COMMONWEALTH of VIRGINIA

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October 1, 2016

The Honorable Thomas K. Norment, Jr., Co-chair
The Honorable Emmett W. Hanger, Jr., Co-chair
Senate Finance Committee
10th Floor, General Assembly Building
910 Capitol Street
Richmond, VA 23219

Dear Senator Norment and Senator Hanger:

Item 308. S. of the 2015 Appropriations Act appropriated funds "*to provide child psychiatry and children's crisis response services for children with mental health and behavioral disorders"*. The language also required the Department of Behavioral Health and Developmental Services to *"report on the use and impact of this funding to the Chairmen of the House Appropriations and Senate Finance Committees beginning on October 1, 2014 and each year thereafter."*

Please find enclosed the report in accordance with Item 308.S. Staff at the department are available should you wish to discuss this request.

Sincerely,

Jack Barber, M.D.

Enc.

Cc: William A. Hazel, Jr., M.D.
Joe Flores
Susan E. Massart
Mike Tweedy

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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:

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Virginia Department of Behavioral Health & Developmental Services

Report on Funding for Child Psychiatry and Children's Crisis Response Services
(Item 308.S.)

October 1, 2016

DBHDS Vision: A Life of Possibilities for All Virginians

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Report on Funding for Child Psychiatry and Children's Crisis Response Services

Preface

This report is submitted in response to Item 308.S. of the 2015 Appropriation Act to address the use and impact of funding appropriated for child psychiatry and children's crisis response services for children with mental health and behavioral disorders.

> *S. Out of this appropriation, $4,150,000 the first year and $6,650,000 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 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 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 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, 2014 and each year thereafter.*

Report on Funding for Child Psychiatry and Children's Crisis Response Services

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Executive Summary

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 Virginia. These services are in short supply due at least in part to the expense of such service models that 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 among the CSBs in a 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.

- DBHDS awarded funding through a request for proposals and application review process to each of the five regions. A map showing the primary DBHDS regional structure is attached as Appendix A. Each region has a lead CSB. The regional lead CSBs are:
- Region 1 - Horizon Behavioral Health,
- Region 2 - Arlington County CSB,
- Region 3 - Mount Rogers CSB,
- Region 4 - Richmond Behavioral Health Authority, and
- Region 5 - Hampton-Newport News CSB.

Overall, the regions have achieved good outcomes in maintaining children living in their homes with their parents and attending school. The regions also increased child psychiatry access through face-to-face visits, tele-psychiatry, and consultation with pediatricians and primary care physicians. Overall, there has been significant growth in the number of children who received child psychiatry services since the beginning of this funding initiative in FY 2013.
Item 308.S. provided $4.15 million the first year and $6.65 million the second year from the general fund for regional child psychiatry and children's crisis response services. Budget language allocates funding to regions based on the availability of services with a report on the use and impact of funding due annually.

The Request for Applications and Selection Process

When the funding first became available on July 1, 2012 (FY 2013), DBHDS issued a competitive request for applications (RFA) for regional proposals that addressed the key requirements described below. As new funding was added for FY 2014, FY 2015, and FY 2016, DBHDS asked the regions to respond to an updated RFA (Appendix B) to receive additional funding. A review team evaluated the regional proposals using a standard set of criteria, including a focus on the following requirements:

- Funding must be used for community-based services for children who can be served in their homes and communities to avoid or reduce the need for publicly-funded inpatient or residential services.
- The goal should be maintaining 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 use disorder 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 access to child psychiatric services. Additionally, crisis response services should include the following modalities.

1. Mobile crisis response teams – Clinical teams that go into homes, schools, and other community locations to help keep a child at home. Mobile teams are dispatched within two hours of a call to the CSB and are available 24 hours a day and seven days a week. CSB emergency services may refer children and families to the mobile crisis team.
2. Residential crisis stabilization units – Short-term, approximately six beds, with 24 hours a day and seven days per week bed-based care to divert children from inpatient or residential care.
3. Combinations of mobile crisis teams and residential crisis stabilization units.

As the funding has increased, services have grown in capacity across the Commonwealth. In the first year, FY 2013, five proposals were received, one from each region. Three proposals were selected: Region 1, Region 3, and Region 4. In FY 2014, Regions 2 and 5 were added. This report describes the services provided by all five regions from July 1, 2015 through June 30, 2016.

Summaries of Regional Programs

For this report, DBHDS asked each region to provide a progress report summarizing its work in FY 2016. DBHDS also asked the regions to share case vignettes that illustrate examples of how specific children and families used the services. A sampling of case vignettes is included as Appendix C.

Region 1 (Horizon Behavioral Health is the lead CSB for the region)
All Region 1 CSBs provide integrated care and wraparound services through their crisis intervention and stabilization programs. The region has chosen to place mobile crisis staff in each CSB to respond to immediate crisis episodes. Crisis clinicians collaborate with CSB emergency services staff to continuously identify children and adolescents who are in immediate need of crisis services in order to prevent hospitalization. Crisis supports are provided in home, school, and community settings. Crisis services also include: primary care linkage, psychiatric care linkage, private or state hospital discharge planning, and linkage of the child and family to ongoing care to prevent future crises. Horizon Behavioral Health provides crisis stabilization

services at their crisis stabilization unit. This program is a day program, provided for up to 15 consecutive days.

Recruitment of second and third child psychiatrists continues to be a challenge for the region. The region has filled the second position with locum tenens (locum tenens physicians fill in for other physicians on a temporary basis); however, this solution is more costly. Region 1 is actively recruiting for the two additional psychiatrists and/or nurse practitioner positions.

Region 1 served a large number of children during FY 2016. Medicaid reimbursement received from the provision of crisis services is reinvested into each CSB's program. However, due to the large number of children served, the region has identified a need for additional staff for crisis services.

Region 2 (Arlington is the lead CSB for the region)
The Children's Regional Crisis Response (CR2) program provides 24 hours a day, seven days a week ambulatory crisis stabilization services. CR2 provides short-term case management to ensure linkages with ongoing services in the community. Services use evidence-based, recovery-oriented models, and incorporate all of the following elements:

- Effective crisis stabilization of individuals referred to the programwith the goal of preventing or reducing psychiatric hospitalizations when clinically appropriate;
- Crisis supports and services to individuals and families 24 hours per day, 365 days per year;
- Linkages with appropriate community services;
- The ability to serve individuals with a high level of needs, including those with serious emotional disturbance, co-occurring substance use disorders, or intellectual or other developmental disabilities.

Service duration is designed to last 45 days, consisting of a tiered approach with two phases: an intensive phase for the first 15 days and a follow-up phase or the subsequent 30 days. Length of stay and duration of phases may vary based on the clinical needs of the child. These services are provided to the residents living within the service areas of the five CSBs in Region 2.

Staffing for this program includes 17 masters-level clinicians:

- One team leader, a mental health therapist who will provide supervision to the team and oversee all program management requirements;
- One licensed supervisor to assist with clinical supervision of the staff and support the program manager with program implementation as needed;
- Eleven Virginia licensed or license-eligible therapists or case managers to provide direct client care and case management services, and
- Four Virginia-licensed or license-eligible therapists who serve as child navigators to provide direct client care and case management services to youth with intellectual or other developmental disabilities.

All staff have experience providing crisis services to children with mental health needs and co-occurring substance use disorders or intellectual or other developmental disabilities and their families. Staff providing the services are fluent in the following languages: English, Spanish, Mandarin, American Sign Language, and Creole. The Language Line, a tele-communication translation service, is used as needed for individuals who require language supports that the team does not have internal resources to provide.

CR2 psychiatry services are contracted for up to 12 hours a week, for 50 weeks per year. The mobile crisis teams arrange follow-up appointments with psychiatrists in their respective jurisdictions, or with private-sector psychiatrists whenever possible. The contracting psychiatrist(s) is available within 24 hours or within five calendar days, depending upon the clinical situation. If the mobile crisis teams are unable to arrange an appointment with a CSB psychiatrist or private provider within 24 hours or within five calendar days, depending upon the clinical situation, an appointment will be made with the contracting psychiatrist(s). The contracting psychiatrist(s) is accessed using telemedicine. The team case manager will ensure that information is exchanged with the contracting psychiatrist, with proper releases in place, prior to the appointment. CR2 psychiatric services utilize tele-psychiatry from a team of psychiatrist(s) and physician's assistants from a medical practice located in Roanoke, Virginia.

There is a growing need for specialized services for individuals with an ID/DD diagnosis. However, CR2 has found access to those services to be slow and limited. Many children and adolescents and their families who receive services from CR2 could benefit from Children's Services Act funding for additional services and supports; however, linking to a Children's Services Act FAPT case manager has been challenging for several families the region.

Region 3 (Mount Rogers is the lead CSB for the region)
The geography of Region 3 results in a need for CSBs to be creative in their approaches to serving children in crisis. Two services are provided throughout the region: telepsychiatry and the Region 3 Youth Crisis Stabilization Unit (CSU). Telepsychiatry is provided via a contract with the University of Virginia (UVA) and has provided over 1,200 contacts since its start in 2013. Implementation of the crisis stabilization unit was challenged by difficulty in finding an appropriate building. These challenges have been overcome and the unit is now open and serving children.

Individual CSBs have developed services to address needs in their catchment areas and to establish an infrastructure to support the regional services as well. As each CSB experiences unique challenges and strengths in addressing youth and families in crisis, approaches have varied greatly.

- Mount Rogers CSB developed the PATH (Positive Alternatives to Hospitalization) program, which offers crisis intervention and ambulatory crisis stabilization services.
- New River Valley Community Services utilized an integrated healthcare liaison to strengthen its collaboration with a large pediatric practice that had a high volume of crisis referrals. The liaison assists in improved identification of needs and expedited access to services.
- Blue Ridge Behavioral Health developed a Kids in Crisis program, which provides crisis counseling and intervention services in a variety of settings within a 30-45 day timeframe.

- Highlands Community Services used funding in two distinct ways: to support a youth emergency services specialist who provides face-to-face evaluations and establish The Safety Zone program, which provides center-based and ambulatory crisis stabilization services.
- Danville-Pittsylvania Community Services has struggled with recruitment of a crisis clinician in the area and has ultimately elected to pursue a position similar to the liaison position initially funded at New River Community Services.
- Piedmont Community Services Board has a dedicated preadmission screening evaluator for children's services, offering evaluations in office, community, and school settings. This position also provides ongoing crisis intervention services.

Staffing has been challenging for some CSBs for two primary reasons: not enough staff to meet the demand and under-qualified or non-existent applicant pools. Due to the inherent unpredictability of crises, it is challenging to develop schedules to meet the demands as they occur. Some CSBs have reported receiving multiple crisis calls a day and some days receiving none, making it difficult to effectively utilize staff time and program resources. Some positions have been left open for months due to applicants often being under qualified for positions requiring a graduate degree or professional license. Recruitment of professionals with advanced degrees and credentials has proven difficult at the majority of CSBs in Region 3. Although several schools of higher education are located in the region, graduates often move or take positions with private agencies instead of employment with the local CSB.

Region 4 (Richmond Behavioral Health Authority is the lead CSB for the region)
The Region 4 children's crisis response demonstration project just completed its fourth fiscal year of program operations. Numerous challenges have been overcome and have strengthened this program and its value to the communities it serves. The program has expanded access to non-CSB-linked youth and this has enhanced access and community collaboration.

The average daily census for the year, including the six beds and two day slots, was 4.15, with a low census of .87 recorded in August 2015 and a high of 7.07 in February 2016. The established pattern of low utilization during the summer months and high utilization during the school year continues. The average length of stay at the CSU in FY 2016 was 10.7 days. As part of discharge planning, the CSU linked children and families with public and private community resources including CSBs, schools, social services, court services, outpatient psychiatrists or therapists, pediatricians, intensive in-home services. Also linked were a variety of community resources such as theatre groups, mentoring programs, and activities related to youth interests.

Below is a summary of the responses from this year's customer surveys. Overall satisfaction remains high, although areas such as family improvement have slightly declined, which emphasizes another opportunity to re-assess what can be offered to respond to the varied and complex needs of the individuals and families served.

	How satisfied were you with the services received at the CSU at St. Joseph's Villa for Children?	Was the urgency of your crisis addressed at the CSU at St. Joseph's Villa for Children?	How likely are you to follow up with recommendations made by CSU staff?	Are you satisfied with your involvement with the CSU services for the children?	How satisfied are you with improvements in family relationships following the child's treatment at the CSU at St. Joseph's Villa for Children?
Youth Surveys	**84%**	**85% Yes**	**76%**	**80% Yes**	**73%**
Parent Surveys	**91%**	**93% Yes**	**85%**	**89% Yes**	**78%**

St. Joseph's Villa continues to partner with Insight Tele-medicine for 15 hours a week of psychiatry services provided by a child psychiatrist. There is a dramatic increase in the amount of contact and number of consultations per child between the child psychiatrist and the youth's prescribing physician in the community. This is a key element that impacts the goal to increase the capacity of child psychiatry services by reaching out to those community physicians who may not have specialized training in child psychiatry but who are prescribing psychiatric medications to children.

Southside CSB (SCSB) provides its community with emergency services that are available 24 hours a day and seven days a week. Outpatient services are available at every location on a walk-in basis so individuals can go through the triage process to determine their level of need, which can include an emergency assessment if necessary at any time during regular business hours. Outpatient services are doctor-driven, and individuals must see the psychiatrist to obtain an evaluation and approval of the individual service plan. Further, SCSB offers emergency psychiatric appointments on an "as needed" basis and opportunities to walk in for psychiatric services for individuals who have difficulty keeping appointments.

Children who are seen by emergency services but not sent to the hospital are referred to CSB services, including outpatient, case management, and psychiatry. For those individuals who do not want CSB services, referrals to community providers are offered. In addition, SCSB offers VICAP assessments, connection to intensive in-home and therapeutic day treatment programs, and contracts out for mentoring services and for youth whose parents request it.

In 2016, the regional partners worked to implement the new CReST services. This is a new approach in which staff is sited at various CSB partner locations. With RBHA's IT and electronic medical record staff support, the team lead set up an 800-number for CReST referrals, finalized the documentation for CReST services, secured the appropriate license modifications for the clinicians to be able to work out of other CSB sites, and developed promotional materials. Beginning in January, the team participated in a variety of clinical and crisis-oriented trainings, including those required for certified preadmission screening evaluators. Staff oriented

themselves to the different host CSBs, emergency services, child REACH, the child CSU, and other community resources for youth.

Between February and June 30, CReST provided crisis intervention services to 63 youth who received a total of 495 hours of intervention. In total, CReST fielded and assisted with 83 referrals to the program during this time with only family refusal of services as the reason for non-enrollment. Only one youth was hospitalized at the conclusion of CReST services, and all youth remained with their families. Nine children who were suspended from school at the start of CReST services were enrolled in school at service termination. Children receiving CReST services were linked with 67 ongoing services at the time of discharge that they may not have accessed otherwise, including psychiatry, CSB services, and intensive in home services.

Region 4 continues to recruit for a full-time child psychiatrist via collaboration with VCU Health Systems; however, none of the candidates interviewed earlier this spring were viable for these services at this time. That said, VCU's Virginia Treatment Center for Children continues to provide consultative services to the child REACH program, and it is now exploring options for providing CReST with two to three hours per week of direct psychiatry services as an interim solution.

Region 5 (Hampton-Newport News is the lead CSB for the region)
Region 5 has collaboratively enhanced region-wide child crisis services and psychiatric services through the following services and supports:

- The Children's Behavioral Health Urgent Care Center operated by the HNNCSB offers crisis intervention, comprehensive assessment and evaluation and crisis psychiatric services. The center is open from 9 a.m. – 5 p.m., Monday through Friday, with phone supports offered 24 hours per day and seven days per week.
- Psychiatry and tele-psychiatry services are available up to 30 hours per week in the region to increase the capacity of psychiatric services for underserved CSBs.
- There are children's mobile crisis units at each of the CSBs within the region. Two FTEs are funded for Colonial Behavioral Health, Middle Peninsula Northern Neck CSB, Virginia Beach CSB, and Western Tidewater CSB. The HNNCSB and NCSB have one FTE position each and are providing crisis intervention services. Chesapeake Integrated Behavioral Health, Portsmouth Department of Behavioral Healthcare Services and the Eastern Shore CSBs have been allotted one FTE each for a mobile crisis worker and are diligently working on getting the crisis intervention services up and running.
- There is a 24 hours per day and seven days per week regional response and funding for short-term crisis supports for all children with a developmental disability through the Child Reach Team operated by Western Tidewater CSB.
- There are quarterly crisis training events for the region coordinated and hosted by the HNNCSB.

Access to psychiatry services continues to be a challenge for the most of the region. All CSBs have access to some psychiatric time provided by full-time or part-time psychiatrists as well as nurse practitioners or physician assistants. There has been funding through the child crisis initiative for the utilization of tele-psychiatry. Psychiatric consultations to primary care physicians and other community stakeholders are available. The Children's Behavioral Health Urgent Care Center has played a critical role in providing urgent pharmacological interventions

for children in the region. These interventions prevent inpatient hospitalization and cover individuals during the wait time to be able to secure medication management at CSBs in the region, whether they are new individuals or are stepping down from inpatient care.

The primary barrier for crisis intervention continues to be finding sufficient resources to hire enough service providers to meet the increasing demand of crisis services in Region 5. The effort to make the service available on a 24 hour per day and seven day per week basis has required a great deal of creativity in terms of resource allocation. Furthermore, many CSBs in the region are struggling to provide outpatient therapy and medication management services that would be a part of the discharge plan from crisis intervention services. The wraparound services, including intensive in-home services, therapeutic day treatment services, and mental health skill building, are only being offered by private providers in most of the CSB areas. There are often delays in being able to access these very necessary services for the children in crisis. In addition, the Department of Medical Assistance Services has reduced a crisis intervention episode from 30 to seven days. This change further complicates linking children and families in crisis with the necessary supports to prevent escalation of the crisis.

Results and Statewide Data

CSBs report data on community services in the DBHDS Community Consumer Submission (CCS) application. The data provided in this report are 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 services, and
- Residential crisis stabilization services.

Because child psychiatry is included in the outpatient services category of CCS, separate data on child psychiatry services are not available from the CCS application. Because child psychiatry is an important part of this initiative, a manual report from the regions was used to gather data on child psychiatry services. These data are shown in Table 3 and provide the numbers of children who received each type of child psychiatry service. Throughout this section on results, data that show improvement in program outcomes are 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 preadmission screening mandated by the Code of Virginia that CSBs provide to assess the need for inpatient psychiatric hospitalization and other activities associated with the judicial admission process. Preadmission screening services are provided by certified preadmission screening evaluators who meet state requirements and have completed training

modules to assure their competency. All regions continued to provide more emergency services to children in FY 2015 than in FY 2014.

Table 1: Emergency Services					
Region	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**Percent Increase (Since 2013)**
1	1,777	2,133	2,682	**2,950**	66.01%
2	1,845	2,071	2,183	**2,301**	24.72%
3	1,692	2,437	2,531	**2,269**	34.10%
4	1,260	1,444	1,485	**1,501**	19.13%
5	986	1,325	1,656	**1,746**	77.08%
Totals	7,560	9,410	10,537	10,767	**42.42%**

Numbers of children are unduplicated. In fiscal year 2016, Allegany-Highlands moved from Region 3 to Region 1 and Southside moved from Region 4 to Region 3.

Outpatient Services (Child Psychiatry is part of this category)

Outpatient services include individual, group, and family therapy sessions provided in the office and other locations. 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. Most regions provided more outpatient services to children in FY 2015 than in FY 2014. Table 3 provides the child psychiatry services provided as part of this initiative.

Table 2: Outpatient Services					
Region	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**Percent Increase (Since 2013)**
1	5,729	6,540	6,690	**7,015**	22.45%
2	2,681	2,940	2,969	**2,962**	10.48%
3	6,266	7,032	7,171	**7,483**	19.42%
4	3,648	4,008	3,717	**3,264**	-10.53%
5	3,885	4,021	4,150	**4,094**	5.38%
Totals	22,209	24,541	24,697	24,818	**11.75%**

Numbers of children are unduplicated. In fiscal year 2016, Allegany-Highlands moved from Region 3 to Region 1 and Southside moved from Region 4 to Region 3.

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 5 served the largest number of children using all three approaches, with 3,775 children receiving a face-to-face visit with a child psychiatrist.

Child psychiatry services continue to be a successful aspect of this initiative, adding capacity in an environment of extreme scarcity of board-certified child psychiatrists. However, some regions still experience delays with hiring because of the shortage of child psychiatrists in the Commonwealth. Regions persistently advertise and utilize different approaches, such as locum tenens, to fill the need. Additionally, tele-psychiatry is used to increase access to child psychiatrists. Child psychiatrists provided face-to-face, tele-psychiatry, and pediatric consultative services to 5,243 children in Virginia, a considerable increase since the first year when only 520 were served. The largest number of children receiving child psychiatry services (3,214) was in Region 5.

Table 3: Child Psychiatry Services Provided by Each Region Compared by Year

Service	Region 1				Region 2			Region 3			
	2013	2014	2015	2016	2014	2015	2016	2013	2014	2015	2016
(1) Face-to Face	189	487	369	**503**				62	80	104	**103**
(2) Tele-Psychiatry	54	93	152	**524**	1	202	**105**	3	303	405	**412**
(3) Consultation	83	170	189	**112**		66	**12**	39	76	39	**50**
Total	326	750	710	**1139**	1	**268**	**117**	104	459	548	**565**

Service	Region 4				Region 5			Statewide Total				Percent Change (Since 2013)
	2013	2014	2015	2016	2014	2015	2016	2013	2014	2015	2016	
(1) Face-to Face	72	68	28		694	3775	**2953**	323	1329	4276	3559	1001.85%
(2) Tele-Psychiatry	18	89	153	**152**	106	133	**179**	75	592	1045	1372	1729.33%
(3) Consultation		11	51	**56**	11	23	**82**	122	268	368	312	155.73%
Total	90	168	**232**	**208**	811	**3931**	**3214**	**520**	**2189**	**5689**	**5243**	**908.26%**

Definitions used in collecting data on child psychiatry:
(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.
(3) Consultation services: total number of consultation contacts by the psychiatrist. Consultations include pediatricians, primary care physicians, other mental health professionals, or other psychiatrists.

The three approaches to child psychiatry have created greater flexibility and access to these critical services. In FY 2016, legislation requiring a face-to-face visit for prescribing certain medications has limited the use of telepsychiatry in some areas. The UVA Center for Telehealth has an exception to this, so regions that have contracts with UVA have not been affected. A stakeholder group is reviewing this legislation and making recommendations which will be very important to the provision of child psychiatry services through telemedicine.

Ambulatory Crisis Stabilization Services

Ambulatory crisis services provide direct care and treatment to non-hospitalized children and are available 23 hours per day. The goals are to avoid unnecessary 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.

Region 2, one of two regions to be funded in FY 2014, had the greatest increase and served the most children through ambulatory care in FY 2015. While Region 5 had the fourth highest number of children served, it significantly increased the number of children served from FY 2014 to FY 2015, as shown below in Table 4.

Table 4: Ambulatory Crisis Stabilization Services

Region	FY 2013	FY 2014	FY 2015	FY 2016	Percent Change (Since 2013)
1	419	281	270	**201**	-52.03%
2	1	1	488	**334**	33,300.00%
3	3	151	239	**311**	30,800.00%
4	6	25	19	**49**	716.67%
5	14	70	209	**267**	1807.14%
Totals	443	528	1225	**1,162**	**162.30%**

Numbers of children are unduplicated. In fiscal year 2016, Allegany-Highlands moved from Region 3 to Region 1 and Southside moved from Region 4 to Region 3.

Residential Crisis Stabilization Services

Based on needs identified in their proposals, each region has different needs and resources for residential crisis stabilization services. All residential crisis stabilization services are short-term and focused on maintaining family contact and returning children to their homes and schools.

St. Joseph's Villa and Region 4 have continued to analyze referral and utilization patterns 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 helped to maintain a steady number of admissions to the unit. With the allocation of new money for FY 2016, Region 3 was approved to open a residential crisis stabilization unit. They encountered significant start-up delays due to finding an appropriate building. However, the unit is now open.

Table 5: Residential Crisis Stabilization Services					
Region	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**Percent Change (Since 2013)**
1	18	0	3	**1**	-16,999.20%
2	1	0	45	**51**	5,000.00%
3	1	0	1	**0**	-100.00%
4	76	97	100	**90**	18.42%
5	3	1	2	**0**	-300.00%
Totals	99	98	151	142	**43.43%**

*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 regional programs reported the living status of children at the start of crisis response services and at the termination of crisis response services in the following categories:

- With parents
- Detention Center
- Foster Care
- Shelter Care
- Inpatient Facility
- Unknown/Not Collected

The data below for four fiscal years show that the largest majority of the children entered crisis response services while living with their parents and also remained in their parents' homes at the end of crisis services. This supports the intent of the crisis response services – to intervene when there is a crisis and maintain family and community stability.

Table 6: Living Status at the Start of Crisis Services by Each Region Compared by Year

Status	Region 1				Region 2			Region 3			
	2013	2014	2015	**2016**	2014	2015	2016	2013	2014	2015	2016
With parents	155	353	976	**2484**	1	276	334	150	212	431	695
Detention Center	2	4	6	**0**	0	1	0				0
Foster Care	4	7	17	**11**	0	7	7	19	12	17	36
Residential Placement		4	10	**11**	0	1	1	0	0	1	0
Shelter Care	8	0	0	**0**	0	0	0	0	0	0	0
Inpatient Facility	3	0	0	**0**	0	0	0	0	0	0	0
Unknown/Not Collected	0	0	3	**9**		2	22	0	1	10	11
Total	173	368	1012	**2515**	1	287	364	169	225	459	742

Status	Region 4				Region 5		
	2013	2014	2015	**2016**	2014	2015	**2016**
With parents	100	167	223	**265**	533	700	**814**
Detention Center		2	1	**2**		1	**2**
Foster Care	2	3	3	**8**	6	10	**16**
Residential Placement	3	4	2	**0**	23	15	**2**
Shelter Care	0	0	0	**0**	0	0	**0**
Inpatient Facility	0	0	0	**0**	0	0	**0**
Unknown/Not Collected	0	0	0	**0**	111	48	**16**
Total	105	176	229	**275**	673	774	**850**

Numbers of children are unduplicated.

Table 7: Living Status at the End of Crisis Services by Each Region Compared by Year

Status	Region 1				Region 2			Region 3			
	2013	2014	2015	**2016**	2014	2015	**2016**	2013	2014	2015	**2016**
With parents	158	353	985	**2476**	1	245	**321**	146	205	400	**693**
Detention Center	2	4	16	**8**	0	4	**0**	18	1	0	**0**
Foster Care	5	7	3	**15**	0	8	**5**	0	15	22	**38**
Residential Placement	0	4	5	**7**	0	5	**16**	0	1	2	**3**
Shelter Care	8	0	0		0	0		0	0	0	
Unknown/Not Collected	0	0	3	**9**	0	25	**22**	5	3	35	**8**
Total	173	368	1012	**2515**	1	287	**364**	169	225	459	**742**

Status	Region 4				Region 5		
	2013	2014	2015	**2016**	2014	2015	**2016**
With parents	87	150	219	**259**	518	685	**770**
Detention Center	0	0	0	**0**	5	2	**2**
Foster Care	3	5	3	**5**	6	9	**13**
Residential Placement	8	12	6	**11**	32	13	**6**
Shelter Care	0	0	0	**0**	0	0	**0**
Unknown/Not Collected	7	9	1	**0**	112	32	**59**
Total	105	176	229	**275**	673	741	**850**

Numbers of children are unduplicated.

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. Tables 8 and 9 below show school attendance at the start and at the end of crisis services. 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 8: School Status at the Start of Crisis Services by Each Region Compared by Year

Status	Region 1				Region 2			Region 3			
	2013	2014	2015	**2016**	2014	2015	**2016**	2013	2014	2015	**2016**
Attending	170	363	975	**2451**	1	277	**325**	154	201	408	**691**
Suspended	3	4	26	**50**	0	5	**16**	13	20	34	**37**
Expelled	0	1	7	**7**	0	1	**1**	0	1	5	**7**
Unknown/Not Collected	0	0	4	**7**	0	4	**22**	2	3	12	**7**
Total	173	368	1012	**2515**	1	287	**364**	169	269	459	**742**

Status	Region 4				Region 5		
	2013	2014	2015	**2016**	2014	2015	**2016**
Attending	100	164	223	**250**	342	586	**770**
Suspended	3	6	3	**15**	25	73	**21**
Expelled	1	3	1	**6**	2	5	**6**
Unknown/Not Collected	1	3	2	**4**	304	110	**53**
Total	105	176	229	**275**	673	774	**850**

Numbers of children are unduplicated

Table 9: School Status at the End of Crisis Response Services by Region and Year

Status	Region 1				Region 2			Region 3			
	2013	2014	2015	**2016**	2014	2015	**2016**	2013	2014	2015	**2016**
Attending	172	363	1000	**2498**	1	253	**338**	146	214	398	**713**
Suspended	1	4	5	**3**	0	5	**3**	13	4	13	**18**
Expelled	0	1	3	**8**	0	2	**1**	3	1	2	**2**
Unknown/Not Collected	0	0	4	**7**	0	27	**22**	7	6	46	**9**
Total	173	368	1012	**2516**	1	287	**364**	169	225	459	**742**

Status	Region 4				Region 5		
	2013	2014	2015	**2016**	2014	2015	**2016**
Attending	100	164	219	**264**	369	631	**749**
Suspended	3	6	2	**2**	2	14	**11**
Expelled	1	3	1	**5**	3	20	**6**
Unknown/Not Collected	1	3	7	**4**	299	96	**84**
Total	105	176	229	**275**	673	761	**850**

Numbers of children are unduplicated.

Conclusion

This report provides the opportunity to look at four years of implementation of crisis response and child psychiatry services using a regional model. Overall, the regions have achieved good outcomes in maintaining children in their homes, with their parents and attending school. This is a significant achievement, as research clearly supports that the best outcomes for children in crisis are achieved when family stability and unity are maintained and school attendance is not disrupted. Perhaps the greatest improvements in service capacity 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 5,689 in FY 2015 and 5,243 in FY 2016, a ten-fold increase over FY 2013.

Each service category of service has shown improvement since FY 2013:

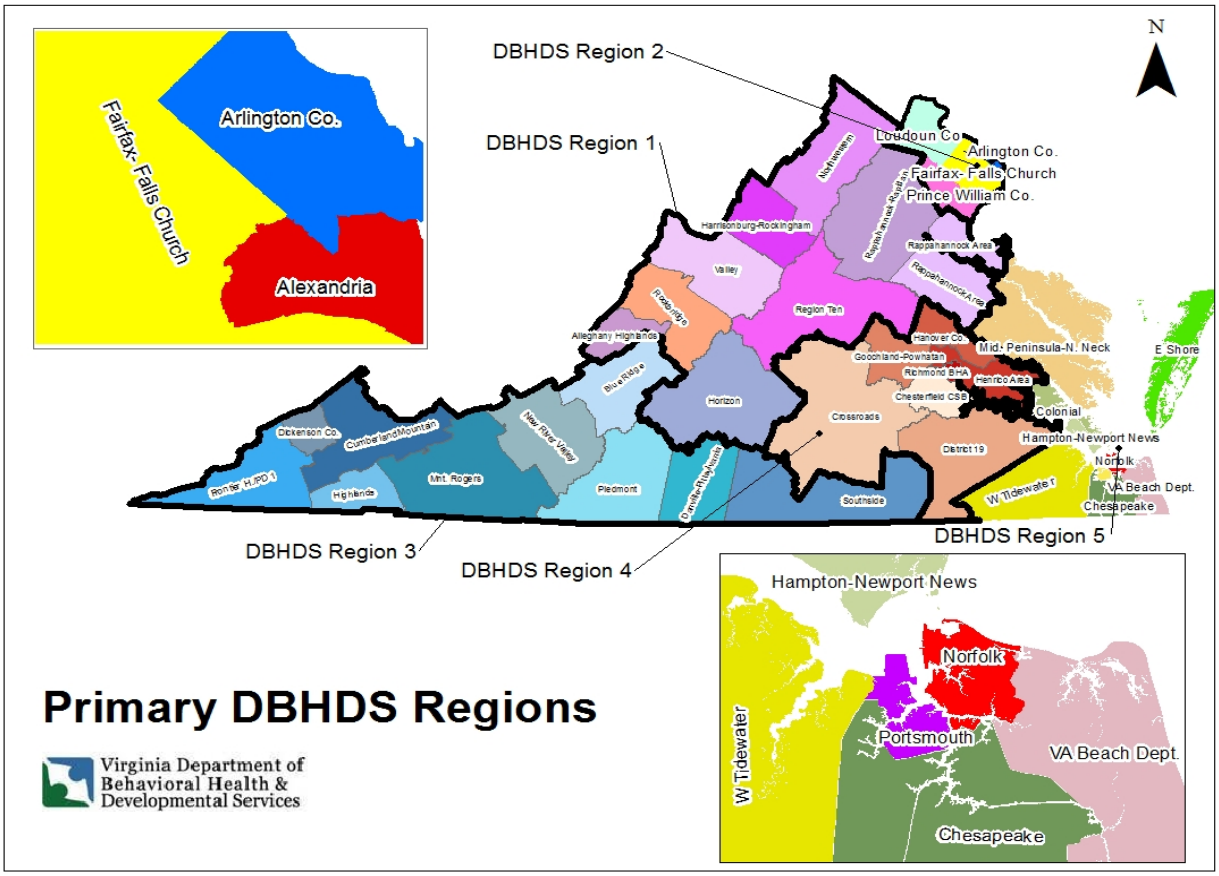
- **Emergency services – 42.42%**
- **Outpatient services – 11.75%**
- **Ambulatory crisis stabilization – 162.30%**
- **Residential crisis stabilization – 43.43%**
- **Child psychiatry services – 908.26%**

This new funding has created the opportunity to test service models and to determine where adjustments are necessary. These services evolved from recommendations in Item 304.M. "A Plan for Community-Based Children's Behavioral Health Services in Virginia," and the accompanying survey of available services. Using those recommendations as a guide, the regions have found the approaches that work best for their unique demographic and geographic needs. Their proposals for FY 2017 demonstrate a vision for future development.

While considerable progress has been made over the past four fiscal years, DBHDS will continue to analyze trends and challenges and strategize with the regions to increase accessibility to these important services. In addition, through our workforce development efforts, funded through federal grants, DBHDS will provide continuing education and opportunities for sharing experiences from the programs. This will be augmented with regional program meetings at service sites across the state, site visits and conference calls.

Appendices

Appendix A: Map of Virginia Showing Primary CSB Regional Structure



Appendix B: Request for Applications

Department of Behavioral Health and Developmental Services Instructions for Proposals for Community Crisis Response and Child Psychiatry Services FY2016

V. ***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 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 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 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 Regions based on the availability of services with a report on the use and impact of funding due annually beginning in 2013.)

VI. ***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.

VII. ***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.

VIII. ***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.

IX. ***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.

X. ***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 C: 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 15-year-old female was referred to mobile crisis services following her discharge from acute hospitalization due to suicide attempt by overdose. Prior to entering into services with mobile crisis the youth had an acute hospitalization. Upon returning home she continued to receive outpatient therapy services focused on substance abuse. While in substance abuse treatment, she began displaying more prominent depressive symptoms and was referred to mobile crisis services for more intensive treatment. The counselor utilized a person-centered therapy focus to aid in the identification of core triggers for depression. The counselor encouraged the ritualized implementation of journaling, active listening to challenge distorted thinking patterns, and positive affirmations to improve overall sense of self. Through education, coaching, and application, the youth was able to improve overall mood and reduce depressive symptoms. The counselor worked with the mother to provide education and implementation of behavioral expectations and effective communication skills to promote family stability. The mother was able to verbalize a greater sense of confidence in parenting skill level and increased appropriate empathic response to meet her daughter's needs. Wrap around services were identified and the youth is currently receiving outpatient counseling and psychiatric services.

- **Case Vignette- Residential Crisis Stabilization Unit (CSU)**

A 16-year-old male who lives with his father, step-mother, and siblings was referred to the CSU due to elopement, suicidal ideation, self-harming (head-banging), aggressiveness (physical and verbal) and other impulsive behaviors, including stealing a relative's car. These behaviors were precipitated by poor impulse control and heightened social anxiety. He was diagnosed with Autism Spectrum Disorder (ASD) Level 1 and ADHD at an early age. The youth and his mother got into an escalated conflict resulting in a physical altercation and elopement from home. His biological parents have been divorced for about 11 years, and have attended co-parenting counseling, reporting that it was not successful. The ongoing conflict between the parents impacts the youth's functioning, causing him to have increased anxiety and acting out behaviors. During this admission, the youth and his family acknowledged that they have difficulty understanding and supporting each other in stressful situations. The youth's father and step-mother stated that they do not know how to intervene when he starts to escalate. Everyone agreed that it would be beneficial to identify safety response plans and learn ways to support the youth when he is upset. The youth expressed wanting to feel understood by family members, to learn coping skills to reduce anxiety, and to have consistent expectations in both of his homes.

The youth responded well to art, mindfulness and strengths-based activities, in addition to role-playing and crisis response planning. He participated in tele-psychiatry sessions, which consisted of medication management, psychoeducation, evaluating crisis symptoms, and coordination with outpatient medical providers. Family sessions focused on developing an incentives plan to engage him in earning back his privileges. He developed the plan based on positive behavior, openly communicating with family, and successfully completing his

responsibilities. They also developed a crisis response plan that consisted of three stages of crisis as defined by color, presenting behaviors and signs, triggers, and risks. The parents successfully developed a parallel response plan to identify their natural supports, supportive responses, and community-based resources to contact.

The CSU staff coordinated with the youth's existing service providers, including REACH services and the local CSB to ensure a smooth transition into the community. Due to his interest in outdoor activities, he was referred to summer camps for adolescents who experience symptoms of ASD and he was provided information regarding online support centers and a social skills group. Through the therapeutic process, he and his family were able to initiate change in their family functioning by identifying their strengths, protective factors and improving their communication skills. Both parents were able to develop common household expectations and safety plans to implement. The youth expressed feeling "relieved" at the end of his treatment due to the understanding and support that the family reinforced during sessions in addition to learning new coping skills.

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

A 16-year-old male was referred to emergency services for pre-admission screening for possible objecting minor admittance. The youth lives with his mother, older brother, and older sister in a private residence. He had a previous diagnosis of ADHD, inattentive type. During the initial evaluation, he presented significant cuts on left arm. His mother reported history of physical aggression towards mother and older brother. He had one prior inpatient hospitalization.
The youth was able to reduce the frequency of cutting and verbal aggression towards his mother. He increased responsiveness with the crisis counselor and appeared to explore and process his thoughts, feelings, and beliefs which contribute to his strengths and maladaptive behaviors. His mother increased her awareness and insight into her son's mental health needs and gained increased abilities and skills with monitoring his safety. His mother presented decreased fear in regards to her and her family's safety.

At discharge, the youth evidenced improved mood and increased ability to abstain from self-mutilation, and decreased verbal aggression towards family members and he was referred to continue outpatient counseling and psychiatric services. The youth was reopened to child and youth mobile crisis 72 days after the initial discharge. The crisis counselor was contacted by his mother for suicidal ideation with a plan and relapse in self-mutilation behaviors. Upon assessment, the youth appeared to be encountering major depressive episode and presented desire to participate in crisis services rather than admission to inpatient treatment.

During crisis treatment, the youth responded to interventions, as evidenced by increased verbal communication, leading to further exploration of thought, feelings, and beliefs. He reported increased mood and self-esteem and efficacy throughout treatment. He was able to set short-term goals and utilized techniques for emotional coping. The crisis counselor referred the family to the Child Urgent Care for further crisis services and immediate psychiatric evaluation. Due to increased crisis services and psychiatric evaluation, the youth and his mother were able to identify PTSD symptoms. Upon discharge, the youth and his mother accessed case management services and continued with the Child Urgent Care's child psychiatrist for outpatient services.

Appendix D: State Hospital Services Provided to Children at the Commonwealth Center for Children and Adolescents 7/1/15-6/30/16

	Admits	Admits Unduplicated	Discharges	Discharges Unduplicated	Readmissions	Readmissions Unduplicated	Bed Days
Region 1							
Harrisonburg-Rockingham	16	15	16	15	3	2	217
Horizon-lead	20	17	20	17	5	3	213
Northwestern	32	27	32	27	10	8	587
Rappahannock Area	17	17	16	16	1	1	153
Rappahannock-Rapidan	13	10	13	10	6	5	296
Region Ten	31	26	30	26	15	12	444
Rockbridge	11	7	11	7	6	2	99
Valley	44	30	45	31	24	13	587
Total	**184**	**149 ***	**183**	**149 ***	**70**	**46 ***	**2,596**
Region 2							
Alexandria	9	7	9	7	3	2	137
Arlington	6	6	6	6	0	0	76
Fairfax-Falls Church	23	21	20	19	3	2	475
Loudoun	19	14	20	14	6	5	365
Prince William	32	29	32	29	9	8	577
Total	**89**	**77 ***	**87**	**75 ***	**21**	**17 ***	**1,630**
Region 3							
Alleghany	4	4	4	4	0	0	56
Blue Ridge	29	27	30	27	6	6	398
Cumberland Mountain	5	4	6	5	1	1	156
Danville-Pittsylvania	21	17	22	18	5	4	294
Dickenson	0	0	0	0	0	0	0
Highlands	19	17	19	18	7	6	216
Mount Rogers-lead	36	34	36	34	7	6	393
New River Valley	39	34	38	34	15	13	385
Piedmont	18	16	18	16	3	3	335
Planning District 1	6	6	6	6	0	0	70
Total	**177**	**159 ***	**179**	**162 ***	**44**	**39 ***	**2,303**
Region 4							
Chesterfield	24	21	23	20	6	5	329

	Admits	Admits Unduplicated	Discharges	Discharges Unduplicated	Readmissions	Readmissions Unduplicated	Bed Days
Crossroads	12	10	11	9	4	3	182
District 19	23	20	23	20	6	4	244
Goochland-Powhatan	1	1	2	2	1	1	33
Hanover	10	8	10	8	4	3	184
Henrico	46	36	46	36	17	9	568
RBHA-lead	22	18	24	21	7	5	335
Southside	6	5	6	8	1	1	75
Total	**144**	**119 ***	**145**	**121 ***	**46**	**31 ***	**1,950**
Region 5							
Chesapeake	27	21	27	21	7	5	377
Colonial	10	8	9	7	3	2	127
Eastern Shore	6	5	6	5	3	3	123
Hampton-Newport News	11	10	10	9	3	3	202
Middle Peninsula	21	18	20	18	9	7	364
Norfolk	31	28	29	26	11	9	521
Portsmouth	14	13	13	12	4	3	222
Virginia Beach	20	18	21	18	8	7	512
Western Tidewater	18	17	17	16	6	5	350
Total	**158**	**134 ***	**152**	**128 ***	**54**	**42 ***	**2,798**
Unknown/Out of State	**10**	**10 ***	**11**	**11 ***	**3**	**3 ***	**201**
GRAND TOTAL	**762**	**644 ***	**757**	**642 ***	**238**	**176 ***	**11,478**