in crisis assessments to increase staff availability for day and after hours crisis response.

Next Steps for Region IV

Region IV plans to continue its robust monitoring of project progress, including service utilization by CSBs, issues related to 'direct access' admissions, quality services, and the provision of psychiatry services. DBHDS leadership will be included in this process to help ensure the project remains on track into FY2015.

Region IV leadership will evaluate the current year budget and identify cost-savings arising from a reduction in SJV contract costs effective the beginning of this year and work to identify and procure

additional services and supports that can meet the needs of children experiencing mental health crises in this region.

Region V (Hampton-Newport News is the lead CSB for the region)
Since opening in late February, The Children's Behavioral Health Urgent Care Center has served 50 children and adolescents. The presenting problems of the children served have included suicidal ideation, homicidal ideation, self injurious behavior, perceptual disturbances and significant decreases in daily functioning. Over one half of the children served (62%) have not had any prior mental health treatment. The referral sources include Emergency Services Workers (17%), Emergency Room Staff (8%), private physicians (3%), psychiatric hospital staff (13%) and school personnel (59%). More than one half of the children were referred for follow-up care at their home Community Services Board. If the child was not referred to the local Community Services Board, it was because the child was already engaged in treatment with a private provider or the local Community Services Board was unable to provide the follow–up care. Eight of the children treated were referred to the Mobile Crisis Stabilization units at Virginia Beach Department of Human Services and Western Tidewater Community Services Board. Thus far, children have been served from the following CSBs: Hampton-Newport News (32%), Western Tidewater (21.6%), Chesapeake (18.9%), Portsmouth (16.2%), Virginia Beach (2.7%), Norfolk (2%), and Eastern Shore (2%).

The staff at the Children's Behavioral Health Urgent Care Center include a Board Certified Child Psychiatrist, Licensed Clinical Social Workers, License Eligible Social Workers, state certified Emergency Service Prescreening staff and Mental Health Technicians. The staff provide each youth and family with the following supports and services:

- A safety plan
- A clear understanding of the crisis
- A manageable treatment plan
- An increased sense of confidence and empowerment to manage the crisis
- An increased sense of security and hope for the future
- Links with community support and treatment providers
- Lists of resources and educational materials

Ongoing support until the crisis is managed or the youth has successfully engaged in services in his or her home community

The region has sent 30-day follow up surveys to the families served thus far. The region is tracking whether the families received the services and supports mentioned above. It has been found that as time progresses the region is improving service delivery and families are reporting increased satisfaction with the services they have received.

IV. Results, Including Data and Case Examples from Programs

The following is information on community services provided by the regions. Data on community services is reported by CSBs in the DBHDS automated data system, the "Community Consumer Submission" (CCS). The data provided in this report is from the service categories in the CCS that are most frequently provided to children in crisis. Those services include:

- Emergency Services;
- Outpatient Services;
- Ambulatory Crisis Stabilization; and
- Residential Crisis Stabilization.

Because child psychiatry is included within the Outpatient Services category of CCS, separate data on child psychiatry services is not available from the automated system. A manual report from the regions was used to gather data on child psychiatry services. Table 3 reports manually collected data from the programs on child psychiatry services to give a picture of the numbers of children who received each type of child psychiatry service. Throughout this section on results, data that shows improvement in program outcomes is highlighted in green.

Emergency Services

Emergency services are scheduled or unscheduled services that include crisis counseling and psychiatric services to children who are in a crisis situation. Services must be available 24 hours per day and seven days per week to children and others seeking services on their behalf. Also included are the code-mandated prescreening services that CSBs provide to assess the need for inpatient psychiatric hospitalization, or other activities associated with the judicial admission process. Pre-screening services are provided by certified pre-screeners who meet state criteria and have completed training modules to assure their competency. All regions provided more emergency services to children in FY 2014 than in FY 2013.

Table 1 – Emergency Services

Emergency Services		
Region	**FY 2013**	**FY2014**
I	1777	2133
II	1845	2071
III	1692	2437
IV	1260	1444
V	986	1325

*Numbers of children are unduplicated.

Outpatient Services (Child Psychiatry is part of this category)

Outpatient services include individual, group and family therapy sessions provided in the office. Also included are child psychiatry and medication services, which are broken out separately in the section below. Table 2 provides the total unduplicated number of children who received outpatient services. All regions provided more outpatient services to children in FY 2014 than in FY 2013. Table 3 and Table 4 provide the child psychiatry services provided as part of this initiative.

Table 2 – Outpatient Services

Outpatient Services		
Region	**FY 2013**	**FY2014**
I	5729	6540
II	2681	2940
III	6266	7032
IV	3648	4008
V	3885	4021

*Numbers of children are unduplicated.

Child Psychiatry Services (Separate from Outpatient Services)

In order to extend the reach of very limited child psychiatry resources, the funded programs were asked to provide child psychiatry in three venues:

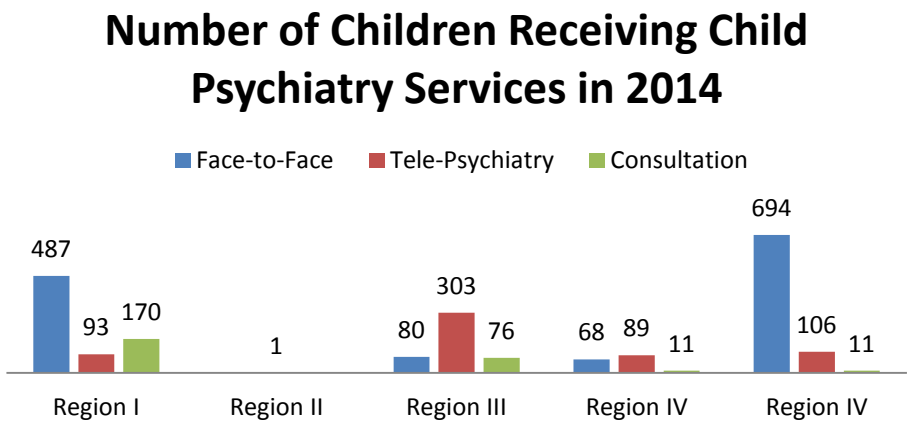
- Face-to-face office visits with children;
- Tele-psychiatry services to children in remote sites; and
- Child psychiatry consultations to other providers, such as pediatricians, primary care providers and others.

Child psychiatry services are being provided face-to-face and via tele-psychiatry in all five regions. Region V, led by Hampton-Newport News served the largest number of children using all three approaches, with 694 children receiving a face-to-face visit with the child psychiatrist.

Overall, child psychiatry services were an extremely successful aspect of this initiative, adding capacity in an environment of extreme scarcity of board-certified child psychiatrists. Child psychiatrists provided face-to-face, tele-psychiatry, and consultative approaches to 2,189 children in Virginia; a significant increase over the 520 children that were served during the previous fiscal year. There were continued delays experienced in start-up due to lengthy contracting processes with universities and challenges in getting appropriate tele-psychiatry equipment in all of the CSBs. The largest number of children receiving child psychiatry services (811) was in Region V.

Tele-psychiatry and consultation have continued to go exceptionally well in Region I, where the same CSB-employed physician provides these services and is available for face-to-face, tele-psychiatry and consultation appointments. In Region III and IV, where delays were experienced with planned contracts with universities in FY 2013, they have greatly increased the number of children seen during fiscal year 2014. Additional child psychiatry hours continue to be greatly needed. Region IV has several strategies as a path to solving these problems, including a plan to use the model employed by Region I, embedding a psychiatrist at one of the CSBs that will be a CSB contract employee serving all CSBs in the region. Some delays with tele-psychiatry were also encountered with some CSBs that did not have compatible teleconferencing equipment and these challenges have been addressed.

Table 3: Child Psychiatry



*Numbers of children are unduplicated.

Table 4: Child Psychiatry Services Provided by Each Region Compared by Year

Service	Region I		Region II	Region III		Region IV		Region V	Statewide Total	
	2013	2014	2014	2013	2014	2013	2014	2014	2013	2014
(1) Face-to Face	189	487		62	80	72	68	694	323	1329
(2) Tele-Psychiatry	54	93	1	3	303	18	89	106	75	592
(3) Consultation	83	170		39	76		11	11	122	268
Regional Total	**326**	**750**	**1**	**104**	**459**	**90**	**168**	**811**	**520**	**2189**

- Definitions used in collecting data:
    1) Face to face: total number of youth that received a face-to-face visit with the psychiatrist;
    2) Tele-psychiatry: total number of youth that received tele-psychiatry services; and
    3) Consultation services: total number of consultation contacts by the psychiatrist. Consultations include pediatricians, primary care physicians, other mental health professionals, or other psychiatrists

Ambulatory Crisis Services

Ambulatory crisis services provide direct care and treatment to non-hospitalized children and are available 23 hours per day. The goals are to avert hospitalization, re-hospitalization, or disruption of living situation, assure safety and security and stabilize children in crisis. Services may involve mobile crisis teams. Ambulatory crisis stabilization services may be provided in an individual's home or in a community-based program licensed by the Department.

As in 2013, Region I served the largest number of children through mobile crisis team services. Horizon, the lead CSB for the region, provided services through their team and also provided consultation and training to other CSBs in Region I that were interested in starting up new mobile crisis services. St. Joseph's Villa provides mobile crisis services for Region IV, targeting clients who were being discharged from the Crisis Stabilization Unit. All clients admitted to the unit are assessed for appropriateness to continue mobile crisis stabilization services as they transition back to their

home environment, to help ensure the crisis episode was resolved and to support the child in their home environment for a short period of time. Regions III, IV and V all increased the number of children that received ambulatory crisis stabilization services.

Table 5: Ambulatory Crisis Stabilization

Ambulatory Crisis Stabilization		
Region	**FY 2013**	**FY2014**
I	419	281
II	1	1
III	3	151
IV	6	25
V	14	70

*Numbers of children are unduplicated.

Residential Crisis Services

Region IV contracts with Saint Joseph's Villa, a private provider, for a unit for the purpose of crisis stabilization. This public-private partnership has reflected a strong commitment on both parts to making overnight crisis stabilization services available in the region. Despite this strong collaboration, the unit was underutilized in FY 2013 and in the early months of FY 2014. Numerous strategy meetings between DBHDS, Richmond Behavioral Health Authority and the other CSBs in Region IV, and the provider have been held to analyze referral and utilization patterns and to develop strategies to increase utilization. The region and the provider continue outreach efforts to increase awareness in the community to help ensure appropriate utilization. These efforts have produced increased utilization, going from 29 children in FY 2013 to 97 in FY 2015. Regions II and V are expected to show increased utilization in the next fiscal year, as they experienced start-up delays in their first year.

Table 6: Residential Crisis Stabilization

Residential Crisis Stabilization		
Region	**FY 2013**	**FY2014**
I	18	0
II	1	0
III	1	0
IV	76	97
V	3	1

*Numbers of children are unduplicated.

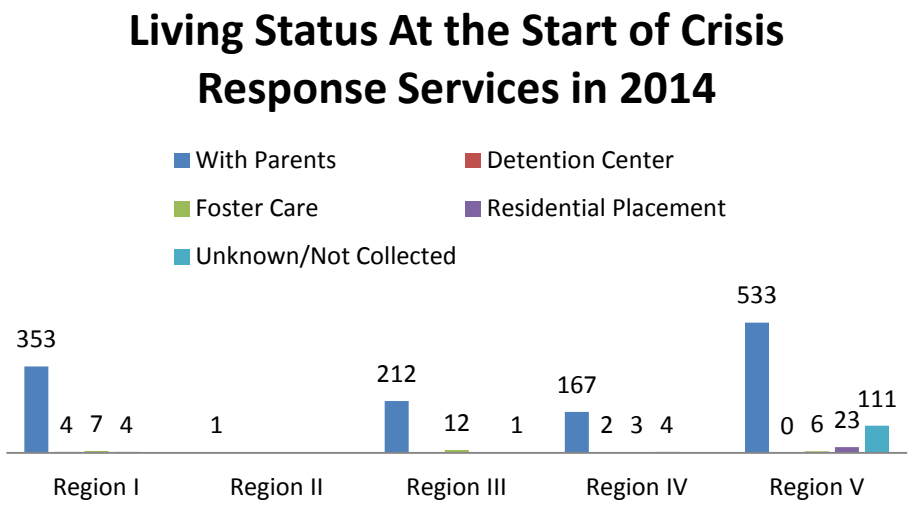
Living Status and School Status of Children Served

With the focus of the initiative being to preserve home and community life, regional programs are asked to report the living status and school status of children as outcome indicators.

- **Living Status of Children**

The charts and tables below show the living status of children upon entry to crisis response services and at the end of services. The data show that the largest majority of the children entered crisis response services while living with their parents and also returned to their parent's home at the end of crisis services.

Table 7: Living Status at the Start of Crisis Services

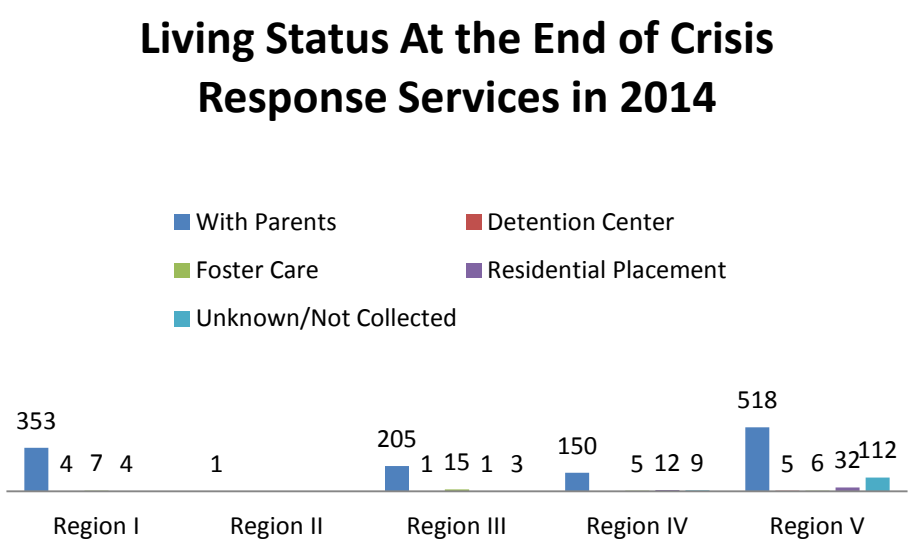


*Numbers of children are unduplicated.

Table 8: Living Status at the Start of Crisis Services by Each Region Compared by Year

Status	Region I		Region II	Region III		Region IV		Region V
	2013	**2014**	**2014**	2013	**2014**	2013	**2014**	**2014**
With parents	155	353	1	150	212	100	167	533
Detention Center	2	4					2	
Foster Care	4	7		19	12	2	3	6
Residential Placement		4				3	4	23
Shelter Care	8							
Inpatient Facility	3							
Unknown/Not Collected					1			111
Total	**173**	**368**	**1**	**169**	**225**	**105**	**176**	**673**

Table 9: Living Status at the End of Crisis Services



*Numbers of children are unduplicated.

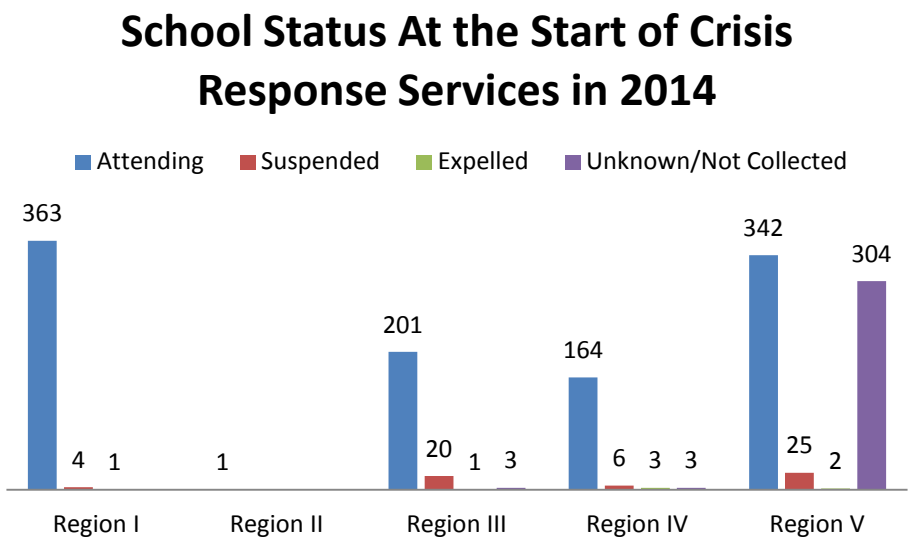
Table 10: Living Status at the End of Crisis Services by Each Region Compared by Year

Status	Region I		Region II	Region III		Region IV		Region V
	2013	**2014**	**2014**	2013	**2014**	2013	**2014**	**2014**
With parents	158	353	1	146	205	87	150	518
Detention Center	2	4		18	1			5
Foster Care	5	7			15	3	5	6
Residential Placement		4			1	8	12	32
Shelter Care	8							
Unknown/Not Collected				5	3	7	9	112
Total	**173**	**368**	**1**	**169**	**225**	**105**	**176**	**673**

▪ School Attendance Status of Children

Attending school in the community is one of the most important outcomes sought in a program designed to keep children in their homes and communities The majority of the children receiving crisis response services were attending school when the services commenced and were still attending school at the end of services, demonstrating the effectiveness of serving the children in their homes and communities.

Table 11: School Attendance at the Start of Crisis Services

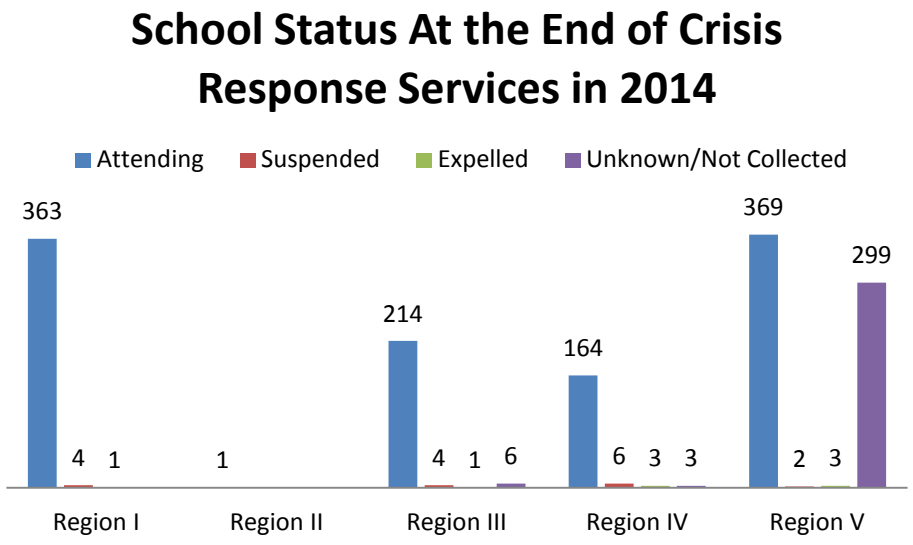


*Numbers of children are unduplicated.

Table 12: School Status at the Start of Crisis Services by Each Region Compared by Year

Status	Region I		Region II	Region III		Region IV		Region V
	2013	**2014**	**2014**	2013	**2014**	2013	**2014**	**2014**
Attending	170	363	1	154	201	100	164	342
Suspended	3	4		13	20	3	6	25
Expelled		1			1	1	3	2
Unknown/Not Collected				2	3	1	3	304
Total	**173**	**368**	**1**	**169**	**269**	**105**	**176**	**673**

Table 13: School Status at the End of Crisis Response Services



*Numbers of children are unduplicated

Table 14: School Status at the End of Crisis Response Services by Each Region Compared by Year

Status	Region I		Region II	Region III		Region IV		Region V
	2013	**2014**	**2014**	2013	**2014**	2013	**2014**	**2014**
Attending	172	363	1	146	214	100	164	369
Suspended	1	4		13	4	3	6	2
Expelled		1		3	1	1	3	3
Unknown/Not Collected				7	6	1	3	299
Total	**173**	**368**	**1**	**169**	**225**	**105**	**176**	**673**

Impact on Utilization of the DBHDS Commonwealth Center for Children and Adolescents

Crisis response services are intended to intervene early and stabilize crises in the community. Even with community crisis response services, inpatient services will still be needed for some children at certain times. One of the goals of crisis response services is to avoid the use of state facility services whenever possible, while preserving the welfare of the child and family, and public safety. When children need to be hospitalized, the focus is on reducing length of stay. The tables below compare FY2013 and FY2014 regional data from the data system (named "Avatar") that tracks utilization of DBHDS state facilities. Data for individual CSBs in each region is included in Table in Appendix C: State Facility Services Provided at the Commonwealth Center for Children and Adolescents.

State Facility Services Provided at Commonwealth Center for Children and Adolescents

Table 15: Comparison of State Facility Admissions FY2013 and FY2014

	FY2013 Admits Unduplicated	FY2014 Admits Unduplicated	FY2013 Admits Duplicated	FY2014 Admits Duplicated	FY2013 Readmissions	FY2014 Readmissions
Region I Total	172	207	208	275	75	116
Region II Total	127	112	147	123	43	26
Region III Total	102	174	129	212	44	62
Region IV Total	104	106	125	126	42	39
Region V Total	65	74	78	89	26	26
Total	**570**	**673**	**687**	**825**	**230**	**269**

Table 16: Comparison of State Facility Bed Days FY2013 and FY2014

	FY2013 Bed Days	FY2014 Bed Days	Change in Bed Days	% plus or minus
Region I Total	3027	3753	726	24.0
Region II Total	2789	1981	-808	-29.0
Region III Total	1841	2603	762	41.4
Region IV Total	2193	2204	11	0.5
Region V Total	1695	1573	-122	-7.2
Total	11,545	12,114	-31	29.7

Case Vignettes Illustrating Outcomes for Children and Families

As part of their quarterly reports, funded programs are asked to submit actual case examples to demonstrate the impact of the services they provided to children and families. The following is a selection of the case examples submitted.

- **Case Vignette - Mobile Crisis Services**

A six year old male was brought to CSB emergency services for possible out-of - home placement due to increasingly aggressive behaviors that include hitting, kicking, biting, and damaging property. The client has had numerous mental health interventions in the past including intensive in-home counseling, crisis stabilization, psychiatric services and outpatient counseling. The client was not linked to a therapist and the client's mother was considering residential placement. Also, the client has a pervasive developmental delay, and he was exposed to domestic violence prior to his parents separating at approximately age three. During the initial contact with the client and his mother, emergency services staff discussed linking the family to crisis stabilization services in order to try and prevent an out of home placement. The crisis stabilization worker on call completed a crisis assessment with the family at their home. Crisis stabilization services were then initiated. Goals during crisis stabilization focused on creating structure and consistency in the home to include clarifying expectations and rules, increasing positive reinforcement of appropriate behaviors, increasing coping strategies and linking the family with ongoing services. Staff modeled behaviors and interventions for the client's mother and supported her as she implemented parenting techniques. The client completed a VICAP Assessment to determine intensive in-home service eligibility. While awaiting intensive in-home counseling to begin, mobile crisis was utilized to provide intensive care coordination to the family after crisis stabilization ended. The client then began seeing an individual and family outpatient therapist. The client completed crisis stabilization and continues to receive ICC and outpatient services. He has followed through with his psychiatrist and to date his mother is not currently seeking an out of home placement.

- **Case Vignette- Residential Crisis Stabilization**

A 16-year old African-American female came to the CSU from the local juvenile detention center, after authorities learned that she had been abducted by a stranger soon after she ran away from home. She had been kept in a hotel room against her will and prostituted until she escaped a few weeks later. Prior to her CSU admission, she had a long history of involvement with the court system, experienced significant domestic disruption and family dysfunction, and was treated in a

psychiatric inpatient setting multiple times including a state facility hospitalization. Her youth was marked by multiple home placements with different family members, substance abuse by her parents and herself, and criminal activity; as well, she expressed symptoms of depression, anxiety, self-injury, and hair pulling.

She was given the choice to come to CSU to address the immediate crisis and develop age-appropriate coping and social skills. She participated fully while on the unit, despite encountering problems with peers. She worked to identify positive skills, like singing, decorating, and hair styling while staying at CSU.

CSU staff provided therapeutic interventions for the child while on the unit but also assisted her and her family with securing wrap-around services in the community prior to discharge which, along with support from her therapist, allowed her to transition successfully back to her home and school settings. She and her family/guardian expressed a high level of satisfaction with the services received and would recommend them to other families in need.

- **Case Vignette – Crisis Stabilization Unit with Child Psychiatry Intervention**

The client was a six-year-old male CSB consumer. His parental involvement was limited and DSS was involved with his family. He had recently transferred to a new elementary school in the area, but within days of his transfer, he was suspended for hitting, kicking, and destroying property and was at risk for hospitalization. He had difficulty managing his symptoms and controlling his impulses, as demonstrated by the self-inflicted scratches on his face. His behavior was constantly leaving him isolated from his classmates, unable to participate in any social activity during the day. Because of the escalation of his behavior and his suspension from school and risk for being hospitalized, his guidance counselor referred him to the CSB's crisis stabilization program (CS) for children. When he arrived at the CS program, he presented severe, aggressive behaviors. A plan was established by the treatment team (current CSB treatment providers, DSS workers, and school personnel) and he was seen by the CSB Psychiatric Services within two days of his admission his improvement became evident to the CSB staff at CS program the more time he spent receiving intensive services. He was able to demonstrate expressing his thoughts with words in lieu of being aggressive. He established trust in authority figures through intensive services at CS program, and it soon became evident that he was being physically abused and neglected at home. He was relocated to a safe environment with his grandparents in another county, appropriate reports were made to DSS, and the scratches on his face soon healed. Because of the CS program, other CSB services, and community partners working together, services were wrapped around this child to protect him and to provide him and his family with much needed services, and ultimately prevent inpatient hospitalization and further isolation. He was discharged from the CS program. CSB service providers (intensive child and family and psychiatric services continued providing services – even though he was no longer in the service area – to provide services to him and his family as he transitioned into a new school, a new home, and to a new community services board.

V. Summary

Overall, the regions achieved good outcomes in keeping children with their parents and attending school. Perhaps the greatest improvements have been seen in child psychiatry access through face-to-face visits, tele-psychiatry and consultation to pediatricians and primary care practitioners. The numbers of children receiving child psychiatry services increased from 520 in FY 2013 to 2,189 in FY 2014. Due to the tragic incident involving the son of Senator Creigh Deeds, FY 2014 was a year

of high state facility utilization overall, and the Commonwealth Center for Children and Adolescents was no exception. While some CSBs reduced their overall utilization of CCCA, the state's only public inpatient facility for children, overall the statewide utilization increased as shown in Tables 15 and 16. Greater improvements in all service areas are expected in FY2016, as all five regions move past the early start-up phase and have a full year of operation.

This new funding has created the opportunity to test service models and to determine where adjustments are necessary. For example, while Report Document 267, "Plan for Children's Behavioral Health Services," and the survey of available services identified residential crisis stabilization as a service very few CSBs provided, the experiences described in Section IV indicate that it was not simply a problem of funding, but of other challenges. Region IV's utilization of the residential crisis stabilization unit was low and several strategies have increased referrals. These efforts resulted in increased utilization in the late spring of 2014, followed by a customary drop in admissions during the summer months. As of August 2013, a change was implemented to accept non-CSB referrals to the residential crisis stabilization unit, assuring that the referrals are screened for appropriateness.

While considerable progress has been made over the past fiscal year, DBHDS will continue to analyze trends and challenges and strategize with the regions to increase accessibility to these services. DBHDS will provide continued opportunity for sharing experiences from the programs through regional program meetings at service sites across the state, site visits and conference calls.

Appendices

Appendix A: Request for Applications

Department of Behavioral Health and Developmental Services Instructions for Proposals for Community Crisis Response and Child Psychiatry Services

FY2013-2014

VI. *Background*

In its Final Report to the General Assembly, Item 304.M, "A Plan for Community-Based Children's Behavioral Health Services in Virginia," the Department of Behavioral Health and Developmental Services described the comprehensive service array needed to meet the needs of children with behavioral health problems. A survey of CSBs indicated that, of all the services in the comprehensive service array, crisis response services, including mobile crisis teams and crisis stabilization units were the least available services in the state. Child psychiatry is an integral part of all crisis response services, and it was also one of the highest rated needed services. The 2012 Session of the General Assembly considered many budget amendments that were intended to increase access to the services highlighted in the 304.M plan, including child psychiatry and crisis response services. The final budget included the following language:

Item 315#1c

U. Out of this appropriation, $1,500,000 the first year and $1,750,000 the second year from the general fund shall be used to provide child psychiatry and children's crisis response services for children with mental health and behavioral disorders. These funds, divided among the health planning regions based on the current availability of the services, shall be used to hire or contract with child psychiatrists who can provide direct clinical services, including crisis response services, as well as training and consultation with other children's health care providers in the health planning region such as general practitioners, pediatricians, nurse practitioners, and community service boards staff, to increase their expertise in the prevention, diagnosis, and treatment of children with mental health disorders. Funds may also be used to create new or enhance existing community-based crisis response services in a health planning region, including mobile crisis teams and crisis stabilization services, with the goal of diverting children from inpatient psychiatric hospitalization to less restrictive services in or near their communities. The Department of Behavioral Health and Developmental Services shall report on the use and impact of this funding to the Chairmen of the House Appropriations and Senate Finance Committees beginning on October 1, 2013 and each year thereafter.

Explanation: (This amendment provides $1.5 million the first year and $1.75 million the second year from the general fund to provided regional funding for child psychiatry and children's crisis response services. Budget language allocates funding to health planning regions based on the availability of services with a report on the use and impact of funding due annually beginning in 2013.)

VII. *Purpose and Restrictions for Use of the Funding*

These funds are intended to fill a significant gap in the comprehensive service array described in the 304.M plan. The comprehensive service array reflects a commitment to systems of care philosophy

and values. As such, services funded under this initiative should be child-centered, family-focused and community-based.

- Funding must be used for community-based services for children who would otherwise need publicly-funded inpatient or residential services.
- The goal should be to divert children from these services to less restrictive services, and to keep children with or as close to their families as possible.
- The target population for the services are children through age 17 who:

  (vi) have a mental health problem, and
  (vii) may have co-occurring mental health and substance abuse problems,
  (viii) may be in contact with the juvenile justice or courts systems,
  (ix) may require emergency services,
  (x) may require long term community mental health and other supports.

- These funds are restricted for at least this and the next biennium. The expenditures associated with them must be tracked and reported separately.

VIII. *Requirements for Proposals*

Please organize your proposal according to the following key elements, assuring that you cover each one:

1. Document the need for the proposed program – you may want to reference the 304.M Plan, the CSA Gap Analysis, regional hospitalization rates, emergency services utilization, etc.

2. Describe the specific crisis response service or services that you propose to provide. **All services must include a child psychiatrist.** Examples may include
   - *Mobile crisis response teams* – clinical team that goes to homes, schools and other community locations to help keep a child at home. Mobile teams are dispatched within 2 hours of a call to the CSB and are available 24 hours, 7 days a week. CSB emergency services may refer children and families to the mobile crisis team
   - *Crisis stabilization units* – short-term 6-bed or less units with 24/7 bed-based care to divert children from inpatient and residential care
   - Combinations of mobile crisis teams and crisis stabilization units
   - Favorable consideration will be given to proposals that leverage existing crisis stabilization units or mobile crisis response teams.

3. Describe how the proposed program assures that the services are **available to children across your region**? Crisis response services and mobile crisis teams are currently available in Virginia on a very limited basis. What approach will be used to extend the service or services beyond the CSB catchment area? Include letters of support, participation and endorsement from public and private partner agencies across the region.

4. Describe how child psychiatry will be provided to children directly served by the program, as well as child psychiatry consultation across your region? **Child psychiatry services *must* be a part of the proposed program**. The psychiatrist(s) (full or part time) should be

available to assess and treat children who are provided mobile crisis services or crisis stabilization bed services. In addition, describe how the psychiatrist will be available to other parts of your region by providing in-person, tele-psychiatry or telephone consultation and training to extend the reach of the psychiatrist to other localities. Collaborative partnerships where the psychiatrist works with pediatrician and family practitioner offices are strongly encouraged.

5. Describe a plan for service availability with **24 hour, 7-day, 365 days-a-year access** to services**.**

6. Describe the **staffing** for the program, including how you will implement a **team approach** to providing crisis response services. These services, whether provided on a mobile basis or residential crisis stabilization model, should use a multi-person clinical team approach, including licensed clinicians, case managers, child psychiatrists, psychiatric nurses and others.

7. Crisis stabilization services should maximize **preservation of the family unit** and help the child remain in the community in his or her own home, kinship or foster model home, or other small, integrated residential setting not larger than 6 beds in one site. Families should be fully engaged in decision-making and planning for the children served.

8. Describe approaches that will be used for **collaboration with other agency providers**, such as social services, juvenile justice, local schools, and others.

9. Private agencies are an important resource in each community and may play a role in the implementation of this funding initiative. Funded localities may contract some or all of the services with private providers. However, as the funded public entity, the region or CSB must retain oversight, accountability and overall responsibility for implementation of the services. **Describe how private providers may be involved in the proposed program.**

10. Other funding resources.

These state funds are intended to serve all children in the target population, regardless of payment source or family ability to pay. Therefore, children who are Medicaid recipients or mandated for CSA should not be prioritized for service, nor should CSA or Medicaid eligibility be the criteria for selecting children for the program. At the same time, your application should provide a plan for **maximizing CSA and Medicaid** for eligible children when appropriate. It will be expected that CSBs work collaboratively with other children's services partners, such as their Community Policy and Management Teams and private providers to appropriately serve children. Services should not be designed to meet minimum Medicaid requirements; rather they should address the criteria in this request for proposals..

IX. *Evaluation and Reporting Requirements*

The budget language in 315 #1c requires the DBHDS to report on the use and impact of this funding to the chairmen of the House Appropriations and Senate Finance Committees on October 1, 2013. **By submitting a proposal, the applicant agrees to provide the required narrative and numerical data reports to DBHDS and to assist DBHDS by providing the information necessary to make the report.** DBHDS will work with the funded entities to design an evaluation plan, identify appropriate data elements and will provide a brief reporting form for this purpose.

Evaluation of the programs will focus on desired outcomes, such as the following:

1. Number of children served who are maintained in their home through the use of the service.
2. Number of children served who are attending their home community school.
3. Number of children served who have not been hospitalized, arrested, placed in juvenile detention or other out-of-home placement within one year of service.

X. *Proposal Submission and Review*

Please submit a proposal, including any additional supporting information such as appendices or letters of support, as one package. The proposal submission package must include everything that is to be considered in the review of proposals. No letters of support, or other supplemental information, that are submitted separately will be considered as part of the review of proposals. Please do not have support letters mailed directly to the Commissioner or elsewhere at DBHDS. This is to assure that we have everything in one package that should be considered as part of the application. You may either send your complete application packet, including any attachments, electronically or in hard copy. On the front page of your proposal, please provide the email address of a contact person. We will email the contact person within 1 business day confirming that we have received your proposal.

DBHDS will convene a review panel to evaluate the proposals based on the proposal requirements above. The panel will make their recommendations for awards to the Commissioner. Individual awards will vary dependent upon actual amounts requested and the total number of sites selected. **Proposals must be submitted in one electronic submission or hard copy package to:**

Office of Child and Family Services
Department of Behavioral Health and Developmental Services
1220 Bank Street
Richmond, VA 23218

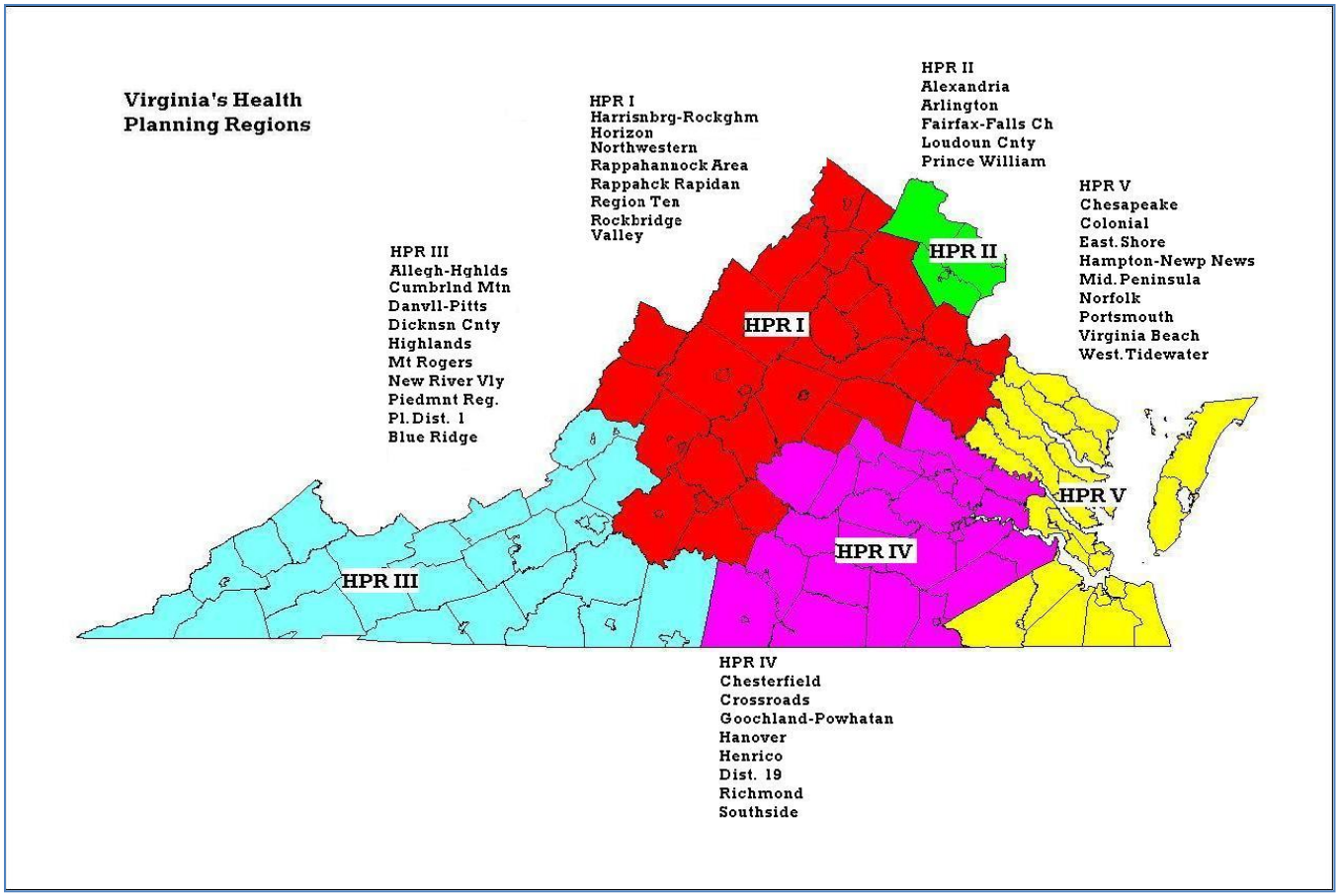
Due Date for Proposals: 5:00 PM on 7/27/12.

- DBHDS will notify the contact person by 7/30/12 that the proposal has been received.

XI. *Technical Assistance Conference Call*

A technical assistance phone conference for prospective applicants will be held at 10:00 a.m. on June 27nd. To RSVP for participation on the call, please reply to: [specific information included when distributed]

Appendix B: Map of Virginia Showing CSB and Regional Structure



Appendix C: State Facility Services Provided at the Commonwealth Center for Children and Adolescents

	FY2013 Admits Unduplicated	FY2014 Admits Unduplicated	FY2013 Admits	FY2014 Admits	FY2013 Readmissions	FY2014 Readmissions	FY2013 Bed Days	FY2014 Bed Days	Change in Bed Days	% plus or minus
Region I										
Harrisonburg-Rockingham	27	22	34	28	11	10	501	326	-175	-34.9
Horizon-lead	10	14	10	16	**3**	4	167	196	29	17.4
Northwestern	29	33	38	50	11	20	583	587	4	0.7
Rappahannock Area	25	15	31	16	13	7	548	280	-268	-48.9
Rappahannock-Rapidan	6	11	6	13	1	3	78	197	119	152.6
Rockbridge	4	11	5	13	1	4	62	101	39	62.9
Region Ten	25	43	30	52	14	21	577	614	37	6.4
Valley	46	58	54	87	21	47	511	1452	941	184.1
Total	***172**	***207**	**208**	**275**	**75**	**116**	**3027**	**3753**	**726**	**24.0**
Region II										
Alexandria	14	14	18	17	6	4	211	210	-1	-0.5
Arlington-lead	9	9	10	10	3	1	240	128	-112	-46.7
Fairfax-Falls Church	46	38	51	40	12	6	1320	794	-526	-39.8
Loudoun	16	14	21	14	7	3	325	246	-79	-24.3
Prince William	42	37	47	42	15	12	693	603	-90	-13.0
Total	***127**	***112**	**147**	**123**	**43**	**26**	**2789**	**1981**	**-808**	**-29.0**
Region III										
Alleghany	2	3	2	3	0	0	30	32	2	6.7
Blue Ridge	9	35	13	42	7	15	202	747	545	269.8
Cumberland Mountain	2	7	5	9	3	2	81	159	78	96.3
Danville-Pittsylvania	9	17	9	17	1	3	164	208	44	26.8
Dickenson	0	0	0	0	0	0	0	0	0	0.0
Highlands	16	18	17	24	3	10	249	368	119	47.8
Mount Rogers-lead	15	14	22	18	9	7	256	180	-76	-29.7
New River Valley	30	49	39	60	15	15	513	518	5	1.0
Piedmont	15	21	18	27	5	8	295	271	-24	-8.1
Planning District 1	4	10	4	12	1	2	51	120	69	135.3
Total	***102**	***174**	**129**	**212**	**44**	**62**	**1841**	**2603**	**762**	**41.4**
Region IV										
Chesterfield	10	20	12	26	4	12	228	663	375	130.2
Crossroads	12	4	13	4	4	0	230	166	-64	-27.8
District 19	20	22	24	25	7	8	357	312	-45	-12.6
Hanover	4	3	5	3	2	0	48	48	0	0.0

	FY2013 Admits Unduplicated	FY2014 Admits Unduplicated	FY2013 Admits	FY2014 Admits	FY2013 Readmissions	FY2014 Readmissions	FY2013 Bed Days	FY2014 Bed Days	Change in Bed Days	% plus or minus
Henrico	30	30	34	34	11	8	789	429	-360	-45.6
Goochland-Powhatan	0	4	0	4	0	0	0	69	69	
RBHA-lead	27	19	34	24	12	10	471	425	-46	-9.8
Southside	2	6	3	6	2	1	10	92	82	820.0
Total	***104**	***106**	**125**	**126**	**42**	**39**	**2193**	**2204**	**11**	**0.5**
Region V										
Chesapeake	3	8	4	15	1	9	39	339	300	769.2
Colonial	7	9	7	9	2	2	226	160	-66	-29.2
Eastern Shore	1	1	1	1	0	0	11	7	-4	-36.4
Hampton-Newport News-lead	9	8	11	8	2	2	169	119	-50	-29.6
Middle Peninsula	12	12	16	14	11	4	519	241	-278	-53.6
Norfolk	12	14	17	16	5	3	332	290	-42	-12.7
Portsmouth	2	4	2	4	0	0	28	132	104	371.4
Virginia Beach	14	11	15	13	3	4	279	194	-85	-30.5
Western Tidewater	5	7	5	9	2	2	92	91	-1	-1.1
Total	***65**	***74**	**78**	**89**	**26**	**26**	**1695**	**1573**	**-122**	**-7.2**

*Regional and statewide unduplicated totals may not equal the sum of the unduplicated totals by CSB