
**Fort Lee Growth Management Plan
Phase II Implementation Tasks**

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Prepared for

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EXECUTIVE SUMMARY

A. HOTEL MARKET ANALYSIS

1. Background

The Lodging Success Program (LSP) at Fort Lee began in 2002, at which time there was one participating hotel. By 2009, the number had increased to 15, and is currently at 17 (totaling 1,818 rooms). The program was begun as a cost-saving measure by the Army and is currently in operation at 19 different bases around the country. The LSP process of contracting hotel stays begins with the Army's Family and Morale, Welfare and Recreation Command (FMWRC) issuing a request for hotels to bid on a military base's off-post lodging needs for the coming fiscal year. Such needs often arise where the supply of on-post lodging is unable to meet the amount of demand generated by temporary stays. In years past within the Fort Lee region, bidding hotels would state their number of available room nights and FMWRC would assign some portion of that figure to the hotels selected to participate. The selection process reflected minimum standards established by the Garrison Command Office and FMWRC.

In order to participate in the program, LSP hotels must offer an 8% discount from the current per diem rate as well as a \$2 per room night rebate to FMWRC (previously \$4 per night). Therefore, participating hoteliers must exchange certainty of room night capture and a discounted room rate in order to order to benefits of this stream of visitors. However, the LSP is the only official way for hotels to participate in serving these soldiers since they are required to stay at LSP hotels.

A number of changes that occurred related to the LSP process for FY 2010 have caused a shift in the off-post lodging landscape around Fort Lee. The following itemized list reflects those changes that have most impacted distribution of room nights to the LSP-selected facilities (in no particular order).

- **Beginning in FY 2010, the FMWRC required Fort Lee Study Region bidders with a list of scheduled courses that are expected to require lodging (referred to as the "J-3" in the bidding contract), as well as their duration and number of students.** The bidders then had to submit their room availability relative to the J-3, essentially outlining the room night demand they would like to service. Those hotels which meet the program's requirements (which include minimum standards of distance to post, security, functionality, and amenities) are then apportioned a share of the demanded room nights by the FMWRC. The LSP utilizes an indefinite delivery, indefinite quantity (IDIQ)-style contract, meaning that no assurance is made regarding the number of hotel stays actually delivered, but a minimum payment equal to 10% of the stays allocated to a hotel are guaranteed by the Army whether they are fulfilled or not by the end of the fiscal year. The J-3 used to contract the hotels for FY 2010 included some errors, including student loads that would actually be housed on-post, as well as courses that would be held on a different post besides Fort Lee.¹ A correct J-3 is currently being assembled.² It is possible that this discrepancy may have caused those parties involved to overestimate the demand for hotel stays, thereby causing participating hotels to also overestimate the amount of stays that they might capture. This miscommunication has bred confusion and mistrust from

¹ Email correspondence from a Program Management Specialist at FMWRC, 16 November 2009.

² Email correspondence from Traci Hackley, General Manager at Comfort Inn and Suites, Prince George, 6 November 2009.

the local hotel market and provided much of the framework for questions related to the validity of class load projections

- **The Army Lodging’s Central Reservation Center (CRC) began providing the reservation service for LSP stays, a task formerly performed by Fort Lee’s Lodging Office.** Soldiers receive their assigned hotel as part of their welcome letter from Fort Lee, but this assignment is not mandatory. Historically, Fort Lee Lodging has guided students to their assigned hotels to promote class unity and best meet the contractual obligations with the LSP hotels. However, anecdotal data indicate the CRC does not operate similarly. Located in Huntsville Alabama, the CRC provides reservation services for any hotel in the LSP program, without preference for the assigned facility. This provides the soldier with the option to stay somewhere different than where assigned. The compulsory nature of the previous method provided a relatively even disbursement of room nights among the participating hotels. It has been brought to our attention that visiting soldiers would not likely be familiar with the area, and generally choose a hotel within close proximity to Fort Lee (this assumption has been validated by interviews with local hoteliers). This new reservation process favors those hotels located most closely to the Fort, and puts those farther away at a disadvantage by shifting the concentration of stays to hotels closest to the Fort.
- **The Army moved away from central billing to individual credit card purchasing.** In the past, lodging costs for visiting soldiers was centrally billed and required the hotels to submit invoices for reimbursement. This system eliminated the potential for non-LSP hotels to house these soldiers, as oversight was held to a handful of facilities. However, the self-pay system requires oversight of thousands of individual reimbursement expenses. As such, the ability to monitor the final destination of the soldiers is much more onerous. In addition, soldiers are not tied to reserving through the CRC, as hotels are not involved in the final payment process. Simply put, hotels are not responsible for collecting money from the Army, and have less incentive to accommodate a soldier booking outside the CRC process.
- **Interviews with local hoteliers suggest that not all soldiers required to utilize the CRC for their stay are doing so, despite the instructions provided with the notification letter.** Instead, some soldiers are making their own reservations and bypassing the CRC. While some of these soldiers attend the hotel assigned to them, it was reported that there are instances where soldiers select other LSP facilities, non-LSP facilities and even venture into short-term apartment rentals. Some reports indicate soldiers are changing hotels during their stay in order to maximize their hotel benefits program rewards or to find lodging more suitable to their tastes. It is believed that soldiers are reimbursed even if not booking through the CRC and/or staying at an LSP-approved hotel as a result of the complexity of tracking each soldier individually. In any case, these stays are not reported to FMWRC nor are the rebates being sent.

The current system no longer evenly distributes LSP hotel stays among the contract hotels and anecdotal evidence indicates that some LSP stays are occurring in non-LSP hotels. In addition, the exact location and number of soldiers staying off-post as part of the LSP program is unclear, causing concern among the hotel community that the Army is not delivering the expected number of stays to the Fort Lee market (discussed in the previous chapter). In December 2009, RKG submitted a FOIA request through Congressman Forbes (VA) office requesting data from FMWRC that would detail where soldiers booking through the CRC are staying. However, this information was not provided to the Consultant prior to the deadline of this project.

These factors have culminated in a situation that no longer evenly distributes LSP hotel stays, with reports indicating some of these stays are being captured by non-LSP hotels. In addition, the exact location and number of soldiers staying off-post as part of the LSP program is unclear, causing concern among the hotel community that the Army is not delivering the expected number of stays to the Fort Lee market (discussed in more detail throughout this analysis). The Consultant submitted a formal FOIA request through Congressman J. Randy Forbes (4th Virginia) office on December 10, 2009 requesting data from FMWRC that would detail where soldiers booking through the CRC are staying. However, this information was not provided to the Consultant prior to the deadline of this project. The August announcement that the 1,000 room Temporary Living Quarters (TLQ) had received funding caused further confusion and concern within the community, since this facility will draw military stays out of the private sector and onto the Fort.

2. Findings

The concerns related to the TLQ and reported problems with the LSP hotel stays are compounded by the impacts created by the national economic downturn and its effects on the lodging industry. The Fort Lee Study Region (see Map 3-1) lodging market historically has performed very well. Prior to 2008, market demand increased steadily bringing occupancy rates above 70% for the market as a whole. Much of this success is related to activity at Fort Lee. Hoteliers report that Fort Lee has accounted for as much as 40% to 50% of all business within the Study Region. However, the economic downturn has resulted in a net decline in market demand each year since 2007. Concurrently, the development of more than seven new hotels and a total of 756 rooms have exacerbated the decline in occupancy levels. The Consultant estimates that the 2009 occupancy rate is 58.8%, or approximately 8% below 2008 levels.

The projected expansion of class load at the Army Logistics University (ALU) will have a substantial impact on the regional market, both short-term and long-term. The projected activity level for FY2011 will result in an additional 480,000 room-nights of demand for the private sector, a 40% increase in one year. The Consultant projects regional occupancy level of more than 81% during this period. Even with the operation of the TLQ facility starting in FY2012, the net benefit to the private sector will assist in negating the impacts of the economic downturn. In short, the growth in lodging business related to operations at Fort Lee are projected to add more than 66,000 room nights of demand above current estimate levels (436,350 room nights), or a 15.1% increase.

The greatest threat to the private market is over speculation. According to the Petersburg Area Regional Tourism Corporation, there are an additional 14 hotels totaling 1,123 rooms within the development approval process that have not yet begun construction. If these facilities are developed as proposed within the timeframe stated, it will result in a 43% increase in hotel rooms within the Fort Lee Study Market since January of 2008. Simply put, the projected market demand will not be able to support that many new hotels, as the downward pressure on occupancy will create a pricing competition that will drive some facilities to failure.

It is important to note there has been concern expressed about the viability of the ALU to deliver the amount of demand projected by the Army. ALU projections indicate the average daily load (ADL) of students at Fort Lee will increase from approximately 1,000 in FY2009 to approximately 2,450 in FY2011 when all new training entities are operational on post.³ Based on the Consultant's analysis, the ALU will need to deliver a minimum of 2,100 ADL once the TLQ facility is operational to maintain equilibrium with current LSP business levels for the private lodging market. Given the uncertain times our nation is still facing locally and globally, substantial changes in training needs could impact the Fort Lee Study Region lodging market. While the data provided by the ALU and the Army are the best information available at this time, the concern about future

³ Projections do not include numbers from the Transportation or Ordnance Corps, which did not have confirmed projections at the writing of this report.

needs and the ability of the Army to meet the 2,100 average daily load threshold to avoid adverse impacts to the private market are reasonable.

3. Lodging Success Program Impacts

The combination of the growth in Fort Lee-related, private sector lodging stays combined with the unforeseen impacts of the changes to the LSP process are projected to cause a reallocation of demand within the Fort Lee Study Region. The projected net increase in LSP stays throughout the private sector will shift hotel capture for those LSP-qualified facilities closest to Fort Lee. These hotels likely will capture this new demand due to their proximity to post. As a result, some of their non-LSP business is projected to be displaced to facilities less competitive in capturing the new LSP demand.

Furthermore, the changes in the LSP reservation system and the inefficient oversight of actual stays have allowed individual soldiers to make choices in hotels, rather than follow the prescribed facility assignment. At a base level, the Central Reservations Center has noted that the reservations process has not encouraged students to adhere to their hotel assignments as diligently as had been done through Fort Lee Lodging. Further analysis revealed that soldiers have circumvented the CRC and official LSP reservation process and booked rooms independently. Data provided by current and former LSP participants indicate this has created an imbalance in room night capture within the market. Most notably, there are confirmed reports that ALU students are booking rooms at non-LSP hotel to take advantage of personal preference or brand loyalty.

While the Fort Lee Study Region lodging industry as a whole is projected to experience a net benefit as a result of the increased Fort Lee operations *after* the opening of the TLQ facility, individual hotel operations will be impacted differently. The uncertainty and ineffectiveness of the current LSP procedures has caused a reallocation of demand within the region. Simply put, some hotel operations have reportedly received a disproportionate share of the Fort Lee LSP business while others have experienced a net loss. Unless the reservation system is adjusted, this trend is projected to continue into the future, with a favorable outlook for the Study Region as a whole but accompanied by a loss for specific hotels.

4. Consumer Spending Analysis

In addition to studying the potential impacts the TLQ facility will have on the Fort Lee lodging industry, the Consultant was retained to analyze the potential impact the proposed new commercial operations on Fort Lee will have on the private retail/service market. Simply put, the economic downturn has impacted local retail and service businesses. Given the BRAC action at Fort Lee includes the development of some new commercial venues, questions were raised as to the potential impact these businesses will have on private ventures outside the gates. To this end, the Consultant studied the current and proposed retail/service offerings at Fort Lee and the spending impacts created by the projected increases in ALU student loads both on-post (in the TLQ facility) and off-post.

In total, there is approximately 304,000 square feet of retail space currently on Fort Lee. The new development projects, including the dining facility at the TLQ, represent an increase of approximately 20,000 to 25,000 square feet, or 8% to 9% over the existing supply. The two notable commercial projects currently under construction include the new car care center complex and the renovation of the Lee Playhouse. The car care center will have multiple businesses operating on-site and is projected to be completed and open in early 2010⁴. The project will be anchored by a Firestone car care center that will include 24 fuel pumps, several service bays and

⁴ Bell, T. Anthony. *AAFES Offers Update on Various Projects*. [Fort Lee Traveller](#). December 3, 2009.

a car wash. In addition, the complex will also include a Popeye’s chicken fast-food restaurant, a Class Six store and a shoppette (convenience store). The Playhouse is currently being transformed into a facility that will be able to show movies in addition to hosting theater events. According to the AAFES Business Operations Manager, the movie theater will have limited operating hours due to the facility’s multiuse program.

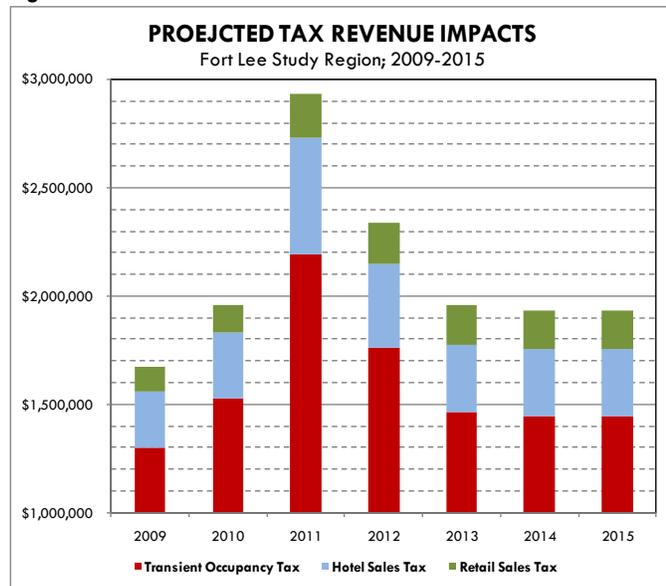
Two other commercial projects in the pipeline are slated to begin construction soon. The first is located in the northern part of Fort Lee. This project will include a shoppette and a barber shop. According to AAFES, these businesses would be the third on-post shoppette and the fourth barber shop, respectively. In terms of the TLQ facility, there is a proposed 300-seat dining facility to be included in the TLQ facility. Although there are no details about the operation or dining type of this facility, this new eatery likely will draw students who are staying at the TLQ.

The Consultant performed a survey of ALU students to better understand the spending habits and needs for on-post and off-post venues. Based on the findings of this effort, the new commercial space proposed on Fort Lee is relatively disproportional to the likely increase in spending related to the net personnel growth. As such, it is likely that business activity occurring both on- and off-post will experience modest levels of increased business activity due to the increase in area military personnel.

5. Fiscal Impact Analysis

The next several years are projected to deliver millions of dollars in tax revenue to the Fort Lee Study Region municipalities. The economic impact analysis indicates that the six Crater PDC jurisdictions most impacted by the Fort Lee expansion will realize a cumulative increase in transient occupancy tax and local sales tax related to hotels stays and retail expenditures (Figure 1). The Region is projected to experience a one-time windfall of tax revenue of \$1.4 million during FY2011 and the beginning of FY2012. This windfall ends as a result of the opening of the TLQ. At this time, the amount of transient occupancy tax (TOT) revenues and hotel-related sales tax revenues are projected to decline to a level below the peak,

Figure 1



Source: Crater PDC and RKG Associates, Inc. 2010

but above current revenue estimate levels. However, the Study Region also is projected to experience a sustained net increase in tax revenue of more than \$260,000 annually as a result of the increase operations at Fort Lee accounting for the impacts of the TLQ facility.

As already mentioned, the shift in lodging demand allocation due to the increased market activity and the inefficiencies in the current implementation of the LSP has resulted in creating bigger “winners” within the Study Region in terms of net new tax revenues. The data indicate that Colonial Heights and Chesterfield County are poised to experience a larger share of this net gain over communities such as Hopewell and Petersburg. While the details of the retail sales tax revenues are not complete for a jurisdiction-level analysis, it is reasonable to assume Prince George County will benefit the most, as the County collects all on-post sales tax revenue.

Given the imminent increase in hotel stays, the most effective means by which a municipality might try to increase its projected tax revenues may be to increase its TOT rate and the length of stays that qualify for exemption. Colonial Heights serves as a prime example, utilizing an 8% rate (among the highest) and only exempting stays of more than 90 days, while all other municipalities exempt stays of more than 30. This is significant given that approximately 90% of all LSP stays fall below 90 days, while only 20% fall below 30 days. This situation is evident in the fact that Colonial Heights only hosts four of the Study Region’s 57 hotels (7%), but is projected to capture up to 30% of collected TOT and 17% of hotel-based sales tax related to Fort Lee stays in 2012.

B. HEALTHCARE ANALYSIS

1. Introduction

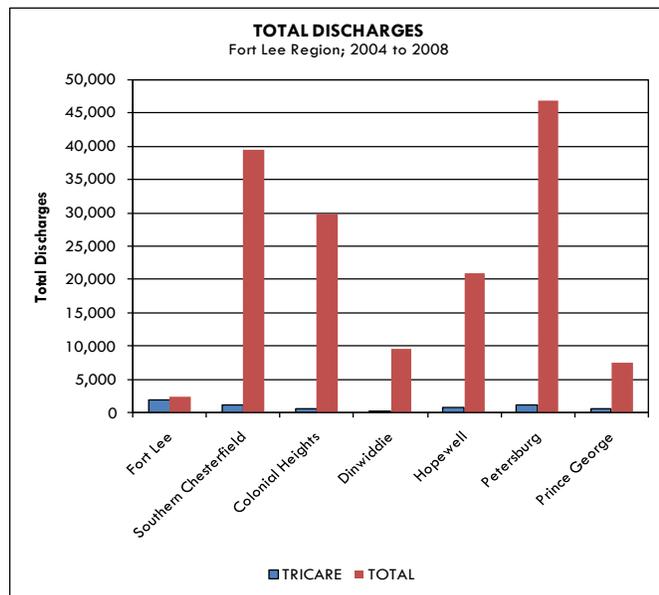
RKG Associates researched the increased demand on health care services relative to the incoming Fort Lee personnel. The assessment provides an examination of physician needs, in-patient service demand including behavioral/psychiatric needs, as well as cursory review of regional health care facilities and planned expansions both at Fort Lee and within the study area.

2. TRICARE Demand

The consultant analyzed TRICARE in-patient discharges in order to obtain a better understanding of the military use of health care in-patient services within the Crater region. Recipients of TRICARE include all active duty members and their families, retirees and their families, and survivors who are not eligible for Medicare. However, it is important to note that some military and retirees choose not to participate in TRICARE. Despite this limitation, the following analysis provides a general sense of the health services used by military service members and their dependents.

The data in Figure 2 shows the amount of TRICARE discharges of each county. As seen in the figure, the amount of TRICARE discharges within a community is relatively low compared to the total in-patient discharges. However, the amount of TRICARE discharges does vary depending on community, and tends to be highest within the Fort Lee, Petersburg, and Southern Chesterfield zip codes. In terms of in-patient demand, there are certain diagnoses that have higher levels of discharge than others. Psychoses and childbirth services are discharge diagnoses that have the highest rates of discharge in almost all the Crater Region communities.

Figure 2



Source: Central Virginia Health Planning Agency and RKG Associates, Inc., 2010

3. Poplar Springs Hospital TRICARE Demand

One of the main psychiatric providers in the Fort Lee Region is Poplar Springs Hospital, located in Petersburg, Virginia. The facility is currently licensed for a total of 199 beds, which include 75 acute beds (intensive treatment unit, adult, active military unit, and adolescent), 108 residential treatment beds, and eight group home beds. Programs include psychological and behavioral treatment for adults and adolescents aged 11-17, adolescent residential, sexually abusive youth services, and group homes.

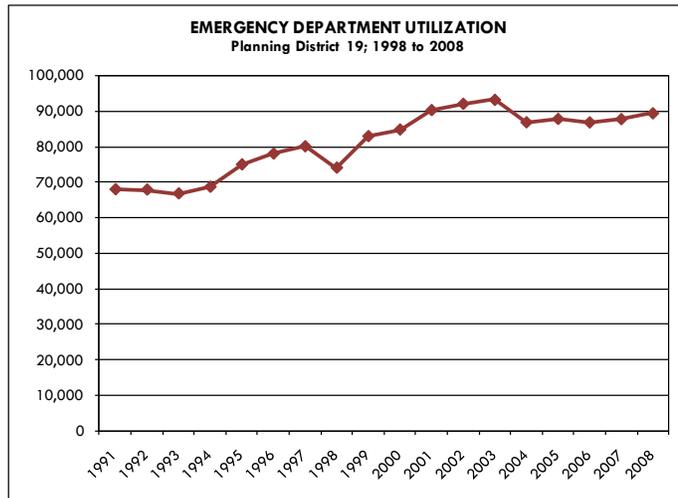
The Adult Acute program accounts for the most discharges in the region (405). The 24-hour acute care includes individual, group, family and marital therapies, groups for trauma survivors, activity therapy, life skills, education groups to deal with anger, loss, grief, substance abuse education, and medication management. The Active Duty Military acute program offers similar services, but is specifically designed to meet the needs of the active duty military. This program provides treatment for the emotional and psychological effects of combat stress and post deployment adjustment-related issues. Soldiers can then step down to a partial hospitalization program to assist with transitioning back to their duty stations.

In order to address the unique behavioral health concerns of the military, Poplar Springs has a strong partnership with the Community Mental Health Clinic at Fort Lee. The health clinic at Fort Lee provides admission and referrals, and Poplar works with the Clinic to form a discharge plan. The facility is also TRICARE Certified and they understand the unique needs of military families. Poplar continues to review how to best meet military needs, and there is a subcommittee that meets regularly to discuss expansion plans and how to refine or create new programs and services. Most recently, Poplar has applied for a new 28-day substance abuse program that will be an inpatient program only for the military.

4. TRICARE Emergency Room Visits

SRMC emergency room data by year indicates that there are a growing number of TRICARE visits. In 2006, there were 2,783 visits in the Fort Lee study area zip codes, which increased 13% to 3,131 visits in 2008. At the same time, the charge for these TRICARE visits increased by 68% to \$1,055,463. The rising cost of services is consistent with national trends. Meetings with healthcare professionals in the Fort Lee study area indicate that there are some doctors that choose not to participate in the TRICARE network because insurance reimbursement rates are too low to cover the increasing cost of providing services. Although the recent health care reform legislation, which passed in March 2010, is not planned to change TRICARE from the current framework, the comparatively low reimbursement rates offered by TRICARE will remain a critical issue for area providers into the future.

Figure 3



Source: Central Virginia Health Planning Agency and RKG Associates, Inc., 2010

In order to more obtain a more in-depth understanding of Emergency Room trends in the Fort Lee Region, the consultant obtained Emergency Room Department utilization data from the Central Virginia Health Planning Agency for Planning District 19. The following data includes all types of insurance carriers and does not break out TRICARE specific Emergency Room visits. However, it does provide a good understanding of how Emergency Room utilization has changed within the region. Planning District 19 includes Colonial Heights, Dinwiddie, Emporia, Greensville, Hopewell, Petersburg, Prince George, Surry and Sussex. Chesterfield is part of a different planning district (Planning District 15), and as such was not included in the following analysis.

Emergency Room utilization has increased almost 32% from 1991 to 2008 (Figure 3). In 2008, there were 89,450 ER visits, as compared to 67,891 in 1991. The increase in ER visits is likely due to increased population.

5. Kenner Army Health Clinic

The Kenner Army Health Clinic is the main out-patient facility which provides primary health care services for eligible customers. Specialty care and in-patient care is provided by network civilian healthcare partners. The number of referrals and visits to the Kenner Army Health Clinic has increased. In 2007, there were 12,256 referrals made to other network providers. The number of referrals increased in 2008 to 13,832 referrals (12.9% increase). Likewise, the number of visits increased by 14.2% from 126,863 visits in 2007 to 144,904 visits in 2008.

In order to better serve the growing number of military personnel and dependants, the Kenner Army Health Clinic has \$14.7 million dollars invested in current repairs and renovation projects. Current projects underway include renovating the behavioral health/social work services (which will occupy the entire third floor of the clinic), army substance abuse program, active duty clinic, preventative medicine, optometry and Bull Dental Clinic. There are also plans to create a new consolidated troop medical/dental clinic. It will be located in the new Ordnance area north of Hwy. 36. The troop medical center is planned to contain 20,545 SF and the new dental clinic is planned to contain 14,370 SF.

6. Southside Regional Medical Center (SRMC) Physician Needs Assessment

SRMC has developed a model for analyzing the physician needs of their service area, which includes Petersburg, Colonial Heights, Chester, Hopewell, Dinwiddie County, Prince George County, Southern Chesterfield County, Surry County, Sussex County and surrounding areas. The SRMC physician needs assessment shows a community need for most specialties. However, there needs analysis indicates a current adequate supply of both cardiologists and nephrologists.

7. Conclusions

The presence of Fort Lee in the Crater Region has largely influenced the medical needs of the communities. Although the Kenner Army Health Clinic provides a variety of services to military personnel and dependents, there is no emergency care or in-patient services offered on-base. That leaves the civilian health care partners to provide these types of services to the military personnel and dependents, as well as the general population.

In terms of in-patient demand, there are certain diagnoses that have higher levels of discharge than others. Psychoses and childbirth services are discharge diagnoses that have the highest rates of discharge in almost all the Crater Region communities. Creation of new programs at Poplar Springs Hospital, and the addition of psychologists/psychiatrists at local community health centers as well as on-post have been in response to the high demand for mental health services. However, it is imperative that psychiatric needs of the Crater Region population are further studied in order to best address the population living within the community. In fact, the Central Virginia Health

Planning Agency published a behavioral health study in 2009. It is an in-depth analysis of the behavioral health needs of the region and is available for download at www.cvhpa.org.

There are also a comparatively large number of childbirth related discharges in the Region. Many of these are planned pregnancies, however interviews with health care officials have indicated that there also is a teenage pregnancy problem. Programs put in place at Planned Parenthood have helped to reduce teenage pregnancies in Petersburg, and similar programs may need to be studied and implemented in order to reduce the number of childbirth related medical services in the region.

SRMC data indicates that is a shortage of physician specialties in the region. Although there is a medical cluster located in Richmond that provides many of the specialty services not directly located in the Crater Region, the need to fill medical physician slots is an issue found in communities all across the country. The J-1 visa program is one way many communities are solving the physician shortage problems. However, the hiring of foreign medical graduates also could bring cultural sensitivity issues for both the patient and physician.

Other approaches to decreasing the physician shortage could lie in a “grow your own” method that encourages high school and college students from medically underserved areas to practice medicine. For example, The Pennsylvania Governor’s School for Health Care, established in 1991, exposes advanced high school students to careers in a variety of health care fields. More than 100 disadvantaged and minority students from rural and urban underserved areas across the state participate in a five-week program in the summer between the junior and senior years of high school. A similar program in the Crater Region could help in filling local physician positions.

The most effective way to bring physicians to the Crater Region may be for the federal and state governments to increase Medicare, Medicaid and TRICARE reimbursement rates. Due to the high number of TRICARE participants in the area, many doctors are more dependent on this insurance program for payment for services. Increasing the reimbursement rates could attract more physicians which will help to provide better services for these insurance carriers. Health policy is a very complex issue, and it may take an array of approaches in order to best meet the needs of the Crater Region.

C. CSA ANALYSIS

1. Introduction

Providing adequate funding for social service programs is difficult for any jurisdiction or non-profit. In the Commonwealth of Virginia, the Comprehensive Services Act for At-Risk Youth and Families (CSA) dictates the funding responsibilities of Virginia local governments in meeting the social service needs of the community. The Comprehensive Services Act was created in 1993 as a state and local funding mechanism for meeting the needs of at-risk youth and their families. More specifically, the CSA is a collaborative system of services and funding that is child-centered, family-focused, and community-based. It is intended to be cost-effective when addressing the strengths and needs of troubled and at-risk youth and their families.

2. Interview Findings

RKG Associates conducted a series of interviews with the social service departments within the Fort Lee growth impact region in order to obtain a better understanding of the strengths and weaknesses of the CSA program and the challenges facing local municipalities. The following section highlights some of the main findings from those interviews.

- **Budget Uncertainty** - Interviews with social service department representatives indicate that meeting the match levels, especially for foster care or residential services, can be a difficult task. In addition, demand for CSA services are very hard to project on a monthly and annual basis. Some years, there may be no children with long-term residential needs, and other years there could be many with these types of needs.
- **Army/Community Service Coordination** - Limited hours of operation of the Army Community Services office can cause coordination issues. Army Community Services is open Monday through Friday from 8 a.m. to 5 p.m. and is closed on the weekends and holidays. It has been mentioned that it is sometimes important to get in touch with Army Community Services during the times they are closed. Longer operating hours or weekend operations were noted as ways to close this service gap.
- **Community Services Cost Escalation** - Interviews with social service departments have indicated that there is little control over what non-profit or private service providers charge and there are limited options available to social services departments. Some needs are very specialized, and there may not be many service providers within the region to choose from. Residential services were cited as one example of where local social services departments may have to negotiate with residential providers located outside the region while trying to arrange an emergency placement of a child. The service providers understand the communities' financial obligation to provide services under CSA and they can exploit that circumstance. In addition, it was mentioned that service providers typically charge the same rates for all jurisdictions. As such, jurisdiction with small populations and budgets are charged the same amount as larger jurisdictions with substantially greater resources.

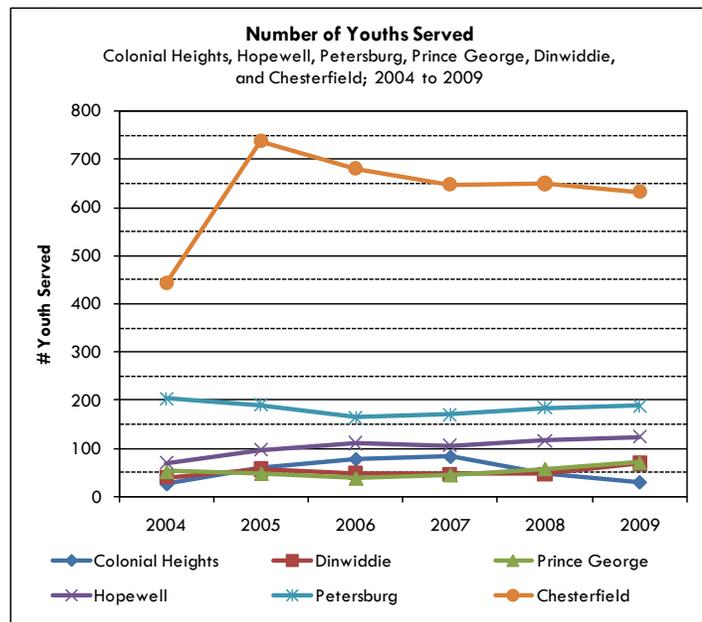
3. CSA Case Load and Expenditure Trends

The Commonwealth of Virginia maintains annual data about CSA usage and payments. RKG Associates has obtained and organized this data into tables which are located in the Appendix Section of this report. Each table has data on the types of CSA services provided, the number of youth served, and CSA funds expended.

The data in Figure 3 indicates the number of youth served has generally increased. As mentioned, the number of youth requiring CSA support is very difficult to project.

- **Prince George** - The number of youths served in Prince George increased from 45 in 2007 to 71 in 2009. In this jurisdiction, special education is a primary service need. In fact, interviews with the social service department confirm this and indicate that Prince George has a good reputation throughout the region

Figure 3



Source: VA Comprehensive Services Act and RKG Associates, Inc., 2009

for providing special needs services. However, this jurisdiction is having difficulty keeping up with the demand for services. CSA costs for Prince George have increased from \$590,039 in 2007 to \$1,138,415 in 2009.

- City of Hopewell - The number of youths served in Hopewell has also increased from 70 in 2004 to 124 in 2009. Special education day services account for the largest proportion of youths served. Although there was a spike in community based interventions in 2008 (18 youths served) the cost for these services is relatively low compared to other services covered under CSA. In fact, the cost for CSA services only increased about 9% from 2004 to 2008, despite the 77% increase in the amount of youth served.
- City of Colonial Heights - Colonial Heights has very erratic amounts of at-risk youths served on a yearly basis. In 2007, a high of 83 children were served, which decreased to 29 in 2009. Likewise, CSA costs reached a high of \$752,645 in 2007 which decreased to \$246,629 in 2009. Currently, special education day placement and special education other day services account for the largest share of services provided. Similar to many other communities in the region, there is a high demand for special education services.
- Dinwiddie County - Dinwiddie has a comparatively smaller population than other jurisdictions within the Fort Lee region, and as such there are less youth served under the CSA. Although there are a comparatively small number of youth served in Dinwiddie compared to the rest of the immediate region, the fiscal impacts of the CSA services have a large impact on the social services budget. In 2009, there were 69 youths served. These services cost a total of \$642,669. Interviews with social service departments indicate that even one or two more children in foster care or residential treatment facilities could severely impact their budget.
- Chesterfield - The data for Chesterfield is for the entire county. Unfortunately, it was not possible to separate out data related to the southern portion of the County. However, the trends for Chesterfield indicate that the amount of at-risk youth served has ranged from 650 to 700 for the past three years. Residential treatment facility costs have been disproportionately high compared to other services. This service is the only CSA service that had costs over \$2 million.

4. Wraparound Service Delivery

Due to sky-rocketing costs, growing attention is being focused on lowering residential care costs and increasing community based services. The local match rates for CSA programs that fall under community based services have therefore recently been reduced by approximately 50% from each counties baseline match rate. At the same time, as a disincentive to long-term residential placement, the local match rates for these services have increased by approximately 30%. Although there will likely always be a need for residential care placement, evidence suggests that providing more comprehensive services for at-risk youth can reduce the number placed in more restrictive environments (i.e., rehab centers, prisons, juvenile detention centers). The communities within the Crater Region may want to increase attention and resources on wraparound services and preventative care in order to reduce their costs.

5. Conclusions

The number of CSA services needed on a yearly basis is very difficult to project from year to year. However, certain steps can be taken to help bring down local matching costs.

- Coordination Among Crater Region Social Service Departments - It is recommended that the region's social service departments continue to coordinate with each other on their overlapping service needs. To a limited degree this is currently happening, but not sufficient to work through difficult CSA cases that might involve multiple jurisdictions. There may be an opportunity to create a partnership among the communities, similar to that found at New River Valley Community Services (NRVCS). Each of the five localities within the NRVCS set aside an annual amount of funding to NRVCS and appoints representatives to the agency's Board of Directors. There are 13-volunteer board members that are appointed by each of the five jurisdictions. This type of structure may be a viable option for the communities in the Fort Lee.
- Coordination Among Army Community Services – Interviews with social service departments indicate that they would like to have increased coordination with Army Community Services. It is recommended that Army Community Services and the Crater Region social service departments hold regular meetings to discuss service and informational needs.
- Streamline Tracking of CSA Youth From Military Families – As mentioned previously, projecting CSA usage into the future is a very difficult task. However, in order to better prepare for times when there is military growth, it is recommended that jurisdictions within the region streamline the tracking system of military children. Currently, there does not seem to be a consistent method used by jurisdictions to keep track of military children served. Having an easily accessible database with this information can give county social service department administrators a better sense of the likely increases in services they will need to prepare for.

One possible way to get a better sense of the military children that require services is to administer an end-of-the-year survey to the parents of all public school students that require special education services. This would not be an indicator of new military children entering the system; however it could provide a good sense of the baseline number of military children that would need services from year-to-year.

It can be assumed that the demand for CSA programs will continue to increase in the future. In order to keep matching costs down, new community-based interventions and techniques will be needed, as well higher levels of coordination among impacted communities. Increased communication between all the social service departments would help to begin the process of finding solutions to the potential CSA cost and funding issues. Similarly, closer coordination with Fort Lee would assist in meeting the needs of military households.



HOTEL MARKET ANALYSIS

1 INTRODUCTION

A. PURPOSE AND NEED FOR STUDY

In the fall of 2009, RKG Associates, Inc. was retained by the Crater Planning District Commission to analyze the market and tax revenue impacts associated with the proposed development of a 1,000-unit Army lodging facility inside the gate at Fort Lee, VA. This new facility is projected to come on line by September 2011. The purpose and need of the study was defined by the host cities of Petersburg, Colonial Heights, and Hopewell and the counties of Dinwiddie, Prince George, and Chesterfield. The municipal impacts associated with this study include hotel/motel occupancy taxes, hotel/motel sales tax, and retail sales taxes.

In addition to the municipal impacts RKG was retained to analyze the market impacts of the proposed lodging facility on the region's private hotel/motel market. During August of 2009, Fort Lee Garrison Command presented the results of an Environmental Assessment of the temporary living quarters (TLQ), which relied on an earlier analysis prepared by RKG Associates and presented in the Fort Lee Growth Management Plan dated February 2008. This limited analysis was not part of the Fort Lee Growth Management Plan scope of services, but was prepared once it was apparent that the TLQ construction funding was in jeopardy and considerable market opportunities might accrue to the region's private hotel/motel market.

The hotel/motel market impact analysis examines: (1) changes in hotel/motel annual room night supply, (2) changes in projected annual room night demand by all market segments, and (3) changes in annual occupancy rates based on changes in room night supply and demand between 2009 and 2015. RKG Associates also prepared an impact analysis associated with the 17 Lodging Success Program (LSP) hotels that are under contract to provide hospitality services to Fort Lee-related personnel, in all its forms. The LSP hotel analysis examines how changes in Fort Lee demand over the 2009-2015 projection period will impact various hotel tiers. Hotel tiers in this context are categorized by their general proximity to Fort Lee. RKG Associates created a "gravity model" that distributed future hotel room night demand by a number of proximity, quality, and price factors

During the course of this analysis, a loosely-formed coalition of hotel operators and small business owners raised concerns about the potential impact that the proposed TLQ would have on the private hotel/motel market. These merchants are collectively concerned that constructing 1,000 new lodging rooms on-post will effectively pull hotel and retail spending from private businesses. In addition, the new facility would be constructed following a period of rapid expansion, which has occurred over the past several years. While RKG was not retained by the hotel coalition and did not meet with the group's leadership, interviews were conducted with a number of independent hotel operators to understand their concerns and to obtain information about their past and current operations.

To the extent possible, RKG has attempted to document all the future demand assumptions made by the Army relative to future training activities at Fort Lee. Unfortunately, it is very difficult for

the Army to truly know its future training loads several years in the future. Undoubtedly, these loads will fluctuate with changing needs and projections made in 2009 may or may not come to fruition. Given these limitations, RKG has taken a conservative approach to this analysis.

The impact analysis consists of the following sections:

- Introduction
- Lodging Market Analysis
- Lodging Success Program Analysis
- Consumer Spending Analysis
- Fiscal Impact Analysis

2 LODGING MARKET ANALYSIS

A. INTRODUCTION

This chapter provides a detailed assessment of lodging market trends and projections for an area defined as the Fort Lee Study Region. The Fort Lee Study Region includes all temporary lodging facilities within nine miles of the Fort Lee boundary (Map 3-1). This area reflects the area most impacted by Fort Lee operations, as identified and confirmed through the consultant's market research, interviews with local hotel operators and discussions with Fort Lee representatives. The results of this effort address the potential impact of the Fort Lee Temporary Living Quarters (TLQ) facility on the regional hotel market.

The analysis is divided into two sections. First, the Consultant researched past and current market trends relating to both Fort-Lee specific and private market influences. This effort established the framework for understanding potential market changes into the future. The second section details the methodology and results of the market projections calculated by the Consultant. The chapter culminates in a narrative and graphic review of the potential impacts created by the TLQ facility.

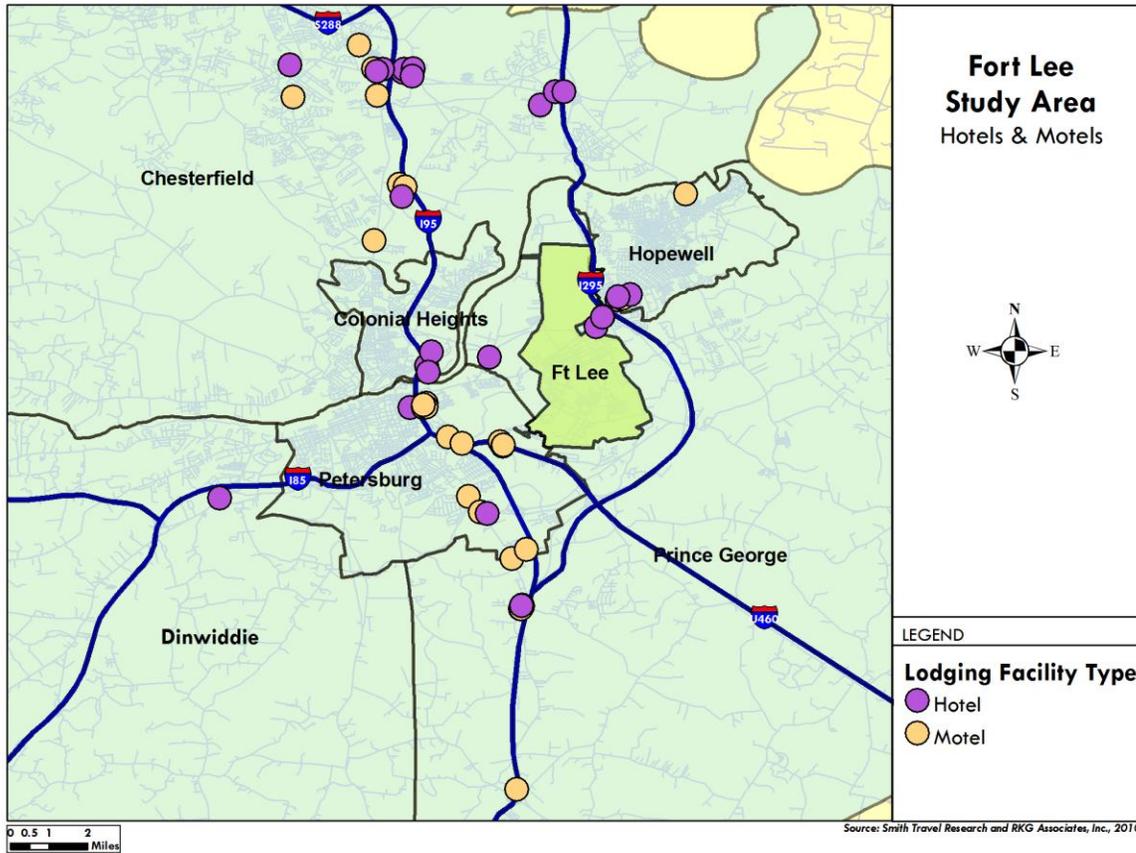
To complete this analysis, the Consultant used a variety of primary and secondary data sources. Most notably, the Consultant collected a myriad of data from the Department of the Army. Information was provided by the Family and Morale, Welfare and Recreation Command (FMWRC), the Army Logistics University (ALU), the Fort Lee BRAC Coordination Office and the Fort Lee Garrison Command Office, among others. Data also was provided by local hotel operators including those operators formerly participating in the Military Training Service Support (MTSS) and currently participating in the Lodging Success Program (LSP). Finally, the Consultant collected data from secondary sources including Smith Travel Research and ESRI⁵.

B. HISTORIC MARKET CONTEXT

1. Competitive Lodging Market

According to Smith Travel Research, there are 57 hotels and motels reporting regular data within the Fort Lee Study Region. These lodging facilities total approximately 5,100 rooms. The Consultant analyzed these facilities to provide the most accurate representation of trends in the local market. It should be noted that the majority of these hotels and motels operate under nationally-recognized banners, such as Hampton Inn and Super 8. While these branded lodging facilities comprise the majority of overnight options in the study region, there other hotels and motels that do not have the support of a national brand. In addition, most of the sole-proprietor hotels and motels do not report data to STR.

⁵ Smith Travel Research and ESRI are independent data vendors that provide market research and data tabulations of the lodging industry.



To better understand impacts that Fort Lee's ALU facility has on local operators, the Consultant also analyzed the market performance of the hotels that have participated in the housing program designed for the Army Logistics University. There currently are 17 lodging facilities under LSP contract for fiscal year 2010. However, the fiscal year began in October of 2009. As a result, there is not sufficient data available for the current LSP facilities to quantify the impact of the Fort Lee housing program. As a result, the Consultant studied the historic trend patterns for the lodging facilities that have consistently participated in the MTSS/LSP programs in the past (Table 3-1). The twelve facilities reporting data account for approximately 1,200 rooms.

2. Market Segmentation

In 2005, Randall Travel released a report for the Crater Planning District Commission (PDC) studying the market segmentation in the greater Crater region. For the purposes of this effort, the Consultant modified the segments from this report to more closely reflect the scope and purpose of this analysis. Most notably, market segments related directly to Fort Lee business were separated from the remaining categories. The result is a more comprehensive review of the factors impacting demand within the region. The Consultant utilized seven demand sectors to analyze the Fort Lee Study Region. The seven demand sectors include:

- Fort Lee – Lodging Success Program – The LSP program, and its predecessor the MTSS program, are the vehicles used by the Army to contract with local hotels for off-post, temporary housing for trainees at the Army Logistics University. All stays associated with the LSP program are included in this segment.

- Fort Lee – Official Business Travelers – The Army conducts business with multiple private-sector contractors and federal and military officials each year. These individuals and groups may stay in the area on a short-term basis for meetings or longer if a job or task requires their presence until completion.
- Fort Lee – Construction Demand – Projects related to the growth of Fort Lee often require out-of-town construction personnel. The most recent example of this need is the development of the new ALU center. Out-of-town construction crews that are contracted with the Army and/or specializing in various skills sets not readily available in-town were needed to complete this project. The length of stay for these crews is solely dependent on the contracted task.
- Business/Corporate Travelers – The corporate presence in the Fort Lee Study Region is comparatively small to the larger centers along the I-95 corridor, but still provides a significant generator of hospitality demand for the region. The areas closest to Richmond draw visitors from both markets. According to the Randall Travel Marketing report prepared for the Crater District Planning Commission on tourism in the region, more than 50% of room stays in Chesterfield and Colonial Heights were business travel related.
- Event-Related Travelers – Many of the hotels and motels that responded to the Randall Travel survey indicated a large percentage of guests were with a special event. Within this group are SERF (Social Educational Religious Fraternal) travelers, which encompass demand from sports travelers. For example, NASCAR-sanctioned events at the Virginia Motor Speedway fall within the SERF market segment. It should be noted that the generally accepted acronym is SMERF, which includes Military. However, military stays were separated for this analysis.
- Leisure/Tourism Traveler - In addition, tourism travel accounts for a portion of total room stays in the region. Most notably, the Petersburg region has a rich Colonial and Civil-War-era history that draws a substantial number of tourists each year. According to the Randall report, tourism travel accounts for between 5% and 20% of business for hotels that responded to the survey.
- Transient Demand – These users are travelers driving through the region en route to a different destination. This group accounts for a small, but significant percentage of demand as the study region is the confluence of North-South Interstates 85 and 95. These two routes connect the major employment and population centers of the Northeast including Washington DC, Philadelphia, New York City and Boston to similar centers in the Southeast (i.e. - Charlotte, Atlanta, Orlando and Miami). The Gateway region also is traversed by an East-West connector (U.S. Highway 460) that ties the Interstates to the Hampton Roads region and the expanding Port of Virginia.

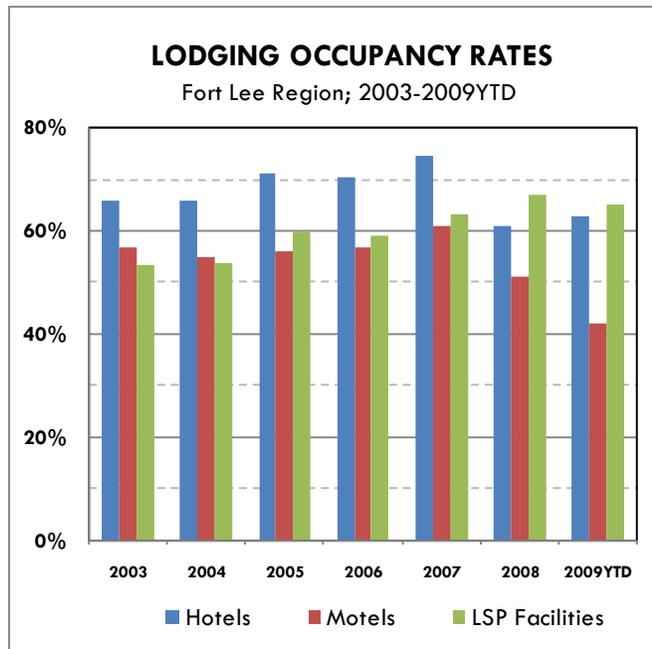
3. Annual Occupancy Trends

Hotels generally have outperformed motels since 2003 within the Fort Lee Study Region. The annual average for occupancy for hotels within the Fort Lee Study Region ranged from 61% in 2008 to 75% in 2007 (Figure 2-1). In contrast, the Study Region motels historically have maintained occupancy rates in the 50% to 60% range. Occupancy rates for regional hotels and motels have substantially declined since the start of 2008. Hotel occupancy has decreased from an annual high of 75% in 2007 to a sustained low around 62% in 2008 and 2009. Motel occupancy rates have decreased at a more severe pace, declining nearly 19% since 2007 to an annual average of 42% in 2009 (year-to-date).

LSP lodging facilities have experienced annual occupancy rates similar to those of local motels. Prior to 2008, the annual average occupancy rate ranged from 53.4% to 63.1%. However, occupancy levels in LSP facilities have increased slightly since 2007, and remain around 66%. It is likely that much of the drop in hotel and motel occupancy is a direct result of the national recession as businesses are reducing travel expenses. However, the consistency in occupancy displayed by the LSP facilities demonstrates the importance Fort Lee business, particularly the LSP program, has on area lodging.

It should be noted that sustained occupancy rates of 65% is a generally sufficient to attract investors to construct additional hotel rooms in a given market. The strong performance of the local market has attracted investment, with several hotels opening since 2007 (detailed later in this Chapter). The unfortunate timing of these investments, and subsequent expansion of the local lodging supply, has exacerbated the impacts of the economic downturn. It was reported to the Consultant that the announcement of Fort Lee’s expansion and the corresponding increase in potential business also contributed to the interest in new hotel/motel development.

Figure 2-1

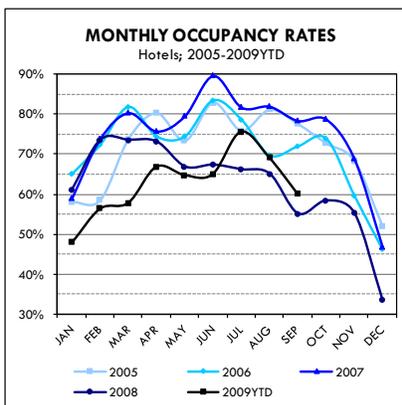


Source: Smith Travel Research & RKG Associates, Inc., 2009

4. Market Occupancy Trends

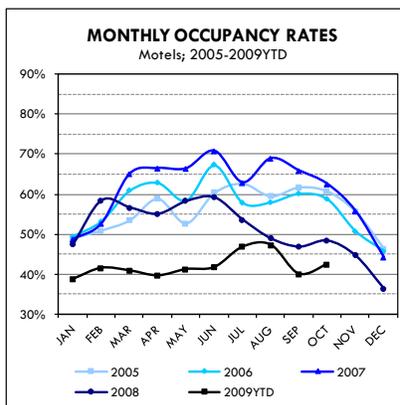
In terms of seasonal occupancy, the Fort Lee Study Region can be defined as a three-season area. Occupancy rates for hotels and motels have traditionally been highest between March and October, dropping substantially from November through January (Figures 2-2 and 2-3). However, seasonal fluctuations in motel occupancy are not as severe as with hotel occupancy. For instance, motel occupancy has remained around 40% throughout 2009 except for in July and August when occupancy rose to approximately 47%. This difference most likely is due to the

Figure 2-2



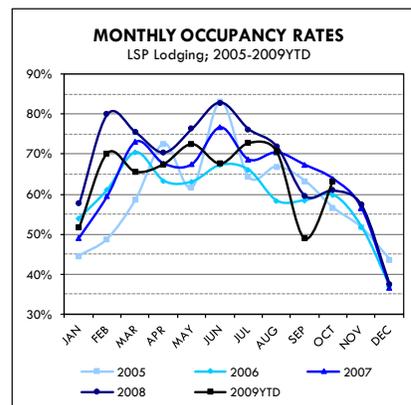
Source: Smith Travel Research & RKG Associates, Inc., 2009

Figure 2-3



Source: Smith Travel Research & RKG Associates, Inc., 2009

Figure 2-4

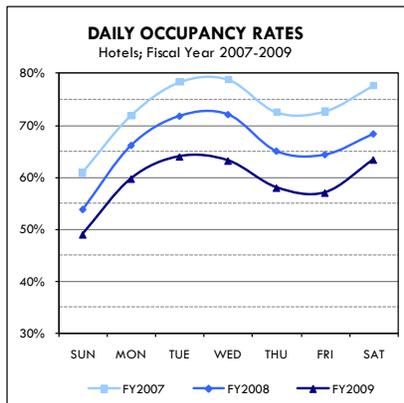


Source: Smith Travel Research & RKG Associates, Inc., 2009

comparatively lower occupancy trends for motels. Simply put, smaller absolute fluctuations in occupancy for motels reflect similar percentage changes as hotels. LSP hotels have recently experienced highest levels of occupancy during February and between May and August (Figure 2-4). These occupancy spikes coincide with historic attendance trends at the ALU facility, where spring and summer tend to have the greatest concentrations of student activity. Similar to the private market, the winter season typically is the slowest at the ALU in terms of training loads.

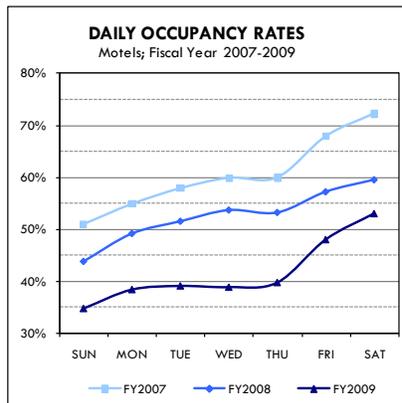
Daily occupancy trends indicate regional hotels and LSP hotels have a more stable level of demand throughout the entire week, while motels peak during weekends. Regional hotels and LSP hotels historically have had high occupancy rates on Tuesday, Wednesday and Saturday nights, indicating a balanced mix between business travel and vacation travel (Figures 2-5 and 2-7). However, the long-term stays of ALU students, which may last between three and eleven weeks, provide a more evenly distributed level of daily occupancy. In contrast, motels generally have thrived on their Spring/Summer weekend traffic (Figure 2-6) often attributed to leisure travelers seeking the greatest affordability. These trends reflect national market tendencies, as weekday travelers (particularly business travelers) tend to patronize hotels more than motels.

Figure 2-5



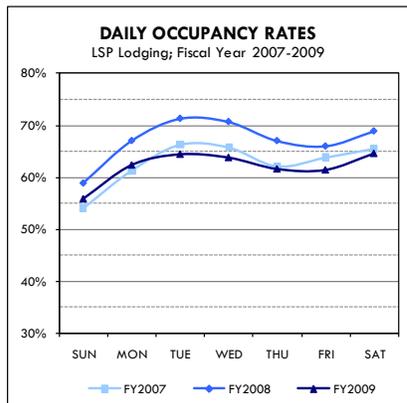
Source: Smith Travel Research & RKG Associates, Inc., 2009

Figure 2-6



Source: Smith Travel Research & RKG Associates, Inc., 2009

Figure 2-7



Source: Smith Travel Research & RKG Associates, Inc., 2009

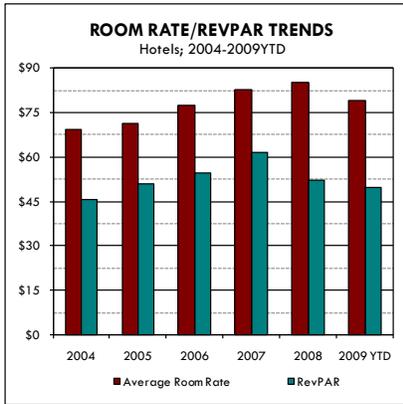
5. Room Rates Trends

The average daily room rate charged by a hotel is another indicator of the quality of hotels. Hospitality venues that have a relatively high room rate within a given market often offer better in-room and hotel-wide amenities. Within the Fort Lee Study Region, regional hotels have maintained the highest average annual room rates, ranging between \$69 and \$85 per night between 2004 and 2009YTD (Figure 2-8). In contrast, the motel sector Lastly, average annual room rates for regional motels has maintained substantially lower room rates than hotels, with average annual room rates ranging from \$43 to \$49 per night during the study period (Figure 2-9). This finding is consistent with national market trends, as motel operators attempt to maintain lower operation costs to be more financially competitive for the value-seeking demand sectors.

In comparison, the LSP hotel market typically has posted more modest room rate levels, as compared to similar hotel operators in the Study Region. LSP hotels have posted lower average daily room rates between \$5 and \$15 below the hotel market average (Figure 2-10). The difference most likely reflects the impacts of the region per diem rates for the Region, currently at \$70 per night. This figure is well below the posted rates for almost all hotels within the Study Region. Furthermore, LSP stays require participating hoteliers to provide an additional 8% discount below the market’s per diem rates as a requirement of participation in the program. The Consultant was able to confirm that all LSP regions within the U.S. require some discount below the

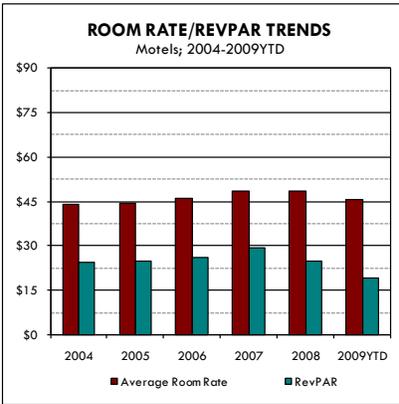
approved per diem rate; however the greater Petersburg region has the lowest per diem in the Commonwealth.

Figure 2-8



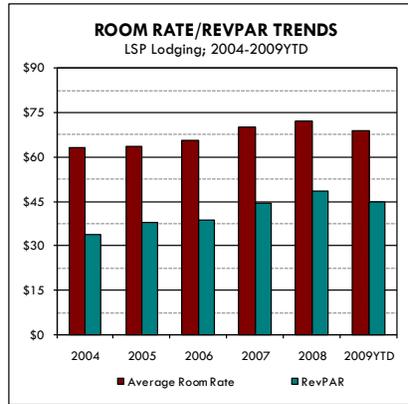
Source: Smith Travel Research & RKG Associates, Inc., 2009

Figure 2-9



Source: Smith Travel Research & RKG Associates, Inc., 2009

Figure 2-10



Source: Smith Travel Research & RKG Associates, Inc., 2009

Average annual room rates for regional lodging facilities peaked in 2008 after steadily increasing since 2004. It is likely that declining occupancy rates between 2007 and 2008 in part prompted the drop in average room rates for 2009. It should be noted that the room rates shown for 2009 reflect the average through September. However, room rates in November and December are typically among the lowest of any month; therefore, room rates for 2009 are likely to end slightly lower than the reported year-to-date (YTD) rates. Declining occupancy and room rates in the Fort Lee region indicate that most lodging facilities are operating with lower revenue streams, which likely limits operating efficiency.

6. RevPAR Trends

Revenue per available room, or RevPAR, is one of the most important measurements in the hotel industry for measuring hotel efficiency. In contrast to average room rates, which reflect the average daily rate charged for occupied rooms, RevPAR is a measure of average revenues per available room-night throughout the entire year. For example, a 100-room hotel has 36,500 annual room-nights (100 rooms x 365 days per year). If this hotel has an occupancy rate of 50% (18,250 room-nights) and gross revenue of \$1,825,000 for a given year, then its average annual room rate would be \$100 and its average annual RevPAR would be \$50 (annual gross revenue/total annual room nights).

While the average room rate only measures current market pricing, without regard to the effectiveness of that room rate, RevPAR measures the efficiency of renting hotel rooms during low occupancy periods. Therefore, hotels with high room rates may experience higher vacancy rates, resulting in lower RevPAR rates. While more aggressively priced competitors with higher occupancy rates will achieve a higher RevPAR and greater operating efficiency. For example, occupancy rates in lower-priced LSP hotels slightly surpassed that of regional hotels in 2008 and 2009 resulting in RevPAR rates becoming more comparable between the two lodging types.

Prior to 2008, operating efficiencies within the Fort Lee Study Region steadily increased. RevPAR increased each year between 2004 and 2008 for both local motels and hotels. This finding is significant when considering average room rate levels also increased steadily during this time period (Tables 2-8 and 2-9). Simply put, market demand was increasing without any commensurate increase in supply, allowing operators to increase room rates while not experiencing any net decline in occupancy. As mentioned, these conditions combined with the noted anticipation

of the impact of the expanded ALU created the opportunity for new hoteliers to enter the market. However, the economic downturn has adversely impacted both average room rate levels as well as RevPAR within the Study Region. While the average room rates for hotels and motels increased in 2008, the average RevPAR decreased more than 15% from 2007. Year-to-date 2009 market performance data indicates both average room rates and RevPAR levels have declined compared to the same period in 2008.

Despite the economic impacts of the changes in the national economy, LSP hotels have experienced a much less severe change in room rates and RevPAR (Figure 2-10). In 2008, LSP hotels maintained positive growth in RevPAR as a result of their comparatively stable occupancy levels. Although year-to-date 2009 data indicate these hotels have experienced some decline in room rate levels and RevPAR, the impact is much smaller than non-LSP hotels and motels. This is consistent within earlier findings, as the impact of the ALU and the LSP program has helped insulate LSP hotels from the decline in demand from the private sector.

C. DEVELOPMENT TRENDS AND PIPELINE PROJECTS

According to information provided by Petersburg Area Regional Tourism, the Fort Lee Study Region has experienced substantial growth in lodging supply over the past two years. Since the beginning of 2008, seven new hotels were delivered and two existing hotels built expansions. These nine facilities added 756 rooms (275,940 annual room-nights) to the Region's existing supply. A couple of hotels recently came online as construction of these facilities began earlier in 2009. These include the Residence Inn in Chesterfield County (136 rooms) and the extended-stay Value Place in Colonial Heights (124 rooms). As of the writing of this report, there are two additional hotels currently under construction that total 160 rooms (58,400 room-nights). Once completed, the Fort Lee Study Region hotel supply will have increased 23% since January 2008.

This level of growth is aggressive but consistent with the market fundamentals within the Study Region, including occupancy rates above 75%, increases in RevPAR for five straight years and limited new development. However, the change in economic climate has created a "double" effect, reducing demand concurrently with increased supply.

There are an additional 14 hotels in the development process. In total, these facilities represent 1,023 new hotel rooms, or an additional 20% above the current supply level. Much of the planned hotel development in the Fort Lee region is on hold or has yet to begin construction. This is likely due to a combination of the economic downturn, increased scrutiny and policy changes in the financial industry, and the proposed construction of a 1,000-room Temporary Living Quarters (TLQ) on post. The following points summarize the hospitality projects currently in the regional development pipeline. It should be noted that this information was collected by the Petersburg Area Regional Tourism Corporation.

- Three hotel projects are currently "in the development pipeline," but development of these properties has been put on hold. Each of these projects are in Chesterfield County and are scheduled to operate under a national banner; Days Inn, Sleep Inn and La Quinta Inn respectively. Combined, the three hotels are planned to add 208 new rooms to the region. While all are planned to open in 2010, development schedules may change prior to opening.
- Most of the lodging projects that have gained approval, but have yet to break ground, are located in Hopewell, Prince George County and Chesterfield County. Conversely, there are no plans to develop new hotels in Petersburg and plans for one new hotel in Colonial Heights that is expected to be no larger than 150 rooms.

- There are three potential hotel projects planned in Prince George County, which largely surrounds Fort Lee. One of these, Puddledock Place, is a 168-room facility that is projected to focus on extended stays for military personnel. The other two projects, which include a hotel near the intersection of South Crater Road and Clary Road and two hotels at Diamond Park near the intersection of Routes 460 and 106, were initially planned in 2004 and 1980, respectively. While it is unlikely these projects will be developed in the short-term due to changes in the economic climate, they are permitted and need to be included in future impact analyses.
- There are seven hotel projects in the development pipeline in Hopewell and Chesterfield County. However, two of the four planned hotels in Chesterfield County, which together are projected to account for 156 rooms, are on hold as the market for lodging has slowed. Of the other two hotel projects, one is awaiting approval and is planned for 109 rooms, while the other planned 53-room project has been approved, but has yet to break ground. Lastly, the three hotels planned for Hopewell have been approved and are expected to account for an additional 211 rooms in the region.

If these facilities are constructed, the lodging market within the Fort Lee Study Region would likely experience a substantial negative impact. Local hoteliers indicated that market demand will not recover to 2007 levels for another 18 months to five years. The sudden infusion of additional supply above the growth experienced over the past two years would drive occupancy rates well below levels considered healthy for a market. While all indications these facilities will not be developed in the near-term, the analysis indicates the perceptions and realities within the local lodging market of the potential of continued economic growth and the impact of an expanded ALU has had a profound effect on the development community.

D. MARKET PROJECTIONS

The market projection analysis builds upon the existing conditions identified in the previous section of this chapter, to determine the potential impact the TLQ facility would have on the region's lodging industry. The Consultant modeled the potential change in lodging demand for each of the various market segments impacting the Fort Lee Study Region. The projections were generated independently for each market segment, based on market conditions, the type of demand and the information available to the Consultant at the time of the analysis. The methodology is discussed in greater detail in the following subsection. The results of these efforts were measured based on the potential impact created by on-post housing, particularly the development of the new 1,000-unit TLQ.

1. Methodology

The projections were calculated for the seven primary demand sectors that comprise Fort Lee's hospitality market. The methodologies for the seven demand sectors are detailed below.

- *Fort Lee – Lodging Success Program* – The Consultant was provided projected class loads for the Army Logistics University for fiscal years 2010, 2011 and 2012. These projections were provided by the ALU administration, the Quartermaster Corps and the U.S. Air Force (confirmed numbers were not available from the Ordnance Corps or the Transportation Corps). These projections include class schedules, anticipated student loads and average length of each class. It was reported that projections beyond FY2012 are not available. The Consultant projected a stable activity level beyond FY2012. The Consultant utilized the official projections in the model.

- Fort Lee – Official Business Travelers** – The Consultant projected future official business travel based on the increase in permanent party activity at Fort Lee. A baseline estimate was created utilizing current estimates for Fort Lee Official Business travel and permanent party personnel levels. The Consultant then applied this ratio to projected future permanent personnel levels provided by the Fort Lee BRAC coordination office. As such, the increase in permanent personnel is projected to result in an increase in Fort Lee Official Business.
- Fort Lee – Construction Demand** – The Consultant calculated estimates of construction jobs based on current and projected expenditures related to the BRAC action. These estimates reflect regional industry averages, as calculated by the Bureau of Economic Analysis' (BEA) Regional Input-Output Modeling System (RIMS II). The construction job levels reflect changes in construction activity based on the start and end-date projections provided by the Fort Lee BRAC Coordination Office. The Consultant apportioned a small percentage of these jobs to workers from outside the region to reflect the need for specialists and project managers for out-of-area contractors not readily available locally.

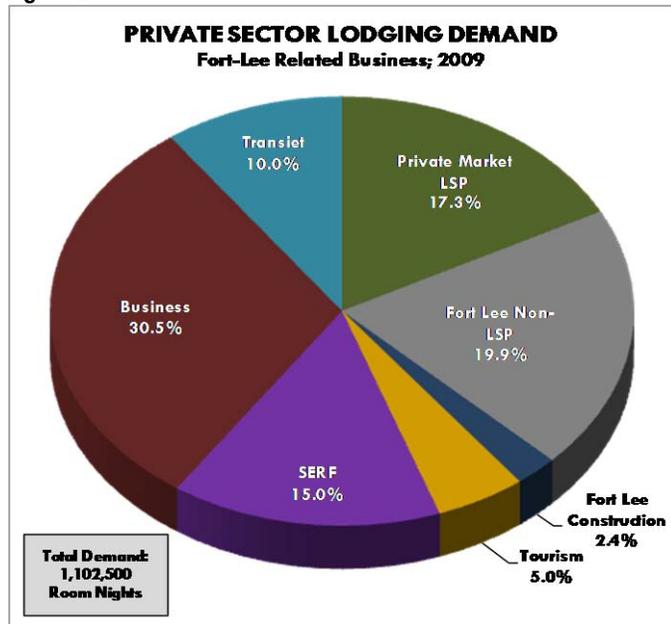
Due to the BRAC action deadline, all construction related to the increased function of Fort Lee are scheduled to be completed by the end of FY2013. As such, all construction stays are projected to end at that time.

- Non-Fort Lee Market Segments** – The Consultant projected demand for each of the four non-Fort Lee market segments based on historic market trends, independent market research and interviews with various hotel operators within the Fort Lee region. This effort resulted in a two-tiered market growth projection model to account for continued effects of the current economic downturn. The growth rates for the business/corporate travel, event-related travel, leisure/tourism travel and transient demand each reflect slow economic recovery through 2013 and then individual recovery growth rates through the end of the study period. The assumptions used for this effort were reviewed and supported by a sampling of local hotel operators during a collaboration meeting.

2. Annual Hotel Demand

As noted earlier in this chapter, total market demand has declined between 2007 and 2009. Total private-sector market demand is estimated to be 1,102,500 room-nights per year, approximately a 10% decline from 2007 levels. In addition to the decline in occupancy detailed earlier, market segmentation has changed slightly within the Study Region due to growth of Fort Lee activities. As a result, Fort Lee-related business accounts for almost 40% of all 2009 lodging demand within the Study Region (Figure 2-11). Non-LSP demand (19.9%) is slightly higher than private-sector LSP demand (17.3%). Business/corporate travel (not related to Fort

Figure 2-11



Source: RKG Associates, Inc. 2010

Lee) accounts for an additional 30.5%, with the remaining non-Fort Lee sectors totaling slightly less than 30%.

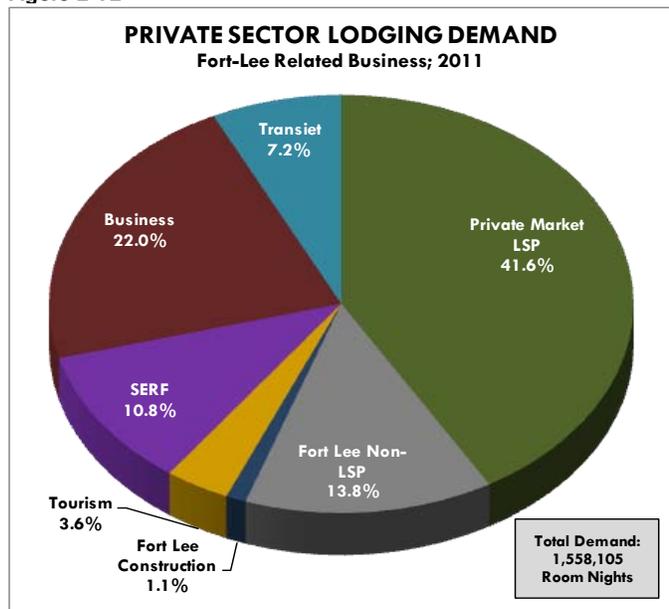
Market demand is projected to increase substantially by the end of fiscal year 2011, primarily due to the ALU reaching full operation. The projection data provided by the ALU, Air Force and Quartermaster Corps indicate the average daily load (ADL) of students will increase from 1,036 students for FY2009 to approximately 2,350 students in FY 2011 (this total does not include the Ordnance Corps or Transportation Corps). The fully operational ALU would result in an additional 480,000 room-nights of demand. The increased permanent-party personnel at Fort Lee likely will bring additional official business travel to the region by FY2011 as well. Permanent-party personnel levels are projected to increase by nearly 14% between FY2009 and FY2011. As such, official business activity is projected to increase proportionally.

In terms of non-Fort Lee business, market research and anecdotal information indicate the non-Fort Lee business demand will begin a slow recovery period in 2010. The Consultant projects these segments (business/corporate, event related, tourism and transient stays) will experience modest growth during the study period, returning to pre-recession levels at around 2013. In total, the Consultant projects the total private market demand to reach almost 1,558,000 room-nights for FY 2011 (Figure 2-12).

Since completion of the TLQ is not proposed to occur until mid-FY2012, all of the new LSP demand would need to be housed in the private market. As a result, the private market LSP segment is projected to account for more than 40% of all business in the Study Region in FY 2011 (Figure 2-12). Despite the comparatively smaller market share, the Fort Lee official business and each of the non-Fort Lee market segments are projected to experience modest increases in demand by FY2011. Only the Fort Lee construction stays segment is projected to experience a decline in private market stays by FY2011. This is due to the slowdown in construction activity, as most BRAC-related projects are projected to be complete by the end of FY2011.

After FY2011, lodging demand is projected to reach a relative equilibrium. Growth in Fort Lee related private market stays are projected to flatten out, as the ALU operations and the permanent personnel levels are expected to reach full capacity by FY2012. Furthermore, BRAC-related construction is proposed to end by the close of FY2013. As such, demand for lodging by construction workers related to Fort Lee will end at that time. While it is likely there will be fluctuations in the total number of room-nights demanded in a given year, the Consultant's research indicates that there are no substantial changes or adjustments planned for Fort Lee beyond 2012. As a result, there is no market-based rationale to project major changes in demand for short-term lodging. In contrast, the non-Fort Lee related business is projected to continue to grow beyond FY2012. These growth rates range from 1.0% to 2.0% annually for the four market segments. This comparatively low growth rate reflects historic market trends, and is consistent with anecdotal

Figure 2-12

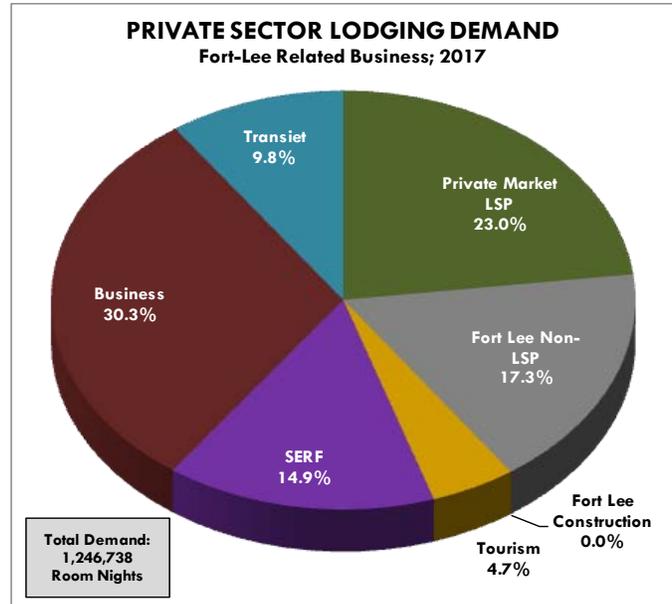


Source: RKG Associates, Inc. 2010

information shared by a sampling of local hotel operators. It is important to note any substantial changes in market conditions or Fort Lee operations beyond normal market operating conditions could alter these numbers.

The most substantial difference in private-market demand is the development of the TLQ facility. The 1,000-unit short-term lodging facility has a 365,000 room-night capacity. The opening of the TLQ in the middle of FY2012 will have a direct impact on the private market demand levels. The FMWRC has a stated mission of maintaining occupancy in on-post facilities. As a result, approximately 75% of the incremental growth in LSP stays will be captured by the on-post facility during its first full year of operation. By FY2017, the total room demand will be slightly below 1,247,000 million room-nights for the Fort Lee Study Region, with the market segmentation levels more closely resembling FY2009 shares than FY2011 (Figure 2-13).

Figure 2-13



Source: RKG Associates, Inc. 2010

While this total reflects a decline in total demand from FY2011, it represents a net increase from current year (2009) demand levels. As such, the development of the Temporary Living Quarters will remove some of the windfall growth experienced in the private market, but the Fort Lee region's hotel market will still experience a net increase in demand once the ALU is fully operational and the TLQ facility is opened.

It is important to note that the "break-even" level for the private market to maintain its current demand levels from the LSP program after the TLQ facility is operational is estimated at 2,100 average daily load. Any operational loads above this number will result in a net increase. Anything below this level will draw existing business out of the market. While current projections from the Logistics University surpass this threshold (currently 2,450 ADL without the Ordnance or Transportation Corps), it is widely recognized that these projections reflect the Army's best estimate on future needs based on current conditions. If the Army's needs change between now and when the TLQ facility goes online, the actual ADL from Fort Lee could change as well (either positively or negatively). Given the FY2009 ADL for Fort Lee was 1,036 students, any changes in training needs could have substantial impacts on the net benefit/reduction for the local private sector lodging industry.

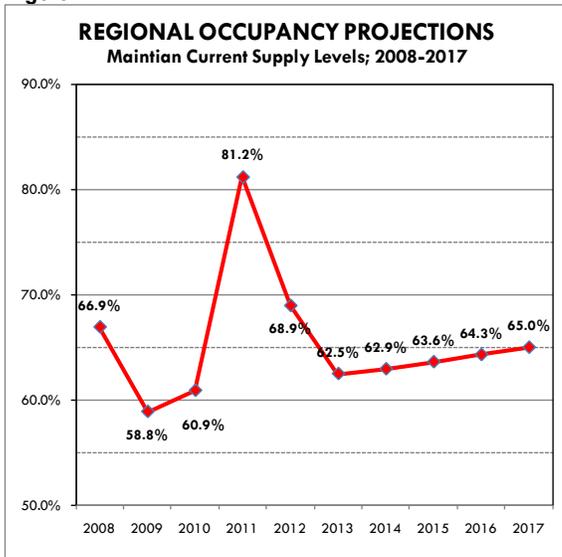
Furthermore, current LSP hotelier participants have expressed concern that they have not received the level of market activity during the first few months of FY2010 similar to FY2009 levels. Several factors have been identified that could be contributing to this discrepancy, including the change in LSP procedure and the current operational difficulties surrounding the Central Reservation Center (CRC). However, the Consultant confirmed that the ALU has been operating at projected levels for the first quarter of 2010. Data provided by the ALU administration indicates approximately 2,400 soldiers have attended during the first quarter of FY2010. This represents an increase of approximately 20% from FY2009. In addition, detailed projection data indicate the ALU has achieved a 98% attendance rate for classes scheduled over the past three months.

While there was one cancelled class and five postponed classes, the data indicate the ALU is operating at its projected capacity. As such, the discrepancy between realized room nights at the hotels and attendance levels at Fort Lee is not related to reduced operations. It is the Consultant's finding that this disparity is reflective of problems in implementing the new policies and procedures related to the LSP program (detailed in the next chapter).

3. Supply

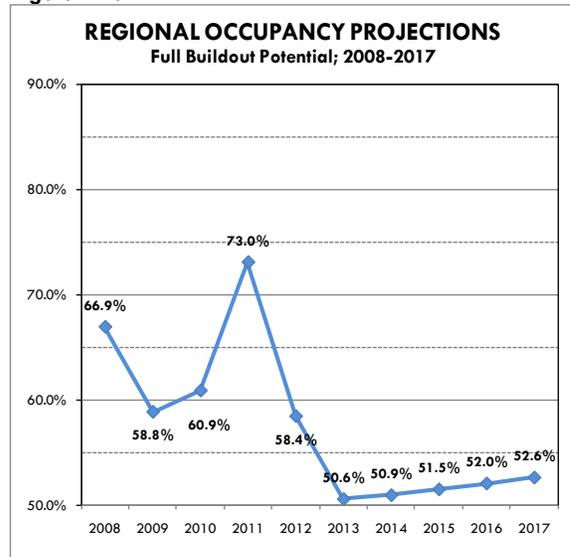
As mentioned earlier in this chapter, the Fort Lee Study Region has experienced substantial growth in lodging supply over the past two years. Since the beginning of 2008, seven new hotels were delivered and two existing hotels built expansions totaling 756 rooms (275,940 room-nights), or approximately a 13.8% increase in the existing supply. In addition, there are two additional hotels currently under construction that total 160 rooms (58,400 room-nights). Once completed, the Fort Lee Study Region hotel supply will have increased 23% since January 2008.

Figure 2-14



Source: RKG Associates, Inc.

Figure 2-15



Source: RKG Associates, Inc.

If the additional 14 hotels totaling 1,023 rooms that have been proposed within the market are completed, these facilities would reflect a net increase of 43% in market supply since January 2008 when combined with the facilities completed since 2007. As of the writing of this report, all 14 facilities are "on hold" for various reasons including site plan review, loss of financing or market impact. However, these potential facilities pose a second substantial increase to the regional market. It was reported to the Consultant that this unprecedented development interest resulted from a range of factors. The particularly strong occupancy rates prior to 2008 and the announcement of the expansion of ALU activities on Fort Lee were cited most often as the genesis of this expansion.

4. Findings

The strong growth in market supply combined with the adverse impacts from the economic downturn substantially impacted the Fort Lee Study Region market occupancy rates. Occupancy levels declined from 66.9% in 2008 to 58.8% in 2009 (Figure 2-14). However, the increase in activity at the ALU and with additional Official Business stays are projected to have substantial

impacts by FY2011, when private sector occupancy could be as high as 81.2% market-wide. The completion of the TLQ facility will reduce the private-sector demand starting in FY2012, with market-wide occupancy projected to be 62.5% in FY2013, the first full year of operation. Beyond FY2013, occupancy is projected to increase slowly as a result of growth of the non-Fort Lee markets.

It is important to note that the development of the 11 proposed hotels would have an adverse impact on occupancy as well. The development of these proposed hotels, with the first to be delivered in FY2011, will bring occupancy levels below 51% in FY2013. Occupancy is not projected to rise above 53% by the end of the study period (FY2017). This finding is consistent with earlier analysis, as a 43% increase in total supply within five years is unsustainable in most any market.

E. IMPLICATIONS

The Fort Lee Study Region lodging market historically has performed very well. Prior to 2008, market demand increased steadily bringing occupancy rates above 70% for the market as a whole. Much of this success is related to activity at Fort Lee. Hoteliers report that Fort Lee has accounted for as much as 40% to 50% of all business within the Study Region. However, the economic downturn has resulted in a net decline in market demand each year since 2007. Concurrently, the development of more than seven new hotels and a total of 756 rooms has exacerbated the decline in occupancy levels. The Consultant estimates that the 2009 occupancy rate is 58.8%, or approximately 8% below 2008 levels.

The expansion of class load at the ALU will have a substantial impact on the regional market, both short-term and long-term. The projected activity level for FY2011 will result in an additional 480,000 room-nights of demand for the private sector, a 40% increase in one year. The Consultant projects regional occupancy level of more than 81% during this period. Even with the operation of the TLQ facility, the net benefit to the private sector will assist in negating the impacts of the economic downturn. The most impending threat to the viability of the private sector is over speculation. IF the additional 11 hotels are developed as proposed within the timeframe stated, the market will not be able to support all facilities. Simply put, the downward pressure on occupancy will create a pricing competition that will drive some facilities to failure.

However, there has been concern expressed about the viability of the ALU to deliver the amount of demand projected by the Army. Given the uncertain times our nation is still facing locally and globally, substantial changes in training needs could impact the Fort Lee Study Region lodging market. Furthermore, the Consultant was unable to obtain certain data from the Army by the writing of this report that potentially could address some of these issues. Most notably, concerns were raised about the status of the FY2010 J-3 class load listing and why LSP hotels are not receiving levels of demand commensurate with their contracted room-night amounts or even activity similar to the previous fiscal year. While some assumptions have been made to explain this discrepancy in the next chapter, the concern about future needs and the ability of the Army to meet the 2,100 average daily load threshold to avoid adverse impacts to the private market remain a legitimate concern.

3 LODGING SUCCESS PROGRAM ANALYSIS

A. INTRODUCTION

The following chapter details the changes within the local off-post Fort Lee-generated hotel demand resulting from the Lodging Success Program (LSP) and the proposed 1,000 room Temporary Living Quarters (TLQ) facility planned for Fort Lee. The Consultant analyzed the expected absorption of this demand by the Fort Lee Study Region’s hotels and motels, and the methodology by which this demand was apportioned. Existing lodging supply is represented by the local hotel market, divided into three distinct tiers, as well as on-post lodging facilities, including the proposed TLQ facility projected to be delivered in February 2012. The methodology and gravity model used to distribute the projected demand is laid out in detail, as well as the results and implications of the analysis.

B. HOTEL TIER DELINIATION

Working from the Fort Lee Study Region, defined in the previous chapter as the nine-mile radius surrounding Fort Lee, the Consultant further divided the market into three tiers. The delineation primarily is based on distance from Fort Lee. In order to determine how best to aggregate the Study Region’s various hotels and motels, the Consultant performed a geospatial analysis to assess the location and concentration of hotels around Fort Lee. Upon doing so, three groupings of lodging facilities were apparent around Fort Lee. The first group was found to be clustered immediately around the Fort within a one mile radius of the post. Due to their convenience and proximity to post, these facilities are ideally located for serving the needs of the military. These hotels and motels represent Tier I. Tier II includes hotels and motels in downtown Petersburg, along South Crater Road, and near Southpark Mall, all of which provide convenient lodging to those requiring immediate access to the Southside Regional Medical Center and the concentration of businesses found around the Mall. These hotels are clustered within one to five miles of Fort Lee. Tier III is mostly composed of the hotels clustered around Interstate 95’s Exit 61 in Chester, but also includes a few hotels scattered to the south and west as well. These lodging facilities are located within five to nine miles of the Fort. A gap in hotels and motels occurs in areas past the nine mile radius, after which the next closest hotels are much better positioned to serve the south suburban Richmond or Richmond International Airport market than to serve the Fort Lee Study Region and are therefore excluded from it.

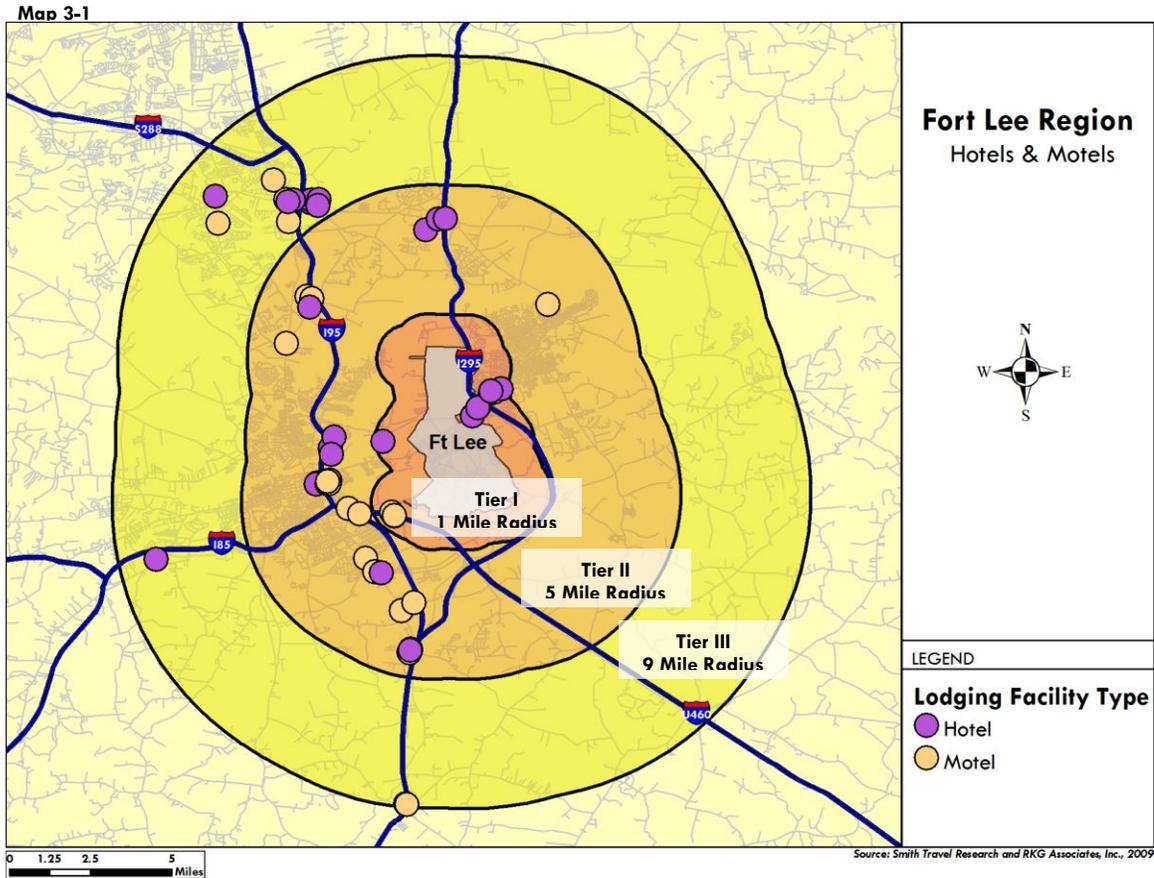
**Table 3-1
Number of Hotels & Rooms by Tier
Fort Lee, Virginia**

	Tier			Total
	I	II	III	
Number of Hotels				
Overall	12	32	13	57
LSP	5	11	1	17
% of Overall	41.7%	34.4%	7.7%	29.8%
Number of Hotel Rooms				
Overall	1,005	2,931	1,163	5,099
LSP	491	1,260	67	1,818
% of Overall	48.9%	43.0%	5.8%	35.7%

Source: Smith Travel Research & RKG Associates, Inc., 2009

Given these findings, the Consultant subdivided the Study Region into three tiers, separated at one, five, and nine miles from Fort Lee (Map 3-1). Of the 5,099 rooms and 57 hotels and motels

in the Study Region, almost 30% of the facilities and almost 36% of the rooms are LSP (Table 3-1). Tier I holds the highest concentration, with almost half of its hotel rooms composed of Lodging Success Program (LSP) rooms. Conversely, Tier III holds the lowest concentration of hotels and rooms, with almost 8% and 6%, respectively.



C. METHODOLOGY

RKG Associates created a gravity model in order to approximate the velocity (“when”) and apportionment (“where”) of Fort Lee-related stays absorbed in the Fort Lee Study Region. Gravity models are used in the social sciences to project human behavior in a similar manner to Newton’s Law of Gravity. For the purposes of this analysis, each hotel or motel was given a certain “weight” which was calculated to include characteristics such as price, distance to Fort Lee, and class (all of which will be described later). This resulting weight is proportional to a hotel’s ability to attract stays, meaning that those hotels with the greatest weight have the best chance of attracting hotel demand, just as in Newton’s Law of Gravity, in which objects with relatively larger mass have a greater attractive power than objects with smaller mass.

It should be noted that limitations of the model and its input data do exist. First, since human behavior does not always act as orderly as inanimate matter, the gravity model cannot account for exceptional behavior or decision-making by an individual who might have a specific preference for a certain hotel or a corporate account with a specific chain which will encourage him or her to act out of accordance with the gravity model. These exceptions are bound to occur,

and no claim is made by the Consultant to be able to account for them. However, it is expected that the gravity model produces a reasonable representation of reality sufficient for this analysis. In addition, the Consultant sought to validate both the model and the input data through interviews with local hotel operators, government officials, Fort Lee personnel, and Department of the Army staff.

Second, the student loads provided for the coming years are projections based on the dynamic needs of the United States military. As such, shifts in the military's staffing requirements may impact actual student loads. However, the numbers utilized herein were the most current figures available at the time of writing. Third, there are some ancillary sources of demand for which the Consultant could not accurately account. For example, visitor counts to the Defense Contract Management Agency (DCMA) were still being calculated and verified at the time of writing, and could not be included in the analysis. However, cases such as DCMA's visitors are expected to represent a relatively small portion of the total demand, the inclusion or exclusion of which will not significantly sway the final results.

1. Input Assumptions

Various military entities at Fort Lee provided documentation of their events and training activities requiring overnight stays. This information included the number of trainees, the length of their stays, and the timing of those stays. These stays are divided into three major categories based on the nature of the visit. These three categories are as follows:

- *Lodging Success Program (LSP) Stays* – These stays include those that are directly related to the Army Logistics University (ALU) and include students who have been ordered to Fort Lee for as little as a few days to as much as thirteen weeks to be trained in a wide range of skills. The soldiers in this pool might be trained at the Army Logistics University (ALU), Quartermaster School, Transportation School, Ordnance School, Military Occupational Specialty Training Course (MOS-T), or the Air Force's Culinary or Transportation Management Schools. Many of these programs are already in place, and all of them are projected to be fully operational by the beginning of FY2011. If the soldier's accommodations were made through the Family and Morale, Welfare and Recreation Command's (FMWRC) Central Reservation Center (CRC), these soldiers will pay the per diem rate (\$70) less a mandated 8% discount. In addition, the hotelier will be required to return a \$2 per room night cost sharing fee to FMWRC. If the soldier has made his own reservations, the model assumes the same rate and discount, less the \$2 cost sharing fee.

The data for these stays was provided by the Army Logistics University, the Quartermaster School, and the FMWRC during fall 2009.⁶ In addition, the Army Logistics University is still confirming its projected student loads for the Transportation and Ordnance School student loads to be instructed at Fort Lee, therefore, at this time the model does not reflect the stays generated by these schools. Anecdotal information indicate the Transportation and Ordnance Corps will add as much as 120 average daily load to the market.

The Consultant is also awaiting additional data on student stays that have already occurred, in order to determine the ratio of scheduled students to fulfilled LSP reservations. On December 7, 2009, a Freedom of Information Act (FOIA) request for this data was made to FMWRC through Virginia's Congressman J. Randy Forbes of the 4th District to the U.S. Congress. FMWRC confirmed receipt of the request on December 10, 2009, but indicated that more time was needed to gather the data. In the mean time, the Consultant

⁶ Data was provided to the Consultant through frequent phone and email contact with Chief Scott Brown at Fort Lee's BRAC Synchronization Office, which provided a single point of contact to the military in gathering the necessary information. Correspondence included several phone calls

has proceeded in its analysis with estimated figures to substitute for the actual data until it can be delivered.

- *Per Diem Stays* – These stays also include visitors who are contractually obligated to visit Fort Lee, but are not being trained at the ALU. These visits are often referred to as temporary duty stays, or TDY stays. Primarily, this grouping includes defense contractors and military personnel travelling on official military business. Visitors to the Defense Contract Management Agency’s (DCMA) Learning Campus (expected to be operating at full capacity by FY2012)⁷ are included in this category. The per diem stay category also includes all permanent party stays.⁸ Permanent party stays include newly assigned permanent personnel at Fort Lee. These new arrivals are housed off-post for as long as ten days during which time they can search for housing.
- *Fort Lee-Related Private Stays* – These stays include visitors who do not qualify for official visit status and will therefore pay the hotel’s market rate as private citizens. Some of the specific events that would be included in this category are an annual golf tournament, a military ball, the Best Warrior Competition, or attendees of a graduation from a training course at Fort Lee. It also includes the hotel stays generated by construction contractors providing their services to Fort Lee’s capital improvements program, which is expected to run through FY2013. Annual attendance numbers for these events were provided by Fort Lee’s BRAC Synchronization Office, while construction figures were calculated by RKG Associates using scheduling plans provided by FMWRC.

The resulting stays for these three categories were then projected from 2009 to 2015 in order to fully illustrate hotel market conditions before and after the delivery of the TLQ. These figures represent the demands generated by the Fort, and were used to apportion projected hotel stays to the Study Region’s lodging facilities, as outlined in the following section.

2. Allocation and Ranking Process

The Consultant created a series of weights for each source of demand (LSP, per diem, and private stays) in order to address the preferences and priorities of each type of hotel stay. These weights were then applied to each of the Study Region’s hotels, providing a score by which each lodging facility could be ranked. For example, soldiers officially assigned to temporary duty (TDY) on-post are much less sensitive to the price of a hotel room, since they are eligible to pay the per diem rate, for which they are reimbursed (the current per diem lodging rate is \$70 per night). Therefore, if a soldier books a room at a \$110 per night hotel, he will only be required to pay the per diem rate of \$70. The ability of a soldier to use per diem rate is expected to influence him to choose the best quality hotel at which he can find an available room, while taking into account distance from Fort Lee. In a contrasting example, a plumbing contractor performing his services on Fort Lee is expected to stay at the least expensive lodging facility he can find, since he is not eligible for the per diem rate and may not be reimbursed for his stay at all. Distance will still act as a factor, but the private visitor is expected to be more price sensitive than those on military assignment. The model is a representation of these sorts of decision-making instances occurring during the study period (2009-2015).

The four weighting factors include distance from Fort Lee, class, price, and capacity for hotel stays. Each hotel receives a score for these four factors, and the total of these scores provides the figure by which the hotel is ranked. The four factors are described in detail as follows:

⁷ Data provided via email from Pam Sutton, Deputy BRAC Program Manager at the Defense Contract Management Agency at Fort Lee on October 20, 2009.

⁸ Data provided via email from Chief Scott Brown, BRAC Synchronization Office at Fort Lee on November 2, 2009.

- Distance from Fort Lee – The distance from the boundary of Fort Lee to each hotel was measured using a geographic information system (GIS). The closer the hotel’s location to the Fort, the higher the rank assigned to the hotel. This is the case for LSP, per diem, and private stays, since it is expected that all stays would prefer to lodge as close to the Fort as possible.
- Hotel Classification – Using Smith Travel Research’s six hotel classifications, each hotel received a rank according to its class, with a higher class associated with a higher rank for LSP, per diem, and private stays (Table 3-2). Hotel class is largely defined by the physical characteristics of the facility and the level of service provided to guests. Luxury class hotels typically offer the highest level of service to their patrons with extravagant features and detail in the rooms and common areas. These hotels typically cost more than the average accommodation and would likely include a wide array of in-house services and features, possibly including a spa, and a gourmet restaurant. Upper upscale hotels will likely have concierge service and extended room service hours. Upscale class hotels might have a well-kept lounge, laundry valet, and flat panel televisions in the guest rooms. Midscale hotels with food and beverage (F&B) services might offer meeting and banquet services, a swimming pool, fitness facilities, and a restaurant. Midscale hotels without food and beverage services may offer a complimentary shuttle, wireless internet, and adequate room furnishings. Economy hotels might have a coin operated laundry and free local calls.

Table 3-2
Hotel Class Descriptions
Fort Lee, Virginia

Hotel Class	Example
Luxury Class	Ritz-Carlton, Four Seasons, Hilton
Upper Upscale Class	Marriott, Sheraton, Embassy Suites
Upscale Class	Crowne Plaza, Courtyard Marriott, Residence Inn
Midscale w/ F&B Class	Clarion, Ramada, Holiday Inn
Midscale w/o F&B Class	Hampton Inn, Country Inn & Suites, Comfort Inn
Economy Class	Econo Lodge, Motel 6, Red Roof Inn

Source: Smith Travel Research & RKG Associates, Inc., 2009

- Price – The Consultant assumes that the Fort Lee hotel market is “efficient”, which, in economic terms, means that price is a reliable indicator of quality, with higher prices correlating with higher quality. However, as explained previously, soldiers temporarily assigned to Fort Lee are not price sensitive, since they pay the per diem rate and are reimbursed for their hotel expenses. Conversely, private visitors are not eligible for per diem stays and may not be reimbursed for their hotel expenses. Therefore, they are expected to be more price sensitive. Given these two different paradigms, price is ranked differently for assigned soldiers and private stays. In the case of soldiers assigned to Fort Lee, a higher hotel price indicates a higher hotel rank, whereas a higher hotel price indicates a lower hotel rank for the private stays.
- Quality - In the case of LSP and per diem stays, the two factors of class and price are integrated into a single “quality” indicator to form a single score. This operation is not executed for private stays since the price and class are not both considered to be positive indicators of demand. It is expected that LSP and per diem stays will be inclined to find the “best” (assuming price and quality are accurate indicators of quality) hotel possible, while private visitors will prefer to find the lowest price, all other things being equal.

- Capacity – The final component considered in ranking the hotels is the hotel's capacity for military (in the case of LSP or per diem stays) or private stays. These figures were gathered from the Randall Travel marketing report created for the Crater District Planning Commission and interviews with local hoteliers, both of which provided business mix data for many of the hotels. By applying the percentage of historical military or non-military stays from the reported business mix, a capacity for each hotel was delivered. The larger the hotel's capacity for military stays (for LSP or per diem stays) or private stays, the higher the hotel's rank.

D. DEMAND CAPTURE RESULTS

In order to model the absorption of Fort Lee-generated hotel demand, the Consultant assembled a model that ranked the hotels by the above characteristics to apportion the demand throughout the Study Region. The model's logic is constructed to distribute all the demand that remains *after* on-post lodging has been filled to capacity. This remaining demand is first apportioned to the highest-ranked hotel, which would capture its share of the market demand. Once the highest-ranked hotel met this level, this process would continue down the list of ranked hotels until no additional demand remained to be served, at which point any hotel not having a sufficiently high rank would not be expected to absorb any demand related to Fort Lee operations.

As discussed earlier, the model has limitations on predicting hotel-by-hotel performance as a result of nature of individual decision-making priorities. The Consultant acknowledges that the "highest ranked" hotel likely will not capture *all* demand until it reached capacity before any other hotel receives any. However, the scope of this project was to identify the potential impact of the TLQ facility on the market, not individual hotels. As such, the results of the model generally reflect historic and current market conditions on an aggregate basis within the Fort Lee Study Region. To this end, the ranking system and demand apportionment applied for this analysis is an adequate representation of market absorption activity.

To illustrate the findings of the model, the Consultant graphed the results of two key performance indicators for the overall Study Region as well as the three Tiers: potential demand capture and potential occupancy rate. Potential demand capture is the number of room nights that would be captured by each Tier as calculated by the gravity model. Potential occupancy rate is the quotient of the potential demand capture divided by the total available room nights for Fort Lee related stays within a given Tier. The former figure depicts the quantity captured by each Tier, while the latter illustrates how much of a Tier's capacity would be filled by the captured room nights. It should be noted that with the exception of the following section, the two indicators are calculated for only one specific source of demand (LSP, per diem, or private) at once. Therefore, an occupancy rate of 3% for private stays does *not* indicate that the tier will *only* have a 3% occupancy rate overall, but simply that approximately 3% of total rooms available for private stays will be occupied by Fort Lee related business.

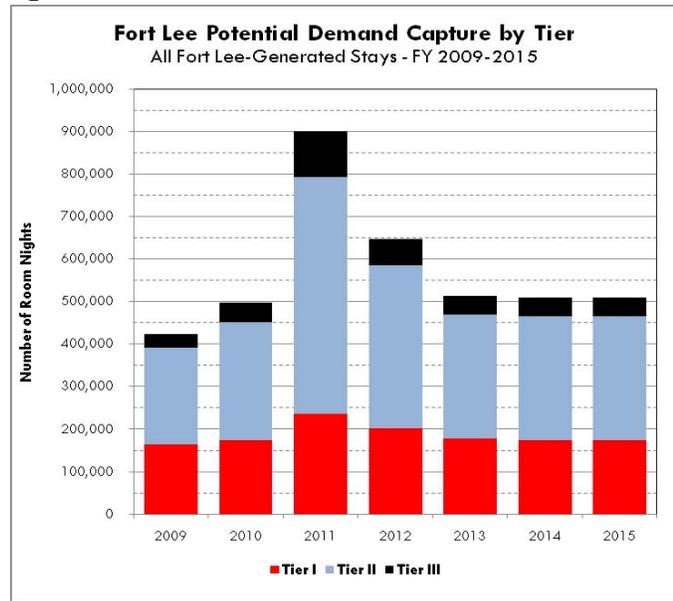
1. All Fort Lee-Generated Stays

In order to provide an overall sense of the projected demand for room nights during 2009-2015, the potential demand capture for all demand types is provided (Figure 3-1). This analysis depicts the impact of the planned increase in temporary and permanent party troops, construction activity, and the delivery of the TLQ on the demand for Fort Lee-generated lodging. The most significant finding is that the increase in ALU activity by the beginning of FY2011 will provide a substantial amount of business for the hotel market prior to the completion of the TLQ facility. Overall demand for off-post lodging spikes by nearly 480,000 room nights from FY2009 to FY2011. The

development of the TLQ facility brings 365,000 room nights of this demand back on-post, effectively limiting the long-term potential gain for the lodging industry.

Tier II facilities stand to experience the greatest fluctuations based on market projections. The results indicate that Tier I’s absorption will remain relatively stable at about 225,000 room nights annually. This stability will likely be the result of the Tier’s relative attractiveness to all Fort Lee market segments, allowing non-LSP demand to supplement changes in private sector activity for ALU students outside Fort Lee. In contrast, Tier II is projected to experience growth from an annual absorption of about 200,000 room nights in 2009 (47% of the market) to about 300,000 in 2015 (57% of the market). In addition, Tier II’s potential capture peaks in 2011, with a total expected capture of about 500,000 room nights, almost 65% of the total market share. The wider fluctuations occurring in Tier II is the result of Tier I’s inability to absorb further demand as it reaches capacity, effectively creating a highly competitive market amongst these hotels.

Figure 3-1



Source: RKG Associates, Inc., 2009

In addition, Tier II’s potential capture peaks in 2011, with a total expected capture of about 500,000 room nights, almost 65% of the total market share. The wider fluctuations occurring in Tier II is the result of Tier I’s inability to absorb further demand as it reaches capacity, effectively creating a highly competitive market amongst these hotels.

Tier III is projected to capture a comparatively small level of demand, reflective of its competitive disadvantage being the furthest from Fort Lee. Substantial changes in demand capture in this Tier generally is a result of exceptional short-term demand levels corresponding to the peak period of new temporary and permanent soldiers before the delivery of the TLQ. **The most significant finding of the overall analysis is that the Study Region will experience a net gain in hotel room demand between 2009 and 2015, despite the delivery of the TLQ in 2012.** The total number of projected room nights for 2015 is more than 30% higher (about 125,000 room nights) than the total room nights estimated to be captured for 2009.

However, it is important to note that this net benefit is based on the projection data provided by the ALU administration. As noted in the previous chapter, the “break even” point for private lodging facilities to maintain current LSP business levels is 2,100 average daily load (ADL) after the TLQ facility is built, more than double what FY2009 ADL levels. If training needs shift substantially away from logistics-based positions, the new TLQ facility potentially could draw existing private-sector LSP business out of the market. While there is no indication these needs may not be met, the uncertainty of global security issues creates a level of risk for the local lodging industry.

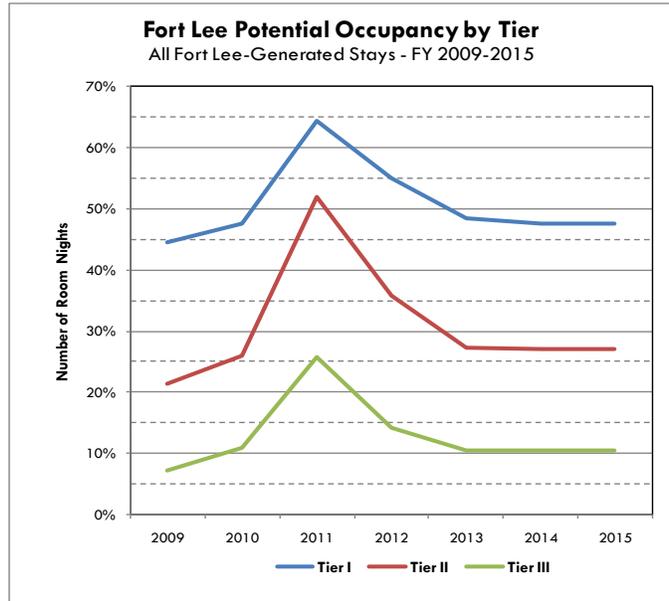
The market projections indicate that the Study Region will experience a net increase in LSP-related occupancy rates, despite the operation of the TLQ (Figure 3-2). This will occur most markedly in Tier II, where potential occupancy is expected to jump from less than 20% of available supply in 2009 to just below 30% in 2015, with a peak of about 45% in 2011. Tier III’s overall potential occupancy capture from Fort Lee-generated stays will also rise, increasing from about 2.6% in 2009 to about 4% in 2015. Tier I will rise from just under 60% to slightly more than 60% during 2009-2015, including a peak of about 65% in 2011.

2. LSP Hotel Stays

The model’s results for LSP stays indicate that Tier I hotels (those within one mile of Fort Lee) are expected to capture a relatively stable number of room nights (about 150,000 annually) between 2009 and 2015 (Figure 3-3). Like the figures for Tier I in the previous section, these hotels closest to the Fort already enjoy the advantage of close proximity to the Fort, and are expected to continue to absorb a disproportionate amount of LSP-related business. However, Tier I does experience a temporary swell of LSP business in FY2011, as the ALU facility is in full operation and the TLQ facility is not complete. The analysis reveals that this swell will exceed the capacity dedicated to LSP stays of these hotels (Figure 3-4), forcing other business types out of these facilities to allow for the LSP demand.

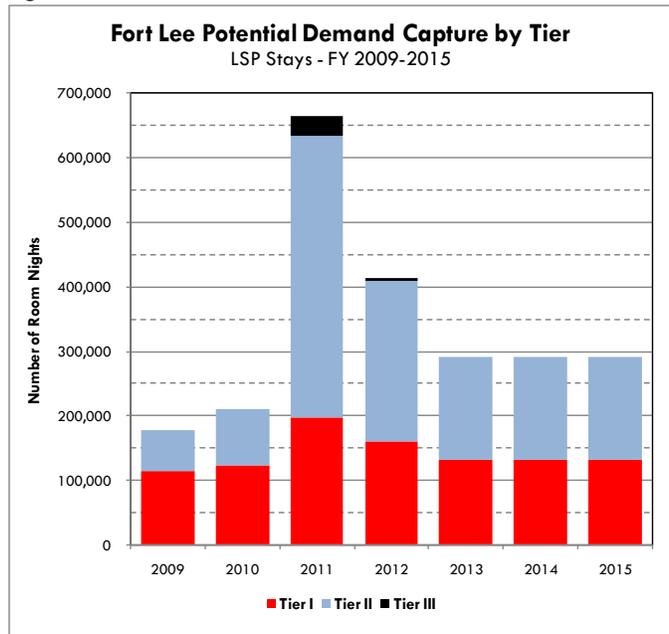
As a result, LSP-related business will be forced into Tier II and Tier III hotels, both LSP-qualified and non-LSP qualified facilities. Simply put, the existing 17 hotels do not have the capacity to handle the FY2011 demand at 100% occupancy and no other business segment activity. Tier II hotels are estimated to have captured fewer than 100,000 room-night of LSP demand in FY2009. In contrast, they are projected to capture more than 500,000 room nights in FY2011. Similarly, Tier II facilities are estimated to capture some LSP demand in FY2011, despite capturing very little in FY2009.

Figure 3-2



Source: RKG Associates, Inc., 2009

Figure 3-3



Source: RKG Associates, Inc., 2009

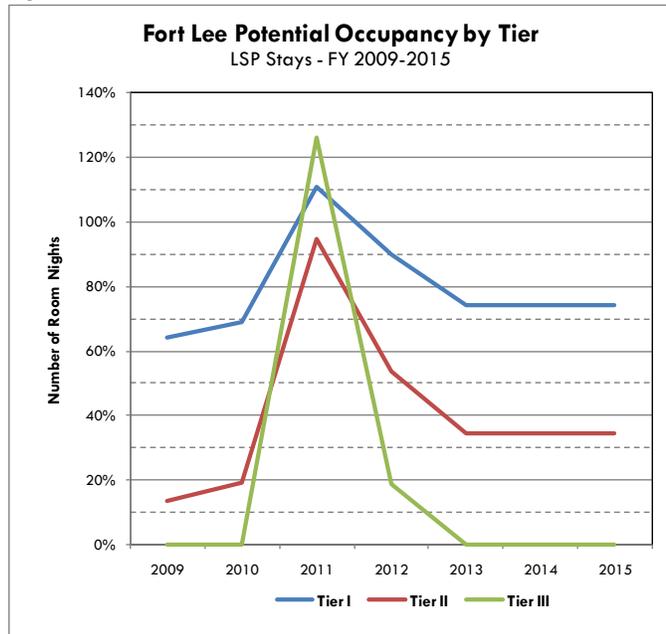
The result of this analysis is similar when comparing actual capture to available supply. Approximately 17% of the supply available to LSP stays in FY2009 within Tier II was occupied. The share of supply to actual capture increases to more than 95% in FY2011, prior to the TLQ facility coming online. Simply put, the ramp up in ALU operations without the TLQ facility creates a substantial change in occupancy and market capture within the Fort Lee Study Region. This impact influences per diem stays as well.

3. Per Diem Hotel Stays

The results of the per diem portion of the analysis yielded a similar trend to the LSP portion, but without the post-peak decline. The stable to modest growing nature of the per diem stays reflects the gradual increase of non-ALU training activity and the general stability in net permanent troops levels at Fort Lee. Projections indicate strong and stable absorption in Tier I, increasing absorption in Tier II, and minimal absorption in Tier III (Figure 3-5). Tier I is projected to take up about 30% of the per diem demand annually, or about 60,000-70,000 room nights. Tier II will also consistently consume about 62% of total demand, but will grow in real numbers from about 130,000 to 160,000 room nights annually. Tier III is expected to experience a growth in room nights captured (from about 11,000 to 17,000 between 2009 and 2015) while maintaining a 5-6% share of the total demand.

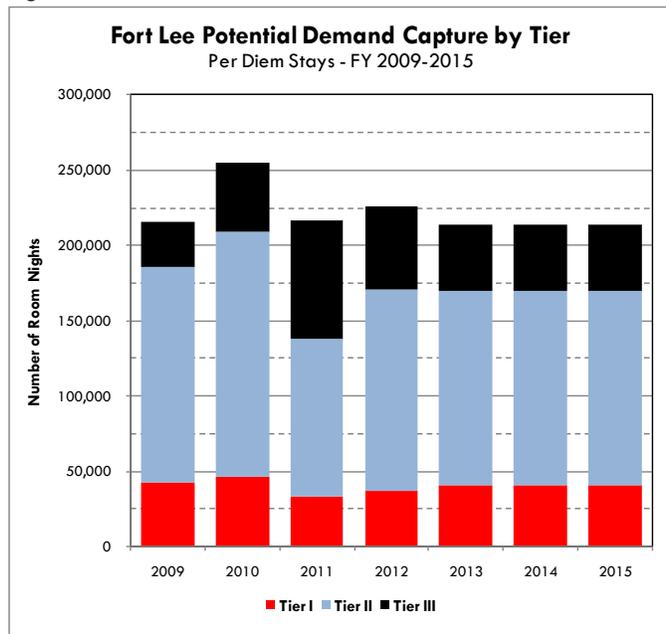
It should be noted that the number of per diem stays within Tiers I and II actually decline in FY2011 as a result of the market pressure from LSP stays (Figure 3-6). As a result, this demand is shifted out into Tier III, where the net demand capture increases from 30,000 room nights in FY2009 to more than 78,000 in FY2011. The occupancy capture levels for Tier I and II actually decline in FY2011 due to the impact of the new LSP stays. In contrast, the Tier III hotels effectively capture this spillover and experience short-term boost in per diem business until the TLQ facility is completed.

Figure 3-4



Source: RKG Associates, Inc., 2009

Figure 3-5



Source: RKG Associates, Inc., 2009

The LSP demand also is projected to have long-term impacts on the distribution of per diem demand. The post-TLQ projection data indicate that per diem stay occupancy levels for Tier I and Tier II will remain below current estimate levels in the market. This is most likely due the net increase in LSP stays, and the need for LSP facilities to accommodate this demand. Conversely, Tier III hotels are projected to experience a net increase in per diem business, on an occupancy basis.

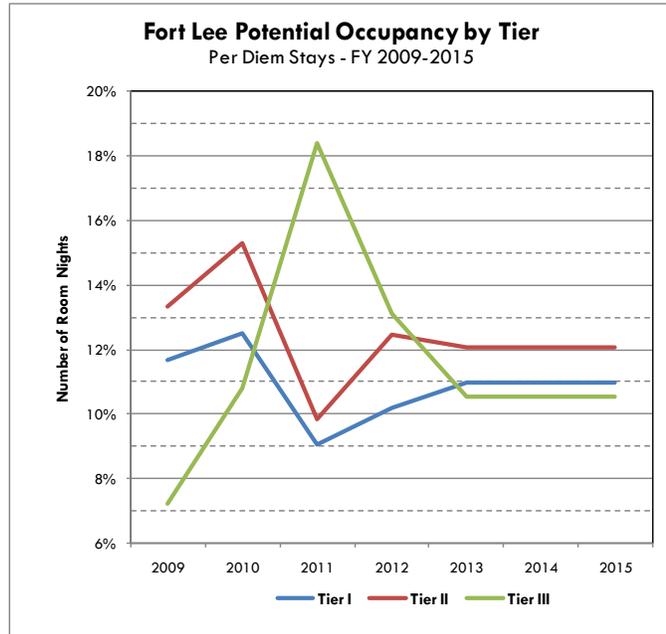
4. Private Hotel Stays

Private stays directly relate to Fort Lee operations are projected to be exclusively captured by Tier I and Tier II facilities. This is due to the comparatively small quantity of private demand relative to the amount of available room nights in the local market. Simply put, Tier I and Tier II have a good mix of hotel types and price ranges for Fort Lee visitors. As a result, all of the demand for private stays is projected to be absorbed before any spill over into Tier III can occur.

Private sector demand is predominantly construction-related stays tied to the approximately \$1.4 billion in capital construction projects tied to the 2005 BRAC action for Fort Lee.⁹ During the capital improvement process, construction contractors are expected to generate several thousand room nights of hotel demand as a result of the influx of temporary work crews and the need for specialists not readily available within the region.

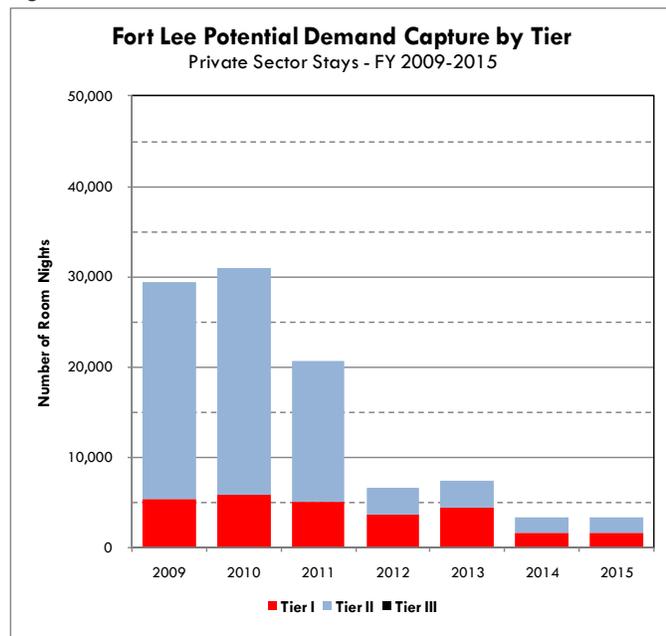
However, most of the private stay demand is projected to end prior to the conclusion of the study period. Federal mandates require all construction activity from this BRAC round to be completed by FY2013. As such, these temporary construction jobs will no longer be required, and transient workers will

Figure 3-6



Source: RKG Associates, Inc., 2009

Figure 3-7

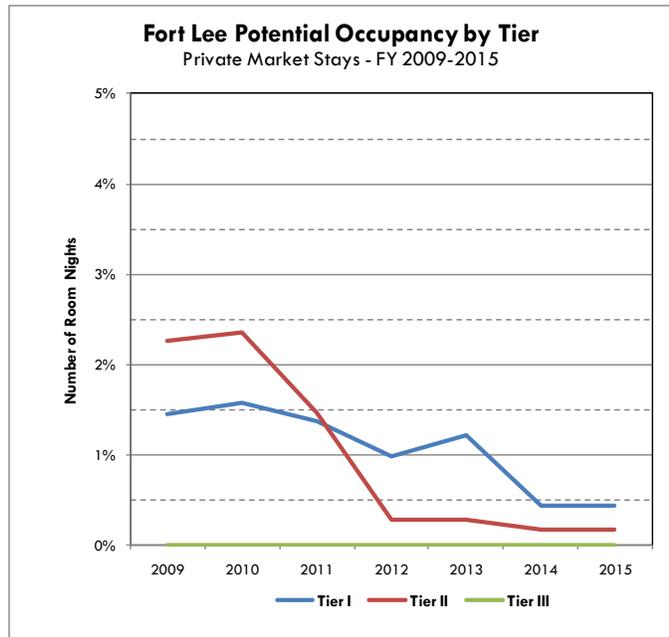


Source: RKG Associates, Inc..

⁹Construction estimates provided by the Crater Planning District Commission.

seek jobs elsewhere. The completion of the construction activity likely will cause a noticeable drop in overall private stays, since little growth is expected to be borne by other Fort Lee-generated sources. The number of private stays captured by Tier I is expected to drop from about 9,000 in 2009 to about 1,500 by 2015 (Figure 3-7). During this time, however, Tier I's share of private stays will increase from less than 30% to almost 50%. Tier II's amount of capture should also decline, decreasing from about 20,000 annually in 2009 to about 2,000 annually in 2015. As mentioned previously, Tier III is not expected to capture any Fort Lee-generated private hotel stays.

Figure 3-8



Source: RKG Associates, Inc., 2009

Potential occupancy rates for private stays follow the trend established by the potential demand capture (Figure 3-8). Occupancy for Tiers I and II decline from about 2.5-3.0% in 2009 to less than 0.5% by 2015. These low occupancy levels are a result of the relatively small amount of private stays generated by Fort Lee. The events included in this category of stays (golf tournaments, military balls, and other annual events) are quite small in nature and therefore will not represent a significant portion of demand in the coming years.

E. IMPLICATIONS

The analysis indicates that the development of the Temporary Living Quarters will not adversely impact the private lodging market when compared to current conditions. The projected increase in Fort Lee related stays is greater than the amount of business that will be drawn back on post by the TLQ facility. The Consultant estimates that Fort Lee operations are directly responsible for approximately 436,350 room nights of demand within the private market, with almost 191,000 of this total from the training operations at the ALU. In FY2011, the net impact of Fort Lee operations is projected to total more than 879,000 room nights to the private sector. More than 647,000 room nights of this demand are ALU students. The development of the TLQ facility will remove 365,000 room-nights from the private market, leaving almost 507,000 room nights of demand during the first full year of operation at the TLQ. While the market will experience a substantial windfall in demand during FY2011 and the beginning of FY2012, the net positive impact to the lodging market will reduce after the TLQ facility is operational.

In terms of the LSP program's influence on the health of local hotels, the average daily load of students needed to maintain the market at its current state *after* the TLQ is built is about 2,100 soldiers. Although recent ADL levels have been approximately 1,000 students, the increased training missions at the ALU are projected to grow to about 2,450 students¹⁰, leaving a buffer of about 18% to 25% between the expected daily load and a minimum threshold needed to

¹⁰ This figure does not include the Transportation or Ordnance Corps loads as well as non-LSP demand generators that could not be verified, such as the Defense Contracting Management Agency Learning Center.

maintain current market equilibrium. However, if the needs of the Department of the Army were to change, Fort Lee's average daily load might very well shift as well. Such a shift would likely have its greatest impact on those hotels farthest from Fort Lee, but on a regional scale, the shift would have to be significant enough to depress the average daily load below 2,100 in order to negatively affect the Study Region at large.

As mentioned, the new reservation procedure for LSP stays caused confusion within the Fort Lee Study Region. Simply put, the new procedures implemented for the FY2010 contracting round have redistributed stays from its former, evenly dispersed arrangement to an inconsistent, concentrated scenario which favors lodging facilities closest to Fort Lee and those facilities with the greatest favor to ALU students. Empirical and anecdotal data provided by local hotel operators shows that the new reservation system operated by the FMWRC Central Reservation Center is not as effective in guiding students to their assigned hotel. The change from the central billing method to self-pay also has created opportunities for students at the ALU to circumvent the reservations system by booking directly with hotel operators. Sufficient evidence was presented by hoteliers to document there even are students staying at non-LSP sanctioned facilities. As such, these disruptions in historic patterns have caused long-time LSP participants to question the validity of current estimate and projection data. Unless the reservation system is adjusted, this trend is projected to continue into the future, with a favorable outlook for the Study Region as a whole but accompanied by a loss for specific hotels.

4 CONSUMER SPENDING ANALYSIS

A. ON-POST COMMERCIAL SUPPLY ANALYSIS

1. Existing Commercial Inventory

The on-post retail, service and dining establishments at Fort Lee are operated by the Army and Air Force Exchange Service (AAFES). Businesses include national chain stores and restaurants, military outlets and unique service providers. It is important to note that the private-sector businesses on-post are contracted with AAFES and therefore considered to be operated by AAFES. The commercial establishments are located primarily in two complexes; the PX (Post Exchange) Complex and the PXtra Troop Mall Complex. Each complex is a one-story building complete with anchor stores, concession stores¹¹ and a food court. Other on-post establishments are located in standalone buildings or within largely non-commercial structures, such as the new Army Logistics University building. This section describes the types of retail, service and dining businesses located on-post.

a) *PX Complex*

The PX Complex is the largest commercial building at Fort Lee. It is an enclosed structure and is anchored by the PX, which is similar to a department store offering a diverse mix of goods. The available items include clothing, electronics, media, sporting goods and home furnishings. It is reported by the AAFES Business Operations Manager that the PX occupies 100,750 square feet of space. The Consultant estimates that the entire complex is approximately 131,000 square feet, which results in the PX occupying nearly 77% of total floor space.

The concession stores in the PX Complex are comprised largely of retail-oriented businesses. These businesses include two beauty accessories stores, three cell phone stores and a florist (Table 4-1). Currently, only two service-related businesses are operating in the Complex; a barber shop and an internet café. However, an optometry clinic is scheduled to open in March 2010. It is estimated by the Consultant that each of these concession stores average 1,000 square feet of space based on other complex occupants and an allocation for common and private areas, such as hallways, restrooms and the food court dining area.

The PX Complex also includes a food court with five dining establishments. With a shared dining space, these restaurants are estimated to individually occupy between 500 and 700 square feet. Recently, any turnover occurring among restaurants at Fort Lee food courts has involved similar dining options. For instance, a Subway sandwich shop recently replaced a Robin Hood sandwich shop in the PX Complex.

¹¹ Concession stores are private businesses operating on military property.

b) PXtra Troop Mall Complex

The PXtra Troop Mall Complex is similar to the PX Complex in most respects, though it is slightly smaller in size. The Consultant estimates the complex at 85,000 square feet. It contains multiple concession stores, has a modest food court and is anchored by another PX. However, this PX, called the PXtra, is substantially smaller than the exchange at the PX Complex and includes a furniture store. In addition, the PXtra Troop Mall Complex includes other retail military outlets, such as a shoppette, a Class VI store and a Military Clothing Sales Store (MCSS). A shoppette is a convenience store offering necessary items, such as over-the-counter medicine, toiletries and snack foods. The Class VI (“six”) store also sells convenience items, but has a large alcoholic beverage inventory. Lastly, the MCSS sells authorized military clothing, uniforms, accessories and weapons.

There is nearly twice the amount of concession stores (19 stores) in the PXtra Troop Mall Complex as in the PX Complex. Additionally, the concession stores at the PXtra Complex are more evenly distributed between retail and service. Among the eight service-oriented businesses is a car rental establishment, a computer repair center, a nail salon and a dry cleaner. Similar to the PX Complex, there are three stores specializing in cell phones and related accessories in the PXtra Complex indicating a strong demand for these items on-post.

The food court only consists of three establishments. Until recently, two of these restaurants were located in both exchange complexes; Robin Hood and Anthony’s Pizza. While Robin Hood was replaced by Subway in the PX Complex, Anthony’s Pizza in the PXtra Complex is being replaced with a Pizza Hut in March 2010. This turnover reemphasizes the efforts made to maintain similar offerings on-post.

c) Stand Alone Businesses

There are a few retail, dining and service establishments on post that operate outside of the exchange complexes. The largest of these establishments is the Commissary, which is the Fort’s grocery store. Located adjacent to the PX Complex, the Consultant estimates that the Commissary building is approximately 75,000 square feet. This size is slightly larger than the 50,000 to 60,000 square feet of a typical grocery store. The substantial size allows for a wide and diverse array of grocery and household items. In addition, this Commissary benefits from the location of the Defense Commissary Agency (DeCA) headquarters at Fort Lee. According to the DeCA, goods are sold at the Commissary at cost plus a 5% surcharge equating to a savings of approximately 30%. The selection and discount is likely to ensure that the majority of grocery spending for military personnel residing on or near post will occur at the Commissary.

Other AAFES-operated businesses on-post includes a Burger King restaurant, a fuel/service station, a cafeteria, a book store, a coffee shop and a Laundromat. Of these establishments, the Burger King, fuel/service station and Laundromat maintain high visibility due to operating out of standalone facilities. However, the Laundromat also includes an interior Internet Café Cyber Zone business. Conversely, the coffee shop is located inside the Kenner Clinic while the book store and cafeteria are located in the Army Logistics Management College, which is part of the ALU facility. Additionally, the new ALU facility also includes new commercial establishments Einstein Bagels, Subway and a barbershop. Each of the aforementioned interior businesses cater primarily to the inhabitants and visitors in these buildings.

d) Competitive Advantage

The retail, dining and service businesses operated by AAFES maintain a cost advantage over local businesses operating off-post. In addition to the modest mark-up over cost for goods at the Commissary, all AAFES businesses exclude state sales tax (5%) from items.

This extends from services rendered at the exchange complexes to the gas sold at the on-post service station.

Another advantage provided by AAFES is their price matching offer¹². The program works in two ways. First, an AAFES cashier may match a competitor’s price ‘on the spot’ provided the difference for the item is less than ten dollars. Secondly, if the price difference for the item is greater than ten dollars, a shopper may show a competitor’s advertisement displaying the lower price to the cashier and receive the reduced price, again ‘on the spot.’ The relatively low costs and price matching program likely contribute to military personnel shopping remaining on-post provided these benefits are well-known.

Table 4-1
Existing On-Post Commercial Businesses
Fort Lee (Virginia)

Business Name	Operated By	Business Name	Operated By
PX Complex		Pxtra Troop Mall Complex	
Main Store	AAFES	Pxtra/Shoppette/Class Six	AAFES
Class VI	AAFES	MCSS (Military Clothing Sales Store)	AAFES
Barber Shop	Concession	Alteration Shop	Concession
GNC	Concession	Specialty Shop	Concession
Hair 'n' More	Concession	Wireless Accessories	Concession
Sports Shop	Concession	Jewelry Shop	Concession
Sprint	Concession	Barber Shop	Concession
Flower Shop	Concession	Sprint	Concession
Optical Shop	Concession	Computer Repair	Concession
Cellular Accessories/Fonefrills	Concession	Thompson Audio	Concession
Internet Café Cyber Zone	Concession	Laundry/Dry Clean	Concession
Beauty Shop	Concession	Air Brush	Concession
Optometry Clinic (under construction)	Concession	KC Fashion & Shoe Repair	Concession
Slides N More Jewelry	Concession	Enterprise Car Rental	Concession
Anthony's Pizza #1	AAFES	GameStop	Concession
Subway	AAFES	Green Bean Coffee	Concession
Cinnabon	AAFES	Cultural Gift Shop	Concession
Charley Steakery	AAFES	T-Mobile	Concession
Manchu Wok	AAFES	Internet Café Cyber Zone	Concession
Stand Alone Businesses		Anthony's Pizza #1	Concession
Car Care Center	AAFES	Ohayo	Concession
Burger King	AAFES	Inside Logistics University Complex	
Laundromat/Internet Café Cyber Zone	Concession	Cafeteria	AAFES
Coffee Shop in Kenner Clinic	Concession	Einstein Bagels	AAFES
Commissary	DeCA	Subway	AAFES
The HideAway	FMWR	Bookstore	AAFES
Lee Playhouse	FMWR	Barbershop	Concession
Regimental Club	FMWR		
The Lee Club	FMWR		
Bowling Center	FMWR		
Batting Cage	FMWR		
Cardinal Golf Club	FMWR		

Source: AAFES, FMWR & RKG Associates, Inc., 2009

Note: DeCA is the Defense Commissary Agency

¹² Crooks, Tara. (2008, March 5) *Your BX/PX: What's the Benefit?* [Online] In *Advisors: Benefits & Lifestyles Columnists*. Retrieved December 19, 2009 from <http://www.military.com/opinion/0,15202,163404,00.html>

2. Pipeline Commercial Inventory

The BRAC action at Fort Lee includes the development of a wide variety of new facilities and operations on-post. Most recently, the new Army Logistics University center and Sustainment Center of Excellence were completed to account for increased military training activity. Along with the construction of these and other projected centers are proposed retail, dining and service establishments. Many of these commercial projects are underway or are expected to begin early in 2010.

Two notable commercial projects are currently under construction as well. These include the new car care center complex and the renovation of the Lee Playhouse. The car care center will have multiple businesses operating on-site and is projected to be completed and open in early 2010¹³. The project will be anchored by a Firestone car care center that will include 24 fuel pumps, several service bays and a car wash. In addition, the complex will also include a Popeye's chicken fast-food restaurant, a Class Six store and a shoppette. The Playhouse is currently being transformed into a facility that will be able to show movies in addition to hosting theater events. According to the AAFES Business Operations Manager, the movie theater will have limited operating hours due to the facility's multiuse program. This limitation is likely to provide only modest levels of competition for larger cinema multiplexes located in the local region.

One other commercial project in the pipeline is slated to begin construction in early 2010. Located in the northern part of Fort Lee, this project will include a shoppette and a barber shop. According to AAFES, the project is scheduled to be completed in September 2010. These businesses would be the third on-post shoppette and the fourth barber shop.

There are a few new businesses that have recently opened or are scheduled to open in the on-post exchanges in addition to those previously mentioned. In the PXtra Troop Mall Complex, the space previously occupied by the Brigade Quartermaster now houses a Thompson Audio, which sells and installs car audio equipment. At the PX Complex, an optometry clinic is expected to open in April 2010. The optometry clinic will offer eye exams, a service not offered by the Optical Shop currently located in the PX Complex.

In terms of the TLQ facility, there is a proposed 300-seat dining facility to be included in the TLQ facility. Although there are no details about the operation or dining type of this facility, this new eatery likely will draw students who are staying at the TLQ.

In total, there is approximately 304,000 square feet of retail space currently on Fort Lee. The new development projects, including the dining facility at the TLQ, represent an increase of approximately 20,000 to 25,000 square feet, or 8% to 9% of the existing supply. This amount of new commercial space projected at Fort Lee is relatively disproportional to the anticipated personnel increase, as the ALU is projected to bring an average of 1,500 additional soldiers to Fort Lee each day. Although permanent party personnel levels are projected to decline slightly (approximately 400 persons) between 2009 and 2015, this loss is more than compensated for by the increase in ALU student growth levels. As such, it is likely that business activity occurring at the AAFES establishments will increase substantially due to this discrepancy. Additionally, businesses located off-post likely will experience modest levels of increased business activity due to the increase in area military personnel.

¹³ Bell, T. Anthony. *AAFES Offers Update on Various Projects*. [Fort Lee Traveller](#). December 3, 2009.

B. ALU STUDENT SURVEY

RKG Associates conducted a survey to analyze the spending activity of military personnel at Fort Lee, specifically the students attending classes at the Army Logistics University. The survey was designed to help identify the types of goods and services typically purchased by the local military population and where these purchases occur. The findings of the survey will provide a clearer understanding of the demand for retail, service, dining and hospitality both on- and off-post.

1. Methodology

RKG Associates designed the Fort Lee spending habit survey to be conducted online. The survey was built using Survey Monkey, an online tool that provides templates for survey creation and analysis. Once the survey was created, the Consultant purchased a simple domain name, www.fortleesurvey.com, to enable potential respondents to easily connect to the survey. The survey was administered online from December 17, 2009 through January 4, 2010. The results were then collected and analyzed by the Consultant on January 6th.

The survey was intended to be brief and consists of eleven questions. These questions are separated into two sections: Background and Spending Activities. The five questions in the Background section focus on the individual respondent's rank/grade, training schedule, mode of transportation and lodging situation. Clarifying the profile of each respondent provides greater insight into their related spending habits. The Spending Activities questions revolve around the respondent's dining, retail and grocery purchases on- and off-post. Questions include ranking the types of businesses each respondent would like to see on-post, the types of purchases made on- and off-post and how often meals, goods and services are purchased off-post.

Advertising the survey to the Fort Lee military population occurred in two ways. Since the survey is directed at ALU students, the Consultant designed an advertisement that was placed in the Fort Lee Traveller and in lobbies of hotels participating in the Lodging Success Program (LSP), where many ALU students reside during their training. The ad occupied a quarter-page in the December 17th issue of the Traveller directing ALU students to the online survey. The advertisement was also enlarged onto letter-sized sheets of paper and distributed to the LSP hotels by a representative of the Crater Planning District Commission (PDC). In an effort to maximize responses, a raffle for a \$100 gift certificate to Best Buy was included for those completing the survey and mentioned in the advertisement. It is important to note that the Consultant was limited to advertising the survey outside of any ALU classrooms by the Office of the Staff Advocate General.

There were 26 survey respondents, 19 of which completed the survey. The relatively low number of responses is likely due to the limitation of advertising outside of the classroom and during the holiday season. While the 19 responses are not enough to justify scientific conclusions of spending activity, the completed responses provide a basis for understanding the purchasing habits of the respondents.

2. Respondent Profile

The profile of the survey respondents share many commonalities. Most of the respondents (15) are classified as officers. Of these, 13 reported an O-1 rank. The four enlisted personnel are classified as either E-6 or E-7. The training schedules for the respondents vary widely, but 15 report to be at the Fort for at least ten weeks during their current stay. This length of time ensures that the majority of trainees will be active purchasers of local goods and services for daily and longer term needs. Additionally, all but one of the respondents report having their own car with them allowing them to venture off-post for goods and services. The lone respondent without a personal car uses the shuttle service to get to the hotel where he/she is residing. Lastly, 18 of the

19 respondents claim to be staying at a local hotel during their training session. The other respondent also reports to be off-post, but at an undisclosed location.

3. Spending Habits

a) Off-Post Spending Habits

A majority of meals consumed by the 19 survey respondents are eaten off-post. Of the three primary meals, breakfast and dinner are eaten off-post an average of 70% and 77%, respectively, off-post during any given week. Conversely, lunch is eaten off-post an average of 50% of the time. The lower off-post lunch consumption is likely due to convenience as students are on-post during the middle of the day for class. Additionally, there is a more diverse selection of breakfast and dinner options located off-post, where most of the respondents reside. Lastly, most of the dining options on-post closes by 6 or 7PM during the week. The standalone Burger King is the only restaurant reporting operating hours after 7PM.

Most of the students shop for non-dining goods and services at least once per week. In fact, only five state that they shop off-post less than once per week. However, this finding may be slightly inflated as all but one of the respondents report having access to personal transportation.

Groceries are the most frequently purchased item or service off-post. More than half (12) of the survey respondents rank groceries as their most frequently purchased item. The other seven students state fast food (3) and sit-down (4) restaurants as their most frequent off-post expense. The fact that dining and food account for the most frequent purchases is likely due to the lack of kitchen facilities in many of the local hotels.

Among the other frequent off-post purchase choices in the survey, seven respondents stated that recreation and entertainment venues were among their top three purchases off-post. While it may lack the capacity for larger crowds, the on-post movie theater currently under construction may absorb some of this demand as recreation and entertainment venues are largely unavailable on-post.

b) Purchase Allocation

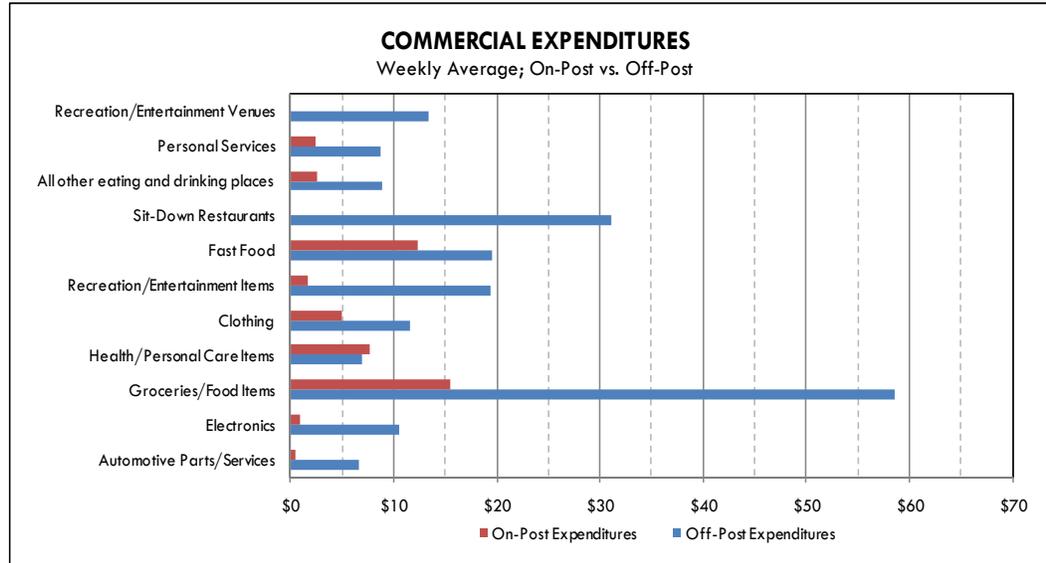
Most of the spending activity of the survey respondents occurs off-post (Figure 4-1). On a weekly basis, the average amount spent off-post on retail, service and dining purchases is nearly \$245. Conversely, the average spent on-post for the same types of goods and services is approximately \$70. It is important to note; however, that these findings reflect survey submissions from a military population residing off-post.

The largest average weekly expenditures occurring off-post and on-post are for groceries. Survey respondents spend a weekly average of \$23 on-post for groceries versus \$64 off-post. This finding is surprising given the substantial discounts available for military personnel at the Commissary located on-post. In fact, 15 of the respondents spend more money weekly on groceries off-post than on-post. This pattern is likely a result of convenience as some grocery stores may be located close to the LSP hotels.

The only category that respondents spend more money on-post than off-post is health/personal care items. Students completing the survey stated that they spend an average of \$16/week on items such as deodorant and toothpaste on-post versus \$7 off-post. These items are widely available at any of the shoppettes, the Commissary or Class VI stores on-post.

One of the categories with relatively low levels of total spending activity is recreation and entertainment venues (\$13). While this category ranked high among most frequented places, the amount of money spent at these venues is low. Of the 19 respondents, only ten reported having spent any money on a weekly basis at recreation or entertainment venues. However, of these ten, the average amount spent on a weekly basis is \$26.

Figure 4-1

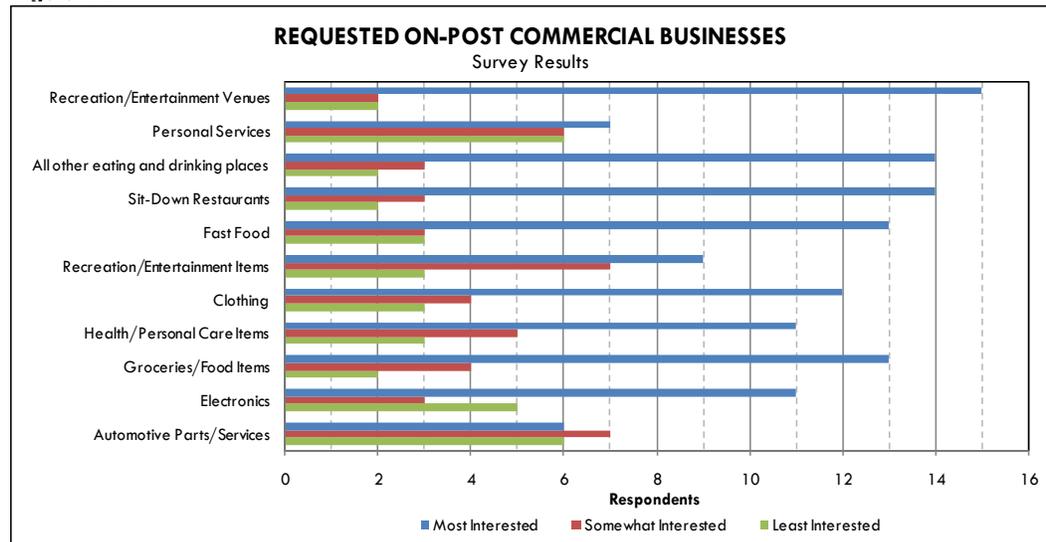


Source: RKG Associates, Inc. 2010

c) Requested On-Post Businesses

The final question posed in the survey asked each respondent to rank his/her level of interest in seeing additional businesses in various commercial categories on-post. The respondent provided a number between 1 and 10 for each category with 1 representing

Figure 4-2



Source: RKG Associates, Inc. 2010

the most interest and 10 the least. It should be noted that for display purposes, the Consultant combined responses equating to 1 through 3 for most interested, 4 through 7 for somewhat interested and 8 through 10 for least interested. The result of this inquiry is that respondents are highly interested in seeing more commercial businesses on-post in nearly every category (Figure 4-2). The highest interest is in additional recreation and entertainment venues, eating and drinking establishments and grocery stores. With the exception of the coffee shops on-post, this finding is reflective of the lack of non-fast food restaurants and entertainment venues on-post. However, it also shows that most of the respondents are either unaware of the Commissary or prefer to shop for groceries off-post.

On the other hand, survey respondents maintain relatively low levels of interest in additional personal services and automotive parts and services. This finding likely reflects the numerous available hair care businesses already on-post, such as the three barber shops, beauty shop, hair shop and shoppettes. As for the low level of interest in increased automotive parts and services establishments, it is likely that most respondents view their stay to be short enough that these services will largely be unneeded.

5 FISCAL IMPACT ANALYSIS

A. INTRODUCTION

In addition to the market impacts created by the construction of the Temporary Living Quarters (TLQ) detailed in the previous chapters, the Consultant also analyzed the potential tax revenue impacts the new development at Fort Lee related to the expansion of operations at the Army Logistics University (ALU). From the lodging perspective, the Consultant measured the how the TLQ facility would impact transient occupancy tax revenues and local sales tax revenues generated by short-term lodging stays within the region. For this analysis, the Consultant compared current estimated revenue generation related to Fort Lee business and projected out future revenue streams accounting for the expanded mission of the ALU and the construction of the TLQ. From a retail perspective, the Consultant studied the potential impacts to retail spending habits of removing 1,000 soldiers from off-post housing and placing them on-post. The result of this effort measured the potential changes to local sales tax revenue generated by the ALU student body.

B. FISCAL IMPACT ANALYSIS

This section details the impact of Fort Lee-related hotel stays on the transit occupancy and sales tax revenues for the Study Region's six cities and counties. These tax revenues are driven by the stays allocated in the gravity modeled discussed in earlier chapters.

1. Transient Occupancy Tax Impacts

Cities and Counties within Virginia are allowed to levy a lodging tax, or transient occupancy tax (TOT). This tax effectively is an enhanced sales and use tax dedicated to short-term lodging stays. The legislation governing TOT is quite involved, as Counties and Cities are treated differently by the State. Counties TOT powers are legislated by the State, with a series of Code Sections dedicated to which Counties are allowed to charge what tax amounts.¹⁴ In contrast, Virginia's incorporated Cities establish their own rates and terms within their city code. Local rates and terms are as follows:

- Chesterfield County – 8.0% for all stays 30 days or less
- Colonial Heights – 8.0% for all stays 90 days or less
- Dinwiddie County – 2.0% for all stays 30 days or less
- Hopewell – 8.0% for all stays 30 days or less
- Petersburg – 6.0% for all stays 30 days or less
- Prince George County – 5.0% for all stays 30 days or less

The Consultant used these rates and terms to determine a current estimate and future projections of TOT revenue by jurisdiction based on growth in Fort Lee stays and the impacts of the TLQ facility. To accomplish this, the Consultant used several data points and assumptions, including:

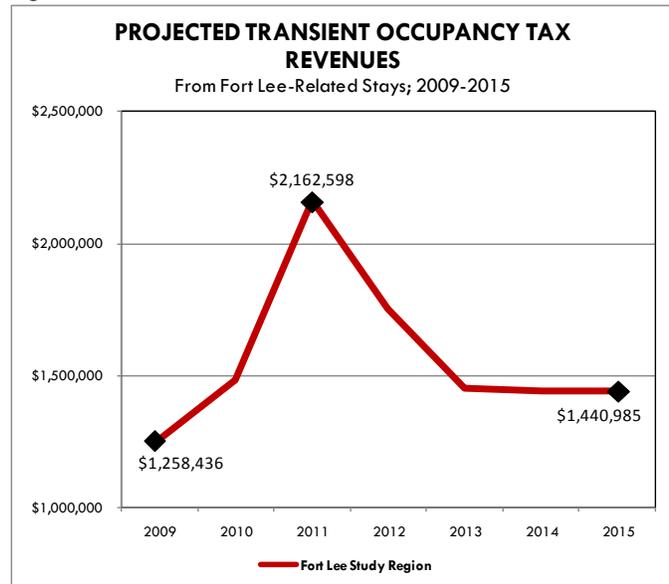
¹⁴ Code of Virginia 58.1-3819 to 3826

- The breakout of hotel room night demand by jurisdiction was taken directly from the hotel market analysis projection model detailed in the previous chapters.
- In order to reflect current market conditions, LSP demand is allocated based on preference of the student rather than hotel assignment through the CRC process. This assumption allows the model to calibrate how introducing choice into the market will impact individual jurisdictions.
- ALU class listing information for FY2009 and FY2011 indicates that approximately 20% of all ALU-related stays are fewer than 30 days. As such, jurisdiction with policies exempting stays over 30 days capture TOT from 20% of their LSP room demand.
- The same class listings indicate approximately 90% of all stays are fewer than 90 days, indicating Colonial Heights will capture TOT revenues from 90% of LSP-related stays.
- All non-LSP stays are expected to be shorter than 30 days, making them all eligible to be taxed under the TOT guidelines.
- All LSP stays are assumed to be charged the \$70 per diem rate less the 8% mandated discount from the LSP contract.
- All per diem stays are assumed to be charged the \$70 per diem rate.
- All private market stays are assumed to pay the average daily room rate for the given municipality’s hotels and motels (ranging between approximately \$50 and \$115).

a.) Fort Lee Study Region Impacts

The Consultant estimates that the Fort Lee Study Region jurisdictions collected approximately \$1.58 million in TOT from Fort Lee related stays in FY2009. Most of the revenue was generated by per diem stays as a result of the relatively similar demand loads between LSP and per diem business. Revenues are projected to peak in FY2011, when the ALU is slated to be fully operational but the TLQ facility is not complete. TOT related revenues are projected to increase more than \$900,000 from FY2009 levels, to \$2.16 million (Figure 5-1). After the TLQ is operational, the average annual TOT revenue for the Study Region is projected to be slightly higher than current year estimates, at approximately \$1.44 million.

Figure 5-1



Source: Crater PDC and RKG Associates, Inc. 2010

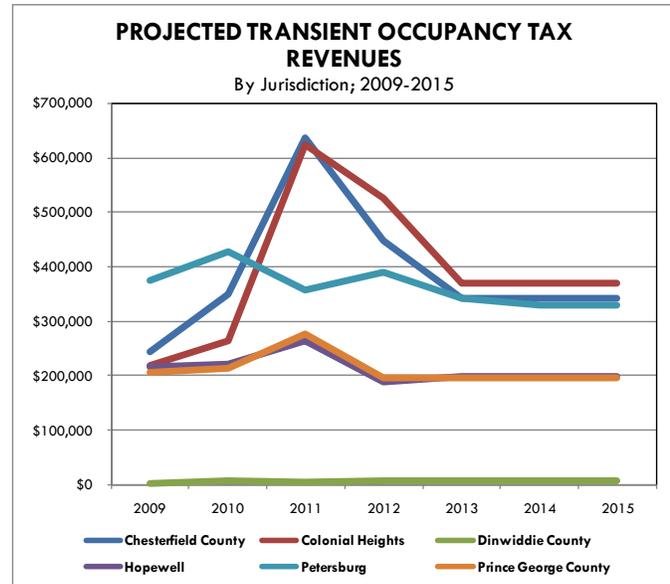
b.) Tax Revenue Reallocation Impacts

Despite the overall benefit to the Fort Lee Study Region lodging market, the changes to the LSP process has resulted in shifts of demand capture within the Region. As mentioned throughout this analysis, the current reservation process is not delivering the room night

demand to the LSP hotels as efficiently as has been done in the past. Introducing preference and choice into the reservation process has benefitted some communities more than others.

Fiscal year 2009 estimates indicate Petersburg constituted the greatest share of TOT, at an estimated \$375,099 (Figure 5-2). However, the growth in market demand and the influence of adding choice to the market has changed this situation. In FY2011, TOT revenues are projected to reach a peak, with Colonial Heights (\$624,592) and Chesterfield County (\$637,475) both exceeding the Petersburg (\$356,276) capture level. Not factoring the windfall revenues that occur in FY2011 and the beginning of FY2012, the net change

Figure 5-2



Source: Crater PDC and RKG Associates, Inc. 2010

from current estimates to the end study year varies by community. Chesterfield County and Colonial Heights both experience substantial gains in TOT revenue levels (\$97,900 and \$152,100 respectively). In contrast, Petersburg and Hopewell both experience a slight loss. This difference occurs for two primary reasons. First, the growth in LSP stays, and the success of LSP hotels within Petersburg and Hopewell, displaces some higher-paying per diem stays. As such, the level of occupancy remains stable, but the taxable value of those stays decreases. Second, Chesterfield County and Colonial Heights have greater concentrations of hotels that rank higher in the model. As such, new demand placed in the market will disproportionately be captured in these areas. While the model’s limitations do preclude any definitive findings, the analysis reveals that changes in the LSP program and the growth of LSP demand in the region does influence the taxable position of the host communities.

2. Lodging-Related Local Sales Tax Impacts

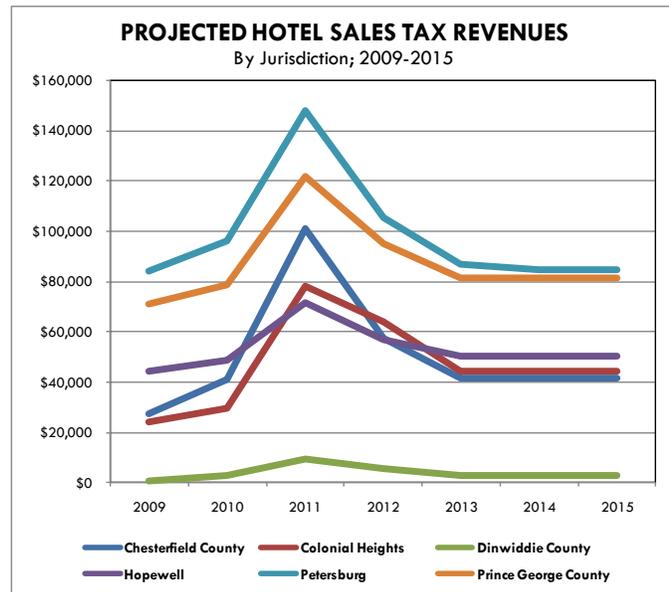
The Commonwealth of Virginia’s sales tax rate is 5%, with 4% directly allocated to the state and a 1% optional allocation for localities. All six localities have implemented the 1% sales tax revenue. In the case of lodging, stays lasting more than 90 days are not charged sales tax. To this end, the Consultant followed a similar methodology for this analysis as for the TOT analysis, replacing the tax rates (1% for all jurisdictions) and the policy length of stay limitations (90 days). The result of this effort produced a jurisdiction-based assessment of local sales tax revenue projections related to Fort Lee operations.

Similar to the TOT analysis, the Region experienced a net gain in sales tax revenue from lodging stays, increasing from an estimate of \$252,166 in FY2009 to \$305,800 in FY2015. However, the distribution of revenues has changed. Most notably, Petersburg and Prince George County represent the largest share of tax revenue within the Study Region for each year of the study (Figure 5-3). This contrasts TOT findings, where Colonial Heights and Chesterfield County account

for the largest share. This disparity reflects the impacts of only being able to tax stays shorter than 30 days. Petersburg and Prince George are heavily influenced by LSP stays, which typically last longer than 30 days. As such, their respective TOT revenues do not reflect the level of activity.

In addition, each jurisdiction experiences a net gain in sales tax revenue between FY2009 and FY2015. The growth of LSP stays in Petersburg and Hopewell without similar growth in non-LSP stays have driven down the net taxable value and the amount of taxable stays under the TOT legislation. In contrast, the 90day exemption for sales tax leaves most of these stays “on the books” and increases the net taxable amount of room revenue for all communities.

Figure 5-3



Source: Crater PDC and RKG Associates, Inc. 2010

3. Retail Local Sales Tax Impacts

The Consultant calculated the potential impact on retail expenditure-related sales tax revenues by measuring the spending habits of ALU students. As detailed in the last chapter, the Consultant performed a survey of ALU students to gauge differences in spending habits on- and off-post for students stationed in the community and students stationed on Fort Lee. This survey provided insight into the average daily spending patterns of students housed off-post. Utilizing this data, the Consultant then estimated spending habits of on-post soldiers, accounting for access and proximity to the venue offered at the PX, PXtra and stand-alone operations. Finally, the Consultant adjusted spending the spending habits for both on-post and off-post soldiers as a result of the new commercial development proposed for Fort Lee (detailed in the previous chapter. The result was spending estimates that allowed the Consultant to test how growth in student population, and subsequent recall of 1,000 students to on-post housing will impact retail sales tax revenues. The projection model considers the following assumptions:

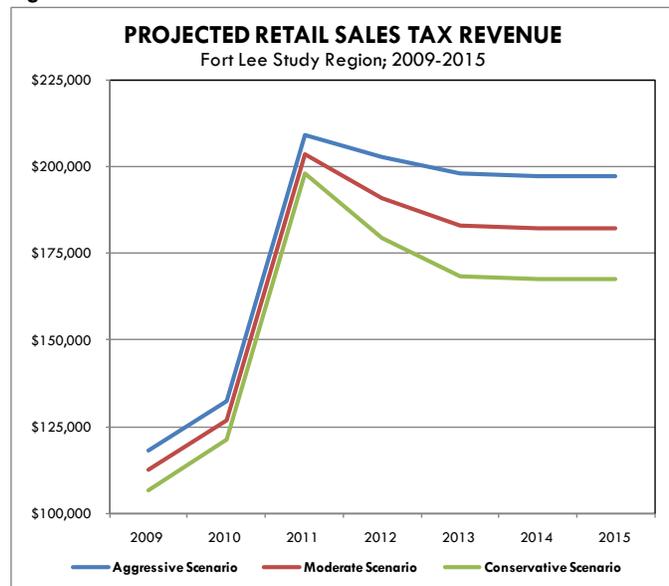
- Off-post students will spend at a level similar to those surveyed, in terms of total dollar amount and distribution between on-post and off-post businesses.
- On-post students are estimated to spend less off-post on certain items. The model interprets spending habits for eleven different retail categories. Adjustments were made to reflect availability on-post.
- Current spending patterns on-post reflect approximately 16.5% is done at non-AAFES businesses, making those sales subject to sales tax. As such, the Consultant allocated on-post spending following these trends.
- The Consultant removed all categories (i.e. groceries) that has tax exempt status in Virginia from the daily spending rates to eliminate overstating impact.

- According to AAFES information provided to the Consultant, the development of new retail venues by FY2011 will shift the concentration of taxable stores on post. As a result, the model assumes a greater share of on-post spending will be taxable starting in FY2011
- As a sensitivity analysis, the Consultant ran two additional scenarios estimating on-post housing. The “moderate” scenario reflects the projected spending habits of students. The “aggressive” scenario assumes on-post students’ spending behaviors more closely reflect off-post students, giving greater weight to off-post spending. The “conservative” scenario assumes on-post students are less likely to patronize off-post facilities.

Retail operations in the Fort Lee Study Region benefit from the growth of the ALU student population. Between FY2009 and FY 2015, more than 444,000 room-nights of demand for lodging will be added to the Region. While much of this demand will be housed at the TLQ facility, the total amount of consumed retail goods and services will increase. At a base level, the net number of off-post student stays will increase between FY2009 and FY2015. This growth in off-post stays is projected to result in additional off-post spending. Additionally, the growth in on-post stays will result in some additional spending off-post. The most substantial difference will occur when the TLQ facility becomes operational. Similar to the hotel market analysis, revenues to the jurisdictions is projected to decline at this point, but remain above the current estimate levels.

The Fort Lee Study Region is estimated to capture approximately \$112,400 in retail sales tax for FY2009 (Figure 5-4) on approximately \$22 million in total spending. Spending on non-taxable goods and at AAFES-owned businesses total nearly \$10.8 million. Tax revenues are projected to peak in FY2011, likely ranging from \$198,000 to \$209,000 on almost \$38 million in total retail spending. This change reflects the “maximum” tax impact, as all of the new LSP stays are housed off-post. Once the TLQ facility is operational, the net spending level is not projected to shift, however, on-post and off-post allocation will. As a result, the soldiers locating on-post likely will spend less in the community. The Consultant projects that FY2015 retail sales tax revenue will range between \$167,000 and \$197,000.

Figure 5-4



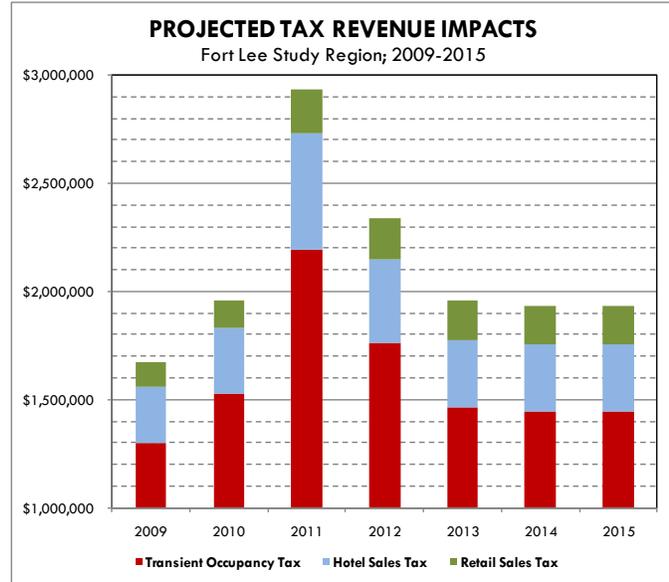
Source: Crater PDC and RKG Associates, Inc. 2010

Simply put, bringing these soldiers back onto post will increase spending at non-taxable venues, such as the commissary at the expense of off-post retailers. However, the net difference between FY2009 and FY2015 indicates the peak of the market is a windfall, and off-post and on-post businesses will ultimately benefit. The allocation within the six jurisdiction likely will change more severely, as additional on-post spending (at taxable businesses) likely will reflect a transfer from surrounding communities to Price George County. Being the retail hub for the Crater region, Colonial Heights likely stands to lose the most if more soldiers are recalled on-post. However, it is not possible to model retail spending habits of all ALU students, so a detailed assessment of jurisdictional allocation has not been completed.

C. IMPLICATIONS

The next several years are projected to deliver millions of dollars in tax revenue to the Fort Lee Study Region. The economic impact analysis indicates that the six Crater PDC jurisdictions most impacted by the Fort Lee expansion will realize a cumulative increase in transient occupancy tax and local sales tax related to hotels stays and retail expenditures (Figure 5-5). The Region is projected to experience a one-time windfall of tax revenue of \$1.4 million during FY2011 and the beginning of FY2012. This windfall ends as a result of the opening of the TLQ. At this time, the amount of TOT revenues and hotel-related sales tax revenues are projected to decline to a level below the peak, but above current revenue estimate levels. However, the Study Region also is projected to experience a sustained net increase in tax revenue of more than \$260,000 annually as a result of the increase operations at Fort Lee.

Figure 5-5



Source: Crater PDC and RKG Associates, Inc. 2010

However, it was noted that the shift in demand due to the increased market activity and the inefficiencies in the current implementation of the LSP has resulted in creating bigger “winners” within the Study Region in terms of net new tax revenues. The data indicate that Colonial Heights and Chesterfield County are poised to experience a larger share of this net gain over communities such as Hopewell and Petersburg. While the details of the retail sales tax revenues are not complete for a jurisdiction-level analysis, it is reasonable to assume Prince George County will benefit the most, as the County collects all on-post sales tax revenue.

Given the relatively imminent nature of the bulk of these stays, the most effective means by which a municipality might try to increase its projected tax revenues may be to increase its TOT rate and the length of stays that qualify for exemption. Colonial Heights serves as a prime example, utilizing an 8% rate (among the highest) and only exempting stays of more than 90 days, while all other municipalities exempt stays of more than 30. This is significant given that approximately 90% of all LSP stays fall below 90 days, while only 20% fall below 30 days. This situation is evident in the fact that Colonial Heights only hosts four of the Study Region’s 57 hotels (7%), but is projected to capture up to 30% of collected TOT and 17% of hotel-based sales tax related to Fort Lee stays in 2012. The analysis indicates that Colonial Heights’ relative effectiveness in generating tax revenue from Fort Lee-related stays is due to its TOT policy. Hence, it is suggested that municipalities consider altering their policies in similar ways in order to capture additional revenues in the coming years. Doing so, especially in communities within significant hotel supply, offers the possibility of increased tax income as Fort Lee-generated demand is projected to take up much of the Study Region’s supply during its peak years.



REGIONAL HEALTHCARE TECHNICAL MEMORANDUM



Technical Memorandum

To: Healthcare Committee Member
Crater Planning District Commission
From: Russell A. Archambault, Vice President and Principal
RKG Associates, Inc.
Re: Health Care Services Analysis
Date: September 2010



A. INTRODUCTION

The following technical memorandum presents RKG Associates' research findings relative to the incoming Fort Lee personnel and the increased demand on health care services. The assessment provides an examination of physician needs, in-patient service demand including behavioral/psychiatric needs, as well as cursory review of regional health care facilities and planned expansions both at Fort Lee and within the study area.

The following analysis is based, in part, on interviews with health care administrators and practitioners within the Fort Lee Study Region (Prince George, Dinwiddie, Chesterfield, Petersburg, Hopewell, and Colonial Heights). In addition, hospital patient discharge data was obtained from the Central Virginia Health Planning Agency, which was preparing the *Cameron Foundation Health Needs Assessment* for the same region. Much of the information on TRICARE in-patient discharge data was pulled from this data. TRICARE is the military's equivalent to a healthcare insurance company.

B. TRICARE DISCHARGES

The consultant analyzed TRICARE in-patient discharges in order to obtain a better understanding of the military use of health care in-patient services within the Crater region. Recipients of TRICARE include all active duty members and their families, retirees and their families, and survivors who are not eligible for Medicare. However, it is important to note that some military and retirees choose not to participate in TRICARE and they are not captured in the data. Despite this fact, the following analysis provides a good indicator of the health services accessed by many active military service members and their dependents. VA medical benefits are provided to veterans and are not offered to non-veterans or active military.

1. Total TRICARE Discharges

TRICARE in-patient discharge data was obtained from the Central Virginia Health Planning Agency. It should be noted that similar out-patient discharge data does not exist. The data were arranged by zip code in order to show areas of medical service demand. As would be expected, the areas closest to Fort Lee have a comparatively high number of TRICARE discharges (Map 1).

The northern Chesterfield area and parts of Hanover County also have comparatively high numbers of patient discharges due to higher population densities.

The data in Figure 1 shows the amount of TRICARE discharges of each county. As seen in the figure, the amount of TRICARE discharges within a community is relatively low compared to the total in-patient discharges. However, the amount of TRICARE discharges does vary depending on community, and tends to be highest within the Fort Lee, Petersburg, and Southern Chesterfield zip codes.

Zip codes within Dinwiddie County experience comparatively less TRICARE discharges, however there is also a comparatively small population in this County. There is one health center, the Dinwiddie Medical Center, in Dinwiddie County. The closest hospital to Dinwiddie is the Southside Regional Medical Center in the City of Petersburg.

In Prince George County there are areas of high discharge, primarily located close to Fort Lee. There are no health centers in this jurisdiction. The closest hospitals are Southside Regional Medical Center or John Randolph Medical Center in the City of Hopewell.

2. TRICARE Discharges by County

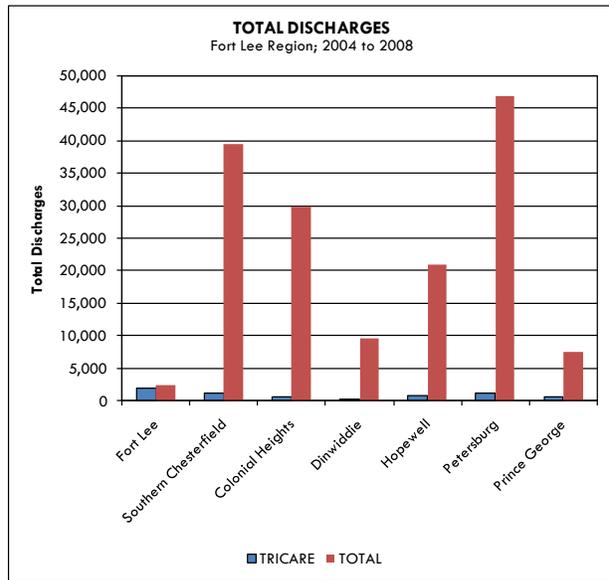
TRICARE participants seek in-patient medical care for a variety of reasons. In order to narrow down the diagnosis groupings, RKG arranged the discharge data by the Diagnosis Related Group (DRG). This allowed for the consultant to identify areas of healthcare needs. In many cases, the top diagnosis only accounts for less than 5% of the total discharges. However, even with the DRG, the range of illnesses is too great to show every grouping. Therefore the top 10 DRG’s are shown for each jurisdiction in Table 1. This provides a better understanding of military in-patient healthcare needs and what the charges are for these services. In order to provide comparative context, the number and discharges for both TRICARE and non-TRICARE patients within each community are included.

a.) Fort Lee Discharges

Although the Kenner Army Health Clinic is located on-post at Fort Lee, this facility is for out-patient services only. Army personnel and their families that live on-post use the hospitals located within the surrounding community for in-patient care. The data presented in Table 1 indicate the largest TRICARE diagnosis for residents living in the Fort Lee zip code was for psychoses. This diagnosis accounted for about 31% of total TRICARE discharges. This diagnosis also reflects the largest financial charges accounting for \$6.2 million or 25.2% of the total TRICARE charges.

The high percentage of psychoses discharges likely reflects the strains and stresses of multiple deployments on military personnel and their families. It should be noted that the comparatively high rate of psychoses discharges is not isolated to the Fort Lee zip code alone.

Figure 1



Source: Central Virginia Health Planning Agency and RKG Associates, Inc., 2010

As will be shown in the following tables, every community within the study area has psychoses listed as a Top Ten discharge diagnosis. This is a problem of growing importance and is affecting the general military population. The high rate of discharges demands an equally large response from the Fort Lee Region’s medical community and all military communities throughout the country.

Table 1
Top 10 DRG Discharge Data by Payer
Fort Lee; 2004 Through 2nd Quarter 2008

DRG	# of Cases			% of Cases		Total Charges			% of Charges	
	Tricare	Other	TOTAL	Tricare	Other	Tricare	Other	TOTAL	Tricare	Other
Psychoses	589	19	608	31.11%	3.26%	\$6,242,852	\$144,949	\$6,387,801	25.16%	1.36%
Vaginal Delivery W/O Complicating Diagnoses	262	7	269	13.84%	1.20%	\$2,087,348	\$65,400	\$2,152,748	8.41%	0.61%
Normal Newborn	234	119	353	12.36%	20.41%	\$269,942	\$199,247	\$469,189	1.09%	1.87%
Cesarean Section W/O Cc	94	6	100	4.97%	1.03%	\$1,320,864	\$78,512	\$1,399,376	5.32%	0.74%
Uterine & Adnexa Proc For Non-Malignancy W/	28	1	29	1.48%	0.17%	\$569,910	\$21,950	\$591,860	2.30%	0.21%
Bronchitis & Asthma Age 0-17	25	1	26	1.32%	0.17%	\$205,133	\$7,402	\$212,535	0.83%	0.07%
Esophagitis, Gastroent & Misc Digest Disord	24	1	25	1.27%	0.17%	\$286,290	\$14,874	\$301,164	1.15%	0.14%
Simple Pneumonia & Pleurisy Age 0-17	24	0	24	1.27%	0.00%	\$238,349	\$0	\$238,349	0.96%	0.00%
O.R. Procedures For Obesity	24	0	24	1.27%	0.00%	\$1,182,221	\$0	\$1,182,221	4.76%	0.00%
Chest Pain	22	2	24	1.16%	0.34%	\$212,123	\$8,382	\$220,505	0.85%	0.08%
TOTAL TOP 10 DRG	737	137	874	38.93%	23.50%	\$6,372,180	\$395,767	\$6,767,947	25.68%	3.72%
TOTAL OTHER DRG	1,156	446	1,602	61.07%	76.50%	\$18,442,542	\$10,249,919	\$28,692,461	74.32%	96.28%
GRAND TOTAL	1,893	583	2,476	100.00%	100.00%	\$24,814,722	\$10,645,686	\$35,460,408	100.00%	100.00%

Source: Central Virginia Health Planning Agency and RKG Associates, Inc., 2009

b.) Southern Chesterfield Discharges

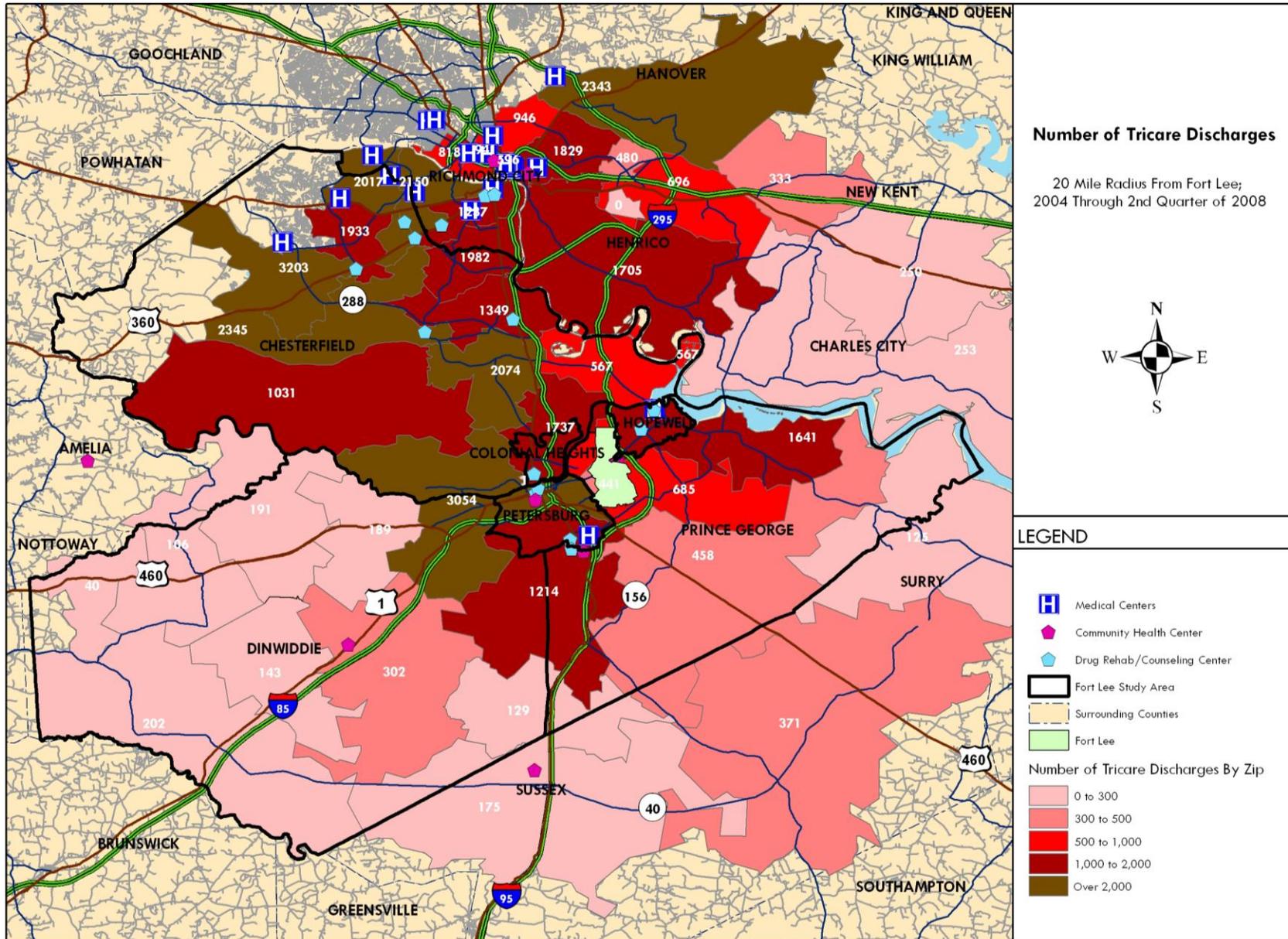
Due to the varying nature and large size of Chesterfield County, the discharge information was taken only for the southern portion of the County, or those zip codes where the majority of growth resulting from the Fort Lee expansion will likely be distributed. Within Southern Chesterfield County, direct childbirth related diagnosis account for almost 30% of all TRICARE discharges (Table 2). These diagnoses are Normal Newborn (156), Vaginal Delivery without Complicating Diagnosis (130), and Cesarean Section (52). These discharges cost \$42.6 million, or 7.3% of the total TRICARE discharge costs. The high incidence of childbirth-related diagnoses in the TRICARE data most directly reflects the young age of many military personnel, many of whom are under the age of 30 and are starting families.

Table 2
Top 10 DRG Discharge Data by Payer
Southern Chesterfield; 2004 Through 2nd Quarter 2008

DRG	# of Cases			% of Cases		Total Charges			% of Charges	
	Tricare	Other	TOTAL	Tricare	Other	Tricare	Other	TOTAL	Tricare	Other
Normal Newborn	156	3,406	3,562	13.65%	8.89%	\$202,580	\$4,397,021	\$4,599,601	0.77%	0.35%
Vaginal Delivery W/O Complicating Diagnoses	130	2,633	2,763	11.37%	6.87%	\$1,004,823	\$20,039,088	\$21,043,911	3.82%	1.61%
Psychoses	73	2,251	2,324	6.39%	5.88%	\$707,636	\$26,227,483	\$26,935,119	2.69%	2.11%
Cesarean Section W/O Cc	52	1,338	1,390	4.55%	3.49%	\$700,563	\$18,192,961	\$18,893,524	2.67%	1.47%
Uterine & Adnexa Proc For Non-Malignancy W/	28	787	815	2.45%	2.05%	\$696,208	\$20,314,111	\$21,010,319	2.65%	1.64%
Neonate W Other Significant Problems	17	643	660	1.49%	1.68%	\$139,714	\$2,513,061	\$2,652,775	0.53%	0.20%
Heart Failure & Shock	3	640	643	0.26%	1.67%	\$54,346	\$17,182,474	\$17,236,820	0.21%	1.38%
Major Joint Replacement Or Reattachment Of	3	574	577	0.26%	1.50%	\$193,038	\$35,745,516	\$35,938,554	0.73%	2.88%
Rehabilitation	5	568	573	0.44%	1.48%	\$78,015	\$19,383,778	\$19,461,793	0.30%	1.56%
Esophagitis, Gastroent & Misc Digest Disord	16	551	567	1.40%	1.44%	\$388,093	\$12,318,461	\$12,706,554	1.48%	0.99%
TOTAL TOP 10 DRG	483	13,391	13,874	42.26%	34.96%	\$4,165,016	\$176,313,954	\$180,478,970	15.85%	14.21%
TOTAL OTHER DRG	660	24,909	25,569	57.74%	65.04%	\$22,107,445	\$1,064,700,477	\$1,086,807,922	84.15%	85.79%
GRAND TOTAL	1,143	38,300	39,443	100.00%	100.00%	\$26,272,461	\$1,241,014,431	\$1,267,286,892	100.00%	100.00%

Source: Central Virginia Health Planning Agency and RKG Associates, Inc., 2009

Map 1



Source: Central Virginia Health Planning Agency and RKG Associates, Inc., 2009

Other major TRICARE discharges include psychoses (73 or 6.4% of total TRICARE discharges), Uterine & Adnexa Procedures with Complications (28 or 2.5% of total TRICARE discharges), and Neonate (newborn infant less than 4 weeks old) With Other Significant Problems (17 or 1.5% of total TRICARE discharges).

Although the number of all the Top Ten TRICARE discharges account for 42.3% of the total TRICARE discharges, the costs for the Top Ten TRICARE discharges only represent 15.9% of the total TRICARE charges. This indicates that the comparatively expensive procedures and diagnosis are for less frequently diagnosis conditions.

c.) Colonial Heights Discharges

In Colonial Heights, Normal Newborn diagnosis account for the largest portion of TRICARE discharges (82 or 14.4% of total TRICARE discharges) (Table 3). Similar to the other communities, childbirth related discharges as well as psychoses discharges (36 or 6.3% of total TRICARE discharges) are other main diagnosis categories. The total charge for those TRICARE diagnoses within the Top Ten account for \$1.7 million, or 16.5% of the total related charges within Colonial Heights.

Table 3
Top 10 DRG Discharge Data by Payer
Colonial Heights; 2004 Through 2nd Quarter 2008

DRG	# of Cases			% of Cases		Total Charges			% of Charges	
	Tricare	Other	TOTAL	Tricare	Other	Tricare	Other	TOTAL	Tricare	Other
Psychoses	36	989	1,025	6.33%	3.38%	\$268,851	\$10,155,782	\$10,424,633	2.58%	1.21%
Normal Newborn	82	840	922	14.41%	2.87%	\$120,179	\$1,248,978	\$1,369,157	1.16%	0.15%
Vaginal Delivery W/O Complicating Diagnoses	62	723	785	10.90%	2.47%	\$496,956	\$5,973,109	\$6,470,065	4.78%	0.71%
Heart Failure & Shock	6	496	502	1.05%	1.69%	\$91,342	\$10,798,449	\$10,889,791	0.88%	1.28%
Cesarean Section W/O Cc	26	344	370	4.57%	1.17%	\$326,725	\$4,747,325	\$5,074,050	3.14%	0.56%
Rehabilitation	1	368	369	0.18%	1.26%	\$11,851	\$8,509,432	\$8,521,283	0.11%	1.01%
Esophagitis, Gastroent & Misc Digest Disord	4	288	292	0.70%	0.98%	\$53,189	\$5,477,819	\$5,531,008	0.51%	0.65%
Chronic Obstructive Pulmonary Disease	1	290	291	0.18%	0.99%	\$12,856	\$6,282,822	\$6,295,678	0.12%	0.75%
Simple Pneumonia & Pleurisy Age >17 W Cc	8	268	276	1.41%	0.91%	\$135,223	\$6,257,191	\$6,392,414	1.30%	0.74%
Uterine & Adnexa Proc For Non-Malignancy	11	254	265	1.93%	0.87%	\$201,711	\$5,126,052	\$5,327,763	1.94%	0.61%
TOTAL TOP 10 DRG	237	4,860	5,097	41.65%	16.59%	\$1,718,883	\$64,576,959	\$66,295,842	16.52%	7.67%
TOTAL OTHER DRG	332	24,430	24,762	58.35%	83.41%	\$8,683,231	\$776,978,580	\$785,661,811	83.48%	92.33%
GRAND TOTAL	569	29,290	29,859	100.00%	100.00%	\$10,402,114	\$841,555,539	\$851,957,653	100.00%	100.00%

Source: Central Virginia Health Planning Agency and RKG Associates, Inc., 2009

d.) Dinwiddie Discharges

Dinwiddie County has the fewest number of discharges within the study region, however the population in this large County is also comparatively less (27,249 current population estimate by ESRI, Inc.). In Dinwiddie, there were 112 total TRICARE discharges that accounted for \$3.3 million in charges (Table 4). Normal Newborn (11 or 9.8% of the total TRICARE discharges) was the top discharge diagnosis from 2004 through the second quarter of 2008. Psychoses (8 or 7.1% of total TRICARE discharges) and Vaginal Delivery without Complicating Diagnosis (8 or 7.1% of total TRICARE discharges) are also top discharge categories.

Table 4
Top 10 DRG Discharge Data by Payer
Dinwiddie; 2004 Through 2nd Quarter 2008

DRG	# of Cases			% of Cases		Total Charges			% of Charges	
	Tricare	Other	TOTAL	Tricare	Other	Tricare	Other	TOTAL	Tricare	Other
Psychoses	8	797	805	7.14%	8.48%	\$59,420	\$9,251,655	\$9,311,075	1.78%	3.44%
Normal Newborn	11	380	391	9.82%	4.04%	\$18,780	\$525,605	\$544,385	0.56%	0.20%
Vaginal Delivery W/O Complicating Diagnoses	8	338	346	7.14%	3.59%	\$75,367	\$2,959,813	\$3,035,180	2.26%	1.10%
Heart Failure & Shock	4	338	342	3.57%	3.59%	\$104,177	\$6,380,097	\$6,484,274	3.13%	2.37%
Rehabilitation	0	223	223	0.00%	2.37%	\$0	\$5,228,371	\$5,228,371	0.00%	1.95%
Cesarean Section W/O Cc	5	206	211	4.46%	2.19%	\$53,931	\$2,933,425	\$2,987,356	1.62%	1.09%
Chest Pain	1	199	200	0.89%	2.12%	\$10,999	\$2,146,702	\$2,157,701	0.33%	0.80%
Uterine & Adnexa Proc For Non-Malignancy W/	4	174	178	3.57%	1.85%	\$77,843	\$2,997,965	\$3,075,808	2.34%	1.12%
Intracranial Hemorrhage Or Cerebral Infarct	1	132	133	0.89%	1.40%	\$20,033	\$4,262,733	\$4,282,766	0.60%	1.59%
Esophagitis, Gastroent & Misc Digest Disord	0	123	123	0.00%	1.31%	\$0	\$2,128,981	\$2,128,981	0.00%	0.79%
TOTAL	42	2,910	2,952	37.50%	30.94%	\$420,550	\$38,815,347	\$39,235,897	12.62%	14.45%
TOTAL OTHER DRG	70	6,494	6,564	62.50%	69.06%	\$2,912,929	\$229,882,515	\$232,795,444	87.38%	85.55%
GRAND TOTAL	112	9,404	9,516	100.00%	100.00%	\$3,333,479	\$268,697,862	\$272,031,341	100.00%	100.00%

Source: Central Virginia Health Planning Agency and RKG Associates, Inc., 2009

e.) Hopewell Discharges

In Hopewell, there were 723 TRICARE discharges that were charged \$15.4 million (Table 5). Similar to the other communities, childbirth diagnosis which include Normal Newborn (101 or 14.0% of total TRICARE discharges), Vaginal Delivery without Complicating Diagnosis (81 or 11.2% of total TRICARE discharges), and Cesarean Section without Complications, account for a comparatively large majority of top diagnosis. Heart Failure and Shock is also a top discharge category within the community, and accounts for 2.3% of total discharges, including TRICARE and other payers. In fact, most communities within the study area have Heart Failure and Shock listed as a Top Ten discharge diagnosis.

Table 5
Top 10 DRG Discharge Data by Payer
Hopewell; 2004 Through 2nd Quarter 2008

DRG	# of Cases			% of Cases		Total Charges			% of Charges	
	Tricare	Other	TOTAL	Tricare	Other	Tricare	Other	TOTAL	Tricare	Other
Psychoses	59	1,546	1,605	8.16%	7.65%	\$486,274	\$14,856,294	\$15,342,568	3.16%	2.19%
Normal Newborn	101	1,103	1,204	13.97%	5.46%	\$136,145	\$1,631,446	\$1,767,591	0.88%	0.24%
Vaginal Delivery W/O Complicating Diagnoses	81	920	1,001	11.20%	4.55%	\$686,380	\$8,282,123	\$8,968,503	4.45%	1.22%
Heart Failure & Shock	2	581	583	0.28%	2.87%	\$35,091	\$17,062,799	\$17,097,890	0.23%	2.52%
Chronic Obstructive Pulmonary Disease	7	498	505	0.97%	2.46%	\$111,883	\$13,719,418	\$13,831,301	0.73%	2.02%
Cesarean Section W/O Cc	34	436	470	4.70%	2.16%	\$549,838	\$6,565,237	\$7,115,075	3.57%	0.97%
Renal Failure	1	345	346	0.14%	1.71%	\$18,077	\$12,296,489	\$12,314,566	0.12%	1.81%
Simple Pneumonia & Pleurisy Age >17 W Cc	8	304	312	1.11%	1.50%	\$128,663	\$10,597,290	\$10,725,953	0.84%	1.56%
Esophagitis, Gastroent & Misc Digest Disord	5	304	309	0.69%	1.50%	\$113,421	\$6,815,424	\$6,928,845	0.74%	1.01%
Intracranial Hemorrhage Or Cerebral Infarct	1	295	296	0.14%	1.46%	\$26,312	\$10,916,008	\$10,942,320	0.17%	1.61%
TOTAL TOP 10 DRG	299	6,332	6,631	41.36%	31.32%	\$2,292,084	\$102,742,528	\$105,034,612	14.88%	15.15%
TOTAL OTHER DRG	424	13,886	14,310	58.64%	68.68%	\$13,115,322	\$575,307,082	\$588,422,404	85.12%	84.85%
GRAND TOTAL	723	20,218	20,941	100.00%	100.00%	\$15,407,406	\$678,049,610	\$693,457,016	100.00%	100.00%

Source: Central Virginia Health Planning Agency and RKG Associates, Inc., 2009

f.) Petersburg Discharges

Petersburg had the highest number of discharges (46,886) in the region over the 5-year study period (Table 6). This is indicative of the higher population of the City of Petersburg. Psychoses are the largest diagnosis category of total payers (including TRICARE and other payers). Approximately 10.6% of the total discharges in the community were for psychoses, but comparatively less (6.1%) for TRICARE patients. Within TRICARE payers, Vaginal Delivery without Complicating Diagnosis (148 or 12.2% of total TRICARE discharges) and Normal Newborn (147 or 12.1% of the total TRICARE discharges) were top discharge categories. The total charges for all TRICARE discharges were \$22.9 million.

Table 6
Top 10 Total DRG Discharge Data by Payor
Petersburg; 2004 Through 2nd Quarter 2008

DRG	# of Cases			% of Cases		Total Charges			% of Charges	
	Tricare	Other	TOTAL	Tricare	Other	Tricare	Other	TOTAL	Tricare	Other
Psychoses	74	4,785	4,859	6.12%	10.48%	\$667,985	\$50,797,691	\$51,465,676	2.92%	4.15%
Vaginal Delivery W/O Complicating Diagnos	148	1,802	1,950	12.23%	3.95%	\$1,393,358	\$16,136,178	\$17,529,536	6.08%	1.32%
Normal Newborn	147	1,526	1,673	12.15%	3.34%	\$236,631	\$2,438,783	\$2,675,414	1.03%	0.20%
Heart Failure & Shock	8	1,653	1,661	0.66%	3.62%	\$122,098	\$2,431,861	\$2,553,959	0.53%	0.20%
Rehabilitation	4	1,010	1,014	0.33%	2.21%	\$79,065	\$22,827,148	\$22,906,213	0.35%	1.86%
Chronic Obstructive Pulmonary Disease	7	940	947	0.58%	2.06%	\$135,456	\$19,009,588	\$19,145,044	0.59%	1.55%
Chest Pain	22	876	898	1.82%	1.92%	\$228,302	\$11,037,661	\$11,265,963	1.00%	0.90%
Esophagitis, Gastroent & Misc Digest Disord	12	808	820	0.99%	1.77%	\$216,482	\$15,332,607	\$15,549,089	0.94%	1.25%
Cesarean Section W/O Cc	68	734	802	5.62%	1.61%	\$1,054,174	\$10,903,928	\$11,958,102	4.60%	0.89%
Simple Pneumonia & Pleurisy Age >17 W Cc	10	697	707	0.83%	1.53%	\$208,011	\$16,072,646	\$16,280,657	0.91%	1.31%
TOTAL TOP 10 DRG	500	14,831	15,331	41.32%	32.47%	\$4,341,562	\$166,988,091	\$171,329,653	18.95%	13.64%
TOTAL OTHER DRG	710	30,845	31,555	58.68%	67.53%	\$18,567,172	\$1,057,546,099	\$1,076,113,271	81.05%	86.36%
GRAND TOTAL	1,210	45,676	46,886	100.00%	100.00%	\$22,908,734	\$1,224,534,190	\$1,247,442,924	100.00%	100.00%

Source: Central Virginia Health Planning Agency and RKG Associates, Inc, 2009

g.) Prince George Discharges

The top discharge categories in Prince George County are similar to the other municipalities in the study area. Psychoses (26 or 4.4% of total TRICARE discharges), Normal Newborn (65 or 10.9% of total TRICARE discharges) and Vaginal Delivery without Complicating Diagnosis (68 or 11.4% of total TRICARE discharges) were the top discharge categories (Table 7). The charges for all TRICARE discharges in Prince George were about \$12.1 million.

Table 7
Top 10 DRG Discharge Data by Payer
Prince George (Less Fort Lee); 2004 Through 2nd Quarter 2008

DRG	# of Cases			% of Cases		Total Charges			% of Charges	
	Tricare	Other	TOTAL	Tricare	Other	Tricare	Other	TOTAL	Tricare	Other
Psychoses	26	508	534	4.36%	7.27%	\$223,766	\$4,364,915	\$4,588,681	1.85%	1.91%
Normal Newborn	65	305	370	10.91%	4.37%	\$95,246	\$474,408	\$569,654	0.79%	0.21%
Vaginal Delivery W/O Complicating Diagnoses	68	277	345	11.41%	3.97%	\$548,073	\$2,598,574	\$3,146,647	4.54%	1.14%
Heart Failure & Shock	1	208	209	0.17%	2.98%	\$17,114	\$5,329,919	\$5,347,033	0.14%	2.33%
Cesarean Section W/O Cc	26	150	176	4.36%	2.15%	\$467,993	\$2,405,230	\$2,873,223	3.88%	1.05%
Uterine & Adnexa Proc For Non-Malignancy W/	18	141	159	3.02%	2.02%	\$372,208	\$2,855,844	\$3,228,052	3.08%	1.25%
Esophagitis, Gastroent & Misc Digest Disord	7	104	111	1.17%	1.49%	\$105,273	\$1,990,816	\$2,096,089	0.87%	0.87%
Chronic Obstructive Pulmonary Disease	1	109	110	0.17%	1.56%	\$6,973	\$2,604,437	\$2,611,410	0.06%	1.14%
Simple Pneumonia & Pleurisy Age >17 W Cc	4	99	103	0.67%	1.42%	\$73,879	\$2,650,268	\$2,724,147	0.61%	1.16%
Neonate W Other Significant Problems	11	64	75	1.85%	0.92%	\$194,640	\$95,246	\$289,886	1.61%	0.04%
TOTAL TOP 10 DRG	227	1,965	2,192	38.09%	28.14%	\$2,105,165	\$25,369,657	\$27,474,822	17.43%	11.10%
TOTAL OTHER DRG	369	5,018	5,387	61.91%	71.86%	\$9,969,983	\$203,120,246	\$213,090,229	82.57%	88.90%
GRAND TOTAL	596	6,983	7,579	100.00%	100.00%	\$12,075,148	\$228,489,903	\$240,565,051	100.00%	100.00%

Source: Central Virginia Health Planning Agency and RKG Associates, Inc, 2009

C. POPLAR SPRINGS HOSPITAL TRICARE DEMAND

One of the main psychiatric providers in the Fort Lee Region is Poplar Springs Hospital, located in Petersburg, Virginia. The facility is currently licensed for a total of 199 beds, which include 75 acute beds (intensive treatment unit, adult, active military unit, and adolescent), 108 residential treatment beds, and eight group home beds. Programs include psychological and behavioral treatment for adults and adolescents aged 11-17, adolescent residential, sexually abusive youth services, and group homes.

In order to assess the demand for Poplar Springs' services from TRICARE patients, RKG obtained discharge data for the past 5 years from the hospital administration. As shown in Map 2, the highest TRICARE discharges were in the Fort Lee zip code (337 discharges). As stated previously, soldiers and their families are experiencing high stress levels from repeated deployments to Iraq and Afghanistan.

RKG also obtained TRICARE payer information by type of program. Although there is an Active Duty Military Care program, the data does not separate out the discharges from this program from the Adult Acute discharges. However, interviews with Poplar Springs representatives indicate that there are 16 beds reserved for active military members (which are part of the 75 acute beds). Additional acute beds could be accessed for the Active Duty Military Care program if needed.

The Adult Acute program accounts for the most discharges in the region (405) (Table 8). The 24-hour acute care includes individual, group, family and marital therapies, groups for trauma survivors, activity therapy, life skills, education groups to deal with anger, loss, grief, substance abuse education, and medication management. The Active Duty Military acute program offers similar services, but is specifically designed to meet the needs of the active duty military. This program provides treatment for the emotional and psychological effects of combat stress and post deployment adjustment-related issues. Soldiers can then step down to a partial hospitalization program to assist with transitioning back to their duty stations.

There is also a demand for adolescent acute care and residential treatment in the Fort Lee Region. There were 96 total adolescent acute care discharges from 2004 to 2009 and 23 boys and girls residential treatment discharges. The strain of war and deployment can affect not only the active duty service member, but also their families. The stress felt by some military children can come from a variety of factors, including the resulting stress from separation during deployment and also a readjustment period when the service member returns home.

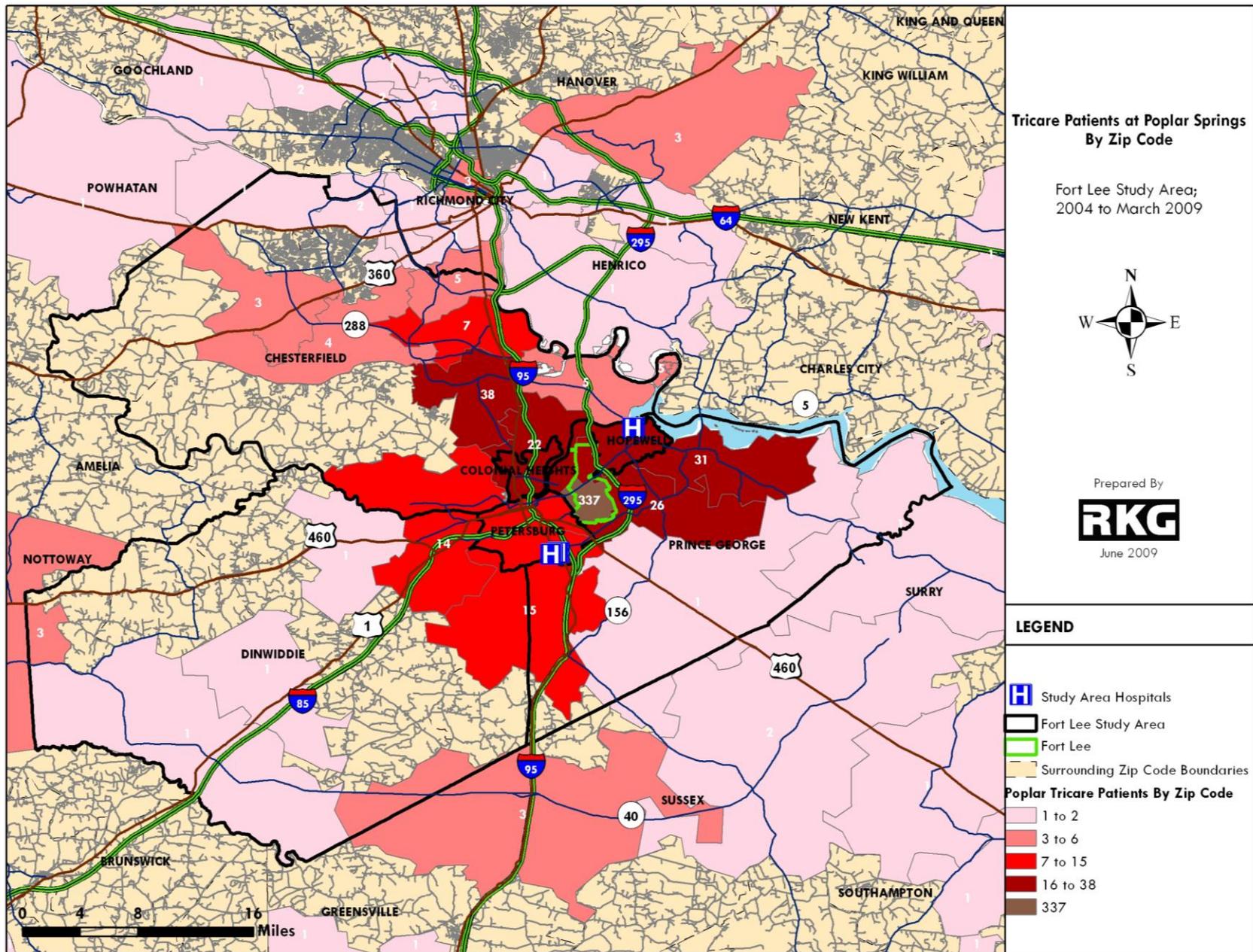
In order to address the unique behavioral health concerns of the military, Poplar Springs has a strong partnership with the Community Mental Health Clinic at Fort Lee. The health clinic at Fort Lee provides admission and referrals, and Poplar works with the Clinic to form a discharge plan. The facility is also TRICARE Certified and they understand the unique needs of military families. Poplar continues to review how to best meet military needs, and there is a subcommittee that meets regularly to discuss expansion plans and how to refine or create new programs and services. Most recently, Poplar has applied for a new 28-day substance abuse program that will be an inpatient program only for the military.

Table 8
Poplar Springs TRICARE Payors
Crater Region; 2004 - Present

Jurisdiction	Number of Discharges				Total	% of Total
	Adult Acute	Adolescent Acute	Boys Residential Treatment	Girls Residential Treatment		
Fort Lee	296	32	4	5	337	64.3%
Chesterfield	29	28	5	1	63	12.0%
Prince George	20	13	3	3	39	7.4%
Hopewell	24	7	0	0	31	5.9%
Petersburg	21	9	1	0	31	5.9%
Colonial Heights	12	6	1	0	19	3.6%
Dinwiddie	3	1	0	0	4	0.8%
TOTAL	405	96	14	9	524	100.0%

Source: Poplar Springs and RKG Associates, Inc., 2009

Map 2



D. TRICARE EMERGENCY ROOM VISITS

RKG Associates also analyzed TRICARE Emergency Room data from the Southside Regional Medical Center (SRMC). The number of visits by patient zip code for year 2008 is shown in Map 3. Although the consultant was not able to obtain similar data from the John Randolph Medical Center, the Emergency Room information from SRMC provides some geographic reference of TRICARE emergency room demand, and how that demand has changed year over year.

The map shows that the zip codes in and closest to Fort Lee, including Petersburg and Southern Chesterfield, have greater concentrations of TRICARE emergency room visits. The Fort Lee zip code had the highest number of visits in 2008 at 1,593. There is one zip code in Petersburg that experienced 405 visits. The other main Petersburg zip code experienced 384 visits. The number of TRICARE emergency room visits significantly decreases in zip codes that are located further from the base.

SRMC emergency room data by year indicates that there is a growing number of TRICARE visits (Table 9). In 2006, there were 2,783 visits in the Fort Lee study area zip codes, which increased 13% to 3,131 visits in 2008. At the same time, the charge for these TRICARE visits increased by 68% to \$1,055,463. The rising cost of services is consistent with national trends. Meetings with healthcare professionals in the Fort Lee study area indicate that there are some doctors that choose not to participate in the TRICARE network because insurance reimbursement rates are too low to cover the increasing cost of providing services. Although the recent health care reform legislation, which passed in March 2010, is not planned to change TRICARE from the current framework, the comparatively low reimbursement rates offered by TRICARE will remain a critical issue for area providers into the future.

Table 9
Southside Regional Medical Center Emergency Room Visits
Fort Lee Study Area; 2006 to 2008

County	2006		2007		2008	
	Visits	Charge	Visits	Charge	Visits	Charge
Fort Lee (23801)	1,620	\$365,683	1,655	\$447,934	1,593	\$547,260
Chesterfield (23831, 23838, 23836)	76	\$18,048	91	\$23,764	105	\$39,186
Colonial Heights (23834)	181	\$39,802	229	\$61,100	263	\$91,134
Dinwiddie (23872,23841,23840,23833,23850,23885)	15	\$5,485	23	\$5,199	33	\$7,823
Hopewell (23860)	67	\$13,558	100	\$30,568	121	\$41,979
Petersburg (23805,23803)	687	\$147,760	696	\$180,456	795	\$247,446
Prince George (23842, 23875)	137	\$36,435	169	\$53,523	221	\$80,635
TOTAL	2,783	\$626,771	2,963	\$802,544	3,131	\$1,055,463

Source: Southside Regional Medical Center and RKG Associates, Inc., 2010

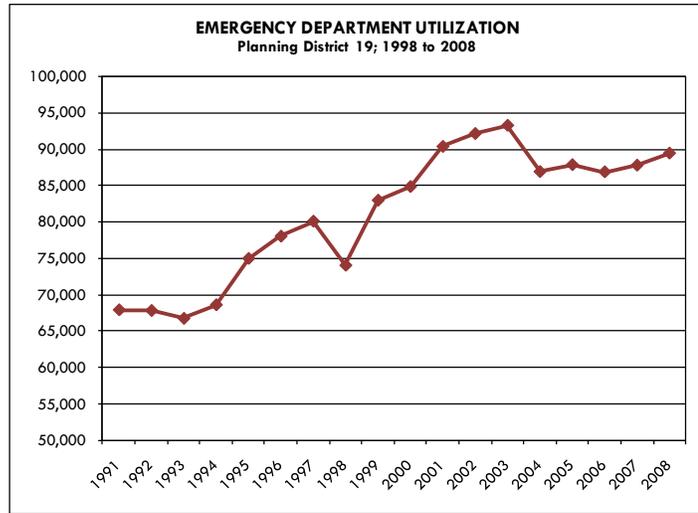
In order to more obtain a more in-depth understanding of Emergency Room trends in the Fort Lee Region, the consultant obtained Emergency Room Department utilization data from the Central Virginia Health Planning Agency for Planning District 19. The following data includes all types of insurance carriers and does not break out TRICARE specific Emergency Room visits. However, it does provide a good understanding of how Emergency Room utilization has changed within the region. Planning District 19 includes Colonial Heights, Dinwiddie, Emporia, Greensville, Hopewell, Petersburg, Prince George, Surry and Sussex. Chesterfield is part of a different planning district (Planning District 15), and as such was not included in the following analysis.

Emergency Room utilization has increased almost 32% from 1991 to 2008 (Figure 2). In 2008, there were 89,450 ER visits, as compared to 67,891 in 1991. The increase in ER visits is likely due to increased population.

Not all types of Emergency Room visits have increased at the same rate (Table 10). There was a very large increase in “Other” ER visits from 2005 to 2006. This is due to a re-categorization of care. The more non-urgent care in the “Other” category was previously categorized as “Medical Emergencies.” Other categories that experienced large increases include trauma visits (115%) and behavioral visits (77%).

As mentioned previously, behavioral and mental health conditions account for a comparatively large amount of discharges within the region. This is also reflected in the ER data, and further exemplifies the need for increased focus and attention on this issue.

Figure 2



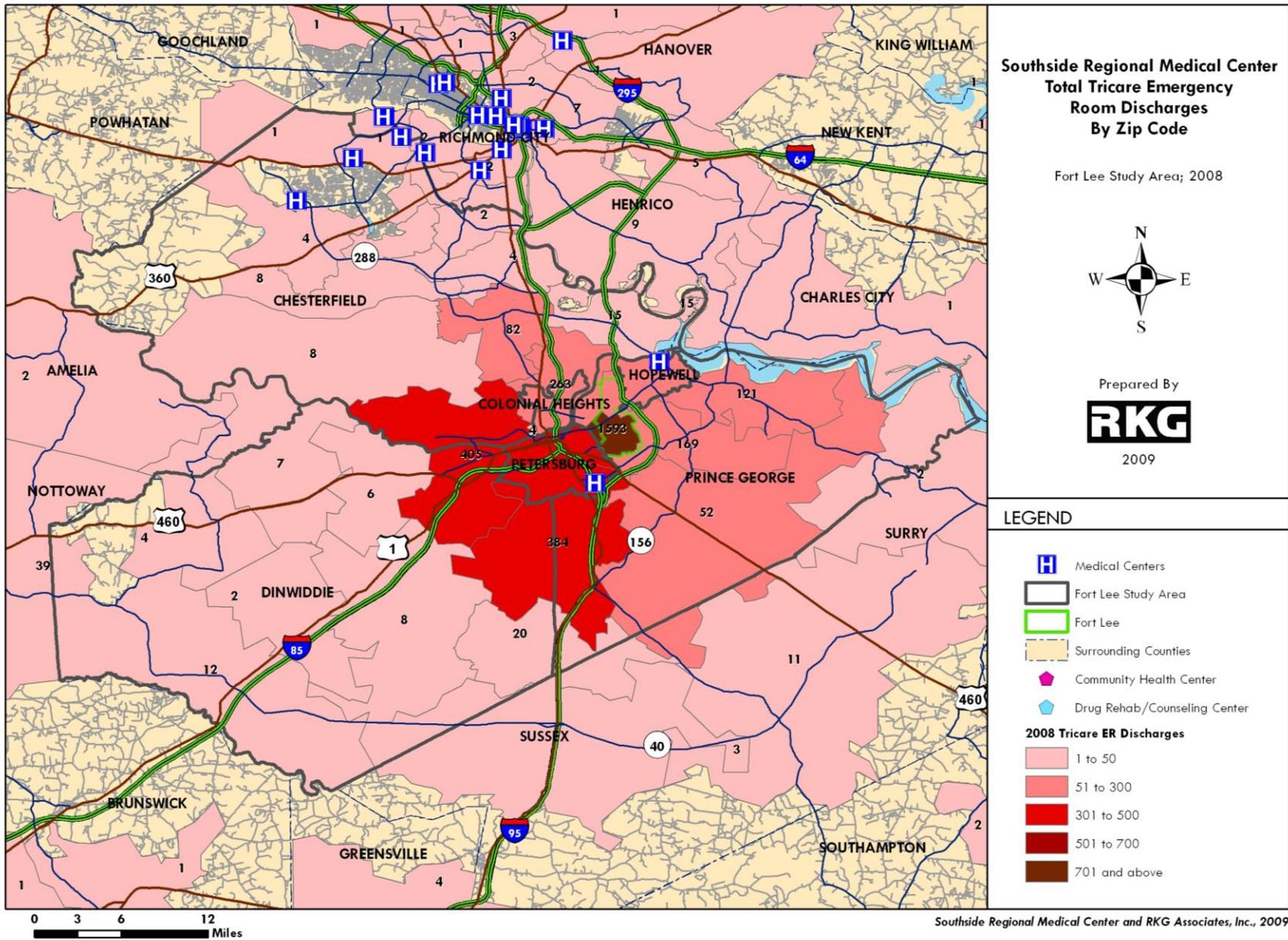
Source: Central Virginia Health Planning Agency and RKG Associates, Inc., 2010

Table 10
Emergency Room Visits By Type
Planning District 19; 1991 to 2008

Year	Reason For Visit								TOTAL
	Medical	Trauma	Cardiac	Burns	Perinatal	Toxic Exposure	Behavioral	Other	
1991	48,201	6,766	8,157	489	756	1,070	1,805	647	67,891
1992	35,914	18,311	4,628	1,870	1,472	1,796	3,261	546	67,798
1993	35,195	18,292	4,468	1,788	1,379	1,772	3,158	666	66,718
1994	21,817	9,797	993	224	490	142	737	658	68,589
1995	40,221	19,587	4,876	2,078	1,611	2,036	3,853	698	74,960
1996	41,115	20,809	5,411	2,202	1,655	2,169	3,928	736	78,025
1997	42,482	21,146	5,848	2,309	1,588	2,191	4,013	511	80,088
1998	36,512	21,474	5,297	2,482	1,746	2,467	4,026	15	74,019
1999	29,419	27,167	19,884	320	1,390	861	3,913	15	82,969
2000	63,078	11,431	4,774	445	1,193	945	2,970	15	84,851
2001	75,882	8,938	1,898	328	1,023	597	1,702	0	90,368
2002	77,402	9,228	1,822	315	1,039	592	1,746	0	92,144
2003	63,093	4,006	15,010	324	1,715	997	8,125	0	93,270
2004	58,667	13,311	7,170	270	987	512	2,614	3,375	86,906
2005	65,549	13,242	5,454	122	729	188	2,574	0	87,858
2006	46,679	16,999	7,584	232	1,277	1,000	3,351	9,750	86,872
2007	51,907	14,113	6,573	112	572	361	3,202	10,951	87,791
2008	51,506	14,530	6,374	207	530	1,078	3,187	12,038	89,450
Change	3,305	7,764	(1,783)	(282)	(226)	8	1,382	11,391	21,559
Percent Change	6.9%	114.8%	-21.9%	-57.7%	-29.9%	0.7%	76.6%	1760.6%	31.8%

Note: Planning District 19 includes Colonial Heights, Dinwiddie, Emporia, Greenville, Hopewell, Petersburg, Prince George, Surry, and Sussex
Source: Central Virginia Health Planning Agency and RKG Associates, Inc., 2010

Map 3



E. KENNER ARMY HEALTH CLINIC

The Kenner Army Health Clinic is the main out-patient facility which provides primary health care services for eligible customers. Specialty care and in-patient care is provided by network civilian healthcare partners. The following section details the referrals, visitations, expansion plans and staff changes of the clinic.

1. Kenner Army Health Clinic Referrals

In 2007, there were 12,256 referrals made to other network providers (Table 11). The number of referrals increased in 2008 to 13,832. There was a large increase in urgent care center referrals, which increased from 612 in 2007 to 2,832 referrals in 2008. According to interviews with Kenner Clinic representatives, the increase in urgent care referrals may be due to the Occupational Health (DSCR) closing in mid-2008 as well as an increase in personnel. At the same time, psychiatry referrals decreased 71.5% from 179 in 2007 to 51 in 2008. This is likely due to an increase in on-post psychiatric care.

Table 11
Kenner Army Health Clinic Referrals to Network
FY 07 and FY 08

Specialty	FY 07	FY 08	% Change
Urgent Care Center	612	2,832	362.7%
Radiology	166	235	41.6%
Gastroenterology	847	1,139	34.5%
Durable Medical Equipment	603	777	28.9%
Cardiology	642	772	20.2%
Dermatology	761	824	8.3%
Orthopedics	868	875	0.8%
Gen Surgery	624	573	-8.2%
Psychiatry	179	51	-71.5%
All Others	6,954	5,754	-17.3%
Total	12,256	13,832	12.9%

Source: HNFS MTF Overview and RKG Associates, Inc., 2009

2. Kenner Army Health Clinic Visits

In 2008, there were 144,904 visits to Kenner Army Health Clinic, which was a 14.2% increase in visits over 2007 levels (126,863) (Table 12). Although there were decreased visits for Internal Medicine issues (decrease of 70 visits), Family Assistance Program (decrease of 190 visits), Army Substance Abuse Program (decrease of 190 visits), Occupational Health (decrease of 235), and Hearing Conservation (decrease of 112), the rest of the clinic’s services experienced an increase in

Table 12
Kenner Army Health Clinic Visits
FY 07 and FY 08

Clinic	TOTAL FY 07	TOTAL FY 08	Change	% Change
Internal Medicine	1,861	1,791	(70)	-3.8%
Nutrition	9	325	316	3511.1%
Pediatrics\Exceptional Family Member Program	16,868	18,491	1,623	9.6%
Orthopedics	2,959	4,199	1,240	41.9%
Psychiatry/Mental Health	7,400	11,763	4,363	59.0%
Social Work\Family Assistance Program	770	580	(190)	-24.7%
Army Substance Abuse Program	5,753	5,475	(278)	-4.8%
Blue & Red Team (Family Practice for family members and retirees only)	25,880	28,580	2,700	10.4%
Soldier Readiness Processing Clinic	1,797	2,129	332	18.5%
Active Duty & Medical Evaluation Board Clinic	21,979	27,205	5,226	23.8%
Troop Medical Clinic	21,079	22,507	1,428	6.8%
Optometry	7,078	7,549	471	6.7%
Community Health	780	876	96	12.3%
Occ Health (KAHC)	1,456	1,771	315	21.6%
Physical Therapy	9,936	10,752	816	8.2%
Occ Health (DSCR)*	748	513	(235)	-31.4%
Hearing Conservation	510	398	(112)	-22.0%
TOTAL	126,863	144,904	18,041	14.2%

Source: Kenner Army Health Clinic and RKG Associates, Inc., 2009

*Closed in mid-2008

patient visits. One of the largest increases was in Active Duty & Medical Evaluation Board (5,226 increase) which is likely due to the increase in active duty personnel during this time. Psychiatry/Mental Health (4,363 increase) and Blue and Red Team services (which are for family members and retirees only) (2,700 increase) also experienced a comparatively large amount of increased visits.

3. Kenner Army Health Clinic Expansion Plans

In order to better serve the growing number of military personnel and dependants, the Kenner Army Health Clinic has \$14.7 million dollars invested in current repairs and renovation projects (Table 13). Current projects underway include renovating the behavioral health/social work services (which will occupy the entire third floor of the clinic), army substance abuse program, active duty clinic, preventative medicine, optometry and Bull Dental Clinic. There are also plans to create a new consolidated troop medical/dental clinic. It will be located in the new Ordnance area north of Hwy. 36. The troop medical center is planned to contain 20,545 SF and the new dental clinic is planned to contain 14,370 SF.

**Table 13
Non-BRAC FUNDED FACILITY PLANS
Kenner Army Health Clinic; 2009**

	Year Complete
RECENTLY COMPLETED REPAIRS/READAPMENT OF EXISTING SPACE¹	
Primary Care Clinic	2004
Orthopedics and Physical Therapy	2004
Pharmacy	2006
Pediatrics	2006
Information Management Division	2007
Total Cost	\$10,000,000
CURRENT REPAIR/READAPTION PROJECTS	
Behavioral Health /Social Work Services	2010
Army Substance Abuse Program	2010
Active Duty Clinic	2010
Preventative Medicine	2010
Optometry	2010
Bull Dental Clinic	2009
Total Cost	\$14,740,000
FUTURE PROJECTS	
Laboratory	Unknown
Radiology	Unknown
Expand Current Troop Medical Clinic (TMC)	Unknown
New Consolidated 34,915 SF TMC/Dental Clinic ¹	2010
Total Cost	\$21,620,000*

1. BRAC Funded and will be located in new Ordnance area north of Highway 36

*Projected Cost

Source: KAHC Resource Management and RKG Associates, Inc, 2008

4. Kenner Army Health Clinic Staffing Changes

In addition to some renovation and expansion plans, there are also plans to increase the staff at Kenner Army Health Clinic. An Automated Staffing Model (ASAM), which is approved by the Army and used for staffing all military treatment facilities, was used to determine the new staff needed at Kenner Army Health Clinic. This model takes into account the population of all active duty and family members, retirees, students, etc. and it estimates what staffing requirements there are for each type of service based on the population. As of 2011, the Clinic will add 10 total providers, 9 registered nurses, and 6 other facility staff (Table 14). The new Troop Medical Clinic will add the majority of new staff (10 new staff). Primary Care (3 new staff) and Managed Care (3 new staff) will also be expanding.

**Table 14
Proposed Medical Staffing
Kenner Army Health Clinic**

Medical Department	Kenner Clinic Staffing Requirements*								
	Existing as of 2007			Addtl by 2011			Post BRAC Total		
	Provider	RN	Other	Provider	RN	Other	Provider	RN	Other
Primary Care	16	6	0	2	1	0	16	7	0
Troop Med. Clinic	3	1	0	7	3	0	10	4	0
Pediatrics	5	3	0	0	0	0	5	3	0
Behavioral Health	1	0	9	1	0	3	2	0	12
Managed Care	0	2	0	0	3	0	0	5	0
Comm. Health	0	1	0	0	1	0	0	2	0
Occup. Health	1	2	0	0	1	0	1	3	0
Orthopedics	1	0	0	0	0	0	1	0	0
Physical Therapy	0	0	2	0	0	1	0	0	3
Optometry	0	0	2	0	0	1	0	0	3
Radiology	0	0	2	0	0	0	0	0	2
Pharmacy	0	0	7	0	0	1	0	0	8
Total	27	15	22	10	9	6	35	24	28

Source: KAHC Resource Management

*Does not reflect all facility staffing. Only key professional staff.

F. FORT LEE REGION PHYSICIAN SERVICE LEVELS

In order to determine if the Fort Lee region is served by an adequate number of physicians, RKG analyzed physician specialty data from the Virginia Department of Health Professions and the Virginia Department of Health. The data was organized by Board Certified specialty within each community. It should be noted that some physicians have more than one specialty. Each of these specialties is reflected in the following tables.

Determining physician need of a community is a very complex task. The RKG physician analysis provides one general overview of physician needs of the Region, but in order to provide context and an alternate perspective, the consultant obtained the Southside Regional Medical Center (SRMC) Physician Needs Assessment. SRMC has their own method for modeling the physician needs of the community. This method takes into account service area populations and needs per physician type. The results of the SRMC analysis is included following the RKG analysis.

1. RKG Associates Physician Needs Analysis

The data indicate that, compared to the Commonwealth of Virginia, the Fort Lee Region has less specialties per 1,000 population (1.93 compared to 4.08 in Virginia) than the Commonwealth as a whole (Table 15). While this may not be surprising given the modest population densities within the region, it should be noted that considerable concentrations of physicians are located just outside the region in the Richmond metropolitan area.

**Table 15
Specialties Per 1,000 Population
Fort Lee Region**

Municipality	Population	Specialties/ 1,000
Southern Chesterfield	93,322	2.24
Prince George	37,791	0.29
Colonial Heights	17,803	5.00
Dinwiddie	27,249	0.26
Petersburg	31,595	2.34
Hopewell	23,344	2.39
Fort Lee Region	231,104	1.93
Commonwealth of VA	7,965,681	4.08

Source: ESRI Inc., VA Dept. of Health, and RKG Associates, Inc., 2010

The number of specialties within the Fort Lee Region greatly varies depending on the jurisdiction. For example, there are only .29 specialties per 1,000 population in Prince George County, and .26 specialties per 1,000

population in Dinwiddie County. These two counties are comparatively large in square miles with lower population densities as compared to the other communities. As such, the comparatively low numbers of physician specialties per 1,000 population is likely attributable to the lower population densities.

On the other hand, Colonial Heights has an average of 5.0 specialties per 1,000 population. It is the only Fort Lee Region jurisdiction to contain a specialty ratio above the Commonwealth level of 4.08. Colonial Heights serves as the retail and services center for the region. Typically physicians like to locate near higher trafficked areas (such as retail centers) and areas with higher median incomes households. Although the two main hospitals, John Randolph Medical Center and Southside Regional Medical Center are located in Hopewell and Petersburg respectively, Colonial Heights is also a very desirable location for physicians.

Table 16 shows the region's physician specialties as compared to current state levels. RKG created an index value that compares the specialties per 1,000 population in each county/city in the study area to the Commonwealth of Virginia specialties per 1,000 population. Those specialties that have an index value above 1.0 (the state average) have comparatively more physician specialties per 1,000 than the Commonwealth of Virginia, and those under 1.0 have comparatively fewer specialties per 1,000 than the Commonwealth. The physician specialty analysis is meant to give a general sense of the specialty composition specific to the Fort Lee Region. Although a certain specialty may be underserved the Fort Lee Region, it should be noted that the same specialty may be available a short drive away in Richmond.

The following table also shows the specialty composition of each jurisdiction. For example, anesthesiologists compose 2.5% of the total Fort Lee Region specialties. In VA, anesthesiologists compose 4.6% of the total specialties, indicating the Fort Lee Region specialty composition is lower than the Commonwealth specialty level composition. In general, the Commonwealth specialty compositions tend to be composed of more of the higher level specialties than in the Fort Lee Region.

Most of the specialties within the Fort Lee Region have an index less than 1.0, indicating there are fewer specialties per 1,000 population than in the Commonwealth. Those specialties that have an index above 1.0 include Emergency Medicine (1.44), Other Specialties (such as nuclear medicine, sleep disorders, neonatal medicine, acupuncture, etc.) (1.15) and Not Board Certified (2.76). It should be noted that those who are "not board certified" may have a self-designated specialty not reflected in the following table.

Although there are not many specialties above the Commonwealth index in the Fort Lee Region as a whole, Colonial Heights does have as much or more specialties per 1,000 population in many categories. Some of the higher indexes include Orthopedic Surgery (4.19), Pulmonary (3.93), Physical Medicine and Rehabilitation (3.12), Cardiovascular (2.65), Emergency Medicine (1.84), and Psychiatry (1.53). Some of the more unique or select specialties, such as Endocrinology (0.0), Gastroenterology (0.0), and Radiology (0.19) may still be underserved, compared to the Commonwealth.

Southern Chesterfield also has a few specialties that are above the state index. These include Emergency Medicine (1.96), Physical Medicine & Rehabilitation (1.19), Other (1.42), and Not Board Certified (4.06). Although the index of specialties is generally below the Commonwealth, most specialties have some representation in Southern Chesterfield. However, there are 0 specialties in Infectious Disease and Urology.

Table 16
Board Certified Specialties of Physicians
Zip Code Prefix 238

Specialty ¹	Southern Chesterfield ²			Prince George			Colonial Heights			Dinwiddie			Petersburg			Hopewell			FORT LEE REGION			TOTAL STATE OF VA		
	Specialties	Composition	Index of State Comparison of Specialties/1,000	Specialties	Composition	Index of State Comparison of Specialties/1,000	Specialties	Composition	Index of State Comparison of Specialties/1,000	Specialties	Composition	Index of State Comparison of Specialties/1,000	Specialties	Composition	Index of State Comparison of Specialties/1,000	Specialties	Composition	Index of State Comparison of Specialties/1,000	Specialties	Composition	Index of State Comparison of Specialties/1,000	TOTAL STATE OF VA SPECIALTIES	Specialty Composition	SPECIALTIES/1,000
Anesthesiology	7	3.3%	0.40	0	0.0%	0.00	1	1.1%	0.30	0	0.0%	0.00	1	1.4%	0.17	0	0.0%	0.00	9	2.0%	0.21	1,494	4.6%	0.19
Cardiovascular	3	1.4%	0.25	0	0.0%	0.00	6	6.7%	2.65	0	0.0%	0.00	1	1.4%	0.25	1	1.8%	0.34	11	2.5%	0.37	1,013	3.1%	0.13
Dermatology	1	0.5%	0.21	0	0.0%	0.00	1	1.1%	1.12	0	0.0%	0.00	1	1.4%	0.63	0	0.0%	0.00	3	0.7%	0.26	401	1.2%	0.05
Emergency Medicine	28	13.4%	1.96	3	27.3%	0.52	5	5.6%	1.84	3	42.9%	0.72	5	6.8%	1.04	7	12.7%	1.96	51	11.5%	1.44	1,217	3.7%	0.15
Endocrinology	3	1.4%	1.38	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	3	0.7%	0.56	186	0.6%	0.02
Family/General Practice	24	11.5%	0.63	2	18.2%	0.13	7	7.9%	0.96	3	42.9%	0.27	8	10.8%	0.62	8	14.5%	0.83	52	11.7%	0.55	3,270	10.1%	0.41
Gastroenterology	1	0.5%	0.20	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	1	0.2%	0.08	420	1.3%	0.05
Gynecology/Obstetrics	3	1.4%	0.17	0	0.0%	0.00	5	5.6%	1.52	0	0.0%	0.00	3	4.1%	0.51	1	1.8%	0.23	12	2.7%	0.28	1,473	4.5%	0.18
Hematology/Oncology	2	1.0%	0.31	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	2	2.7%	0.93	1	1.8%	0.63	5	1.1%	0.32	544	1.7%	0.07
Hepatology ⁴	2	1.0%	n/a	0	0.0%	n/a	0	0.0%	n/a	0	0.0%	n/a	0	0.0%	n/a	0	0.0%	n/a	2	0.4%	n/a	n/a	n/a	n/a
Infectious Disease	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	1	1.8%	1.42	1	0.2%	0.14	241	0.7%	0.03
Internal Medicine	28	13.4%	0.37	2	18.2%	0.07	18	20.2%	1.26	0	0.0%	0.00	13	17.6%	0.51	7	12.7%	0.37	68	15.3%	0.37	6,414	19.7%	0.81
Neurology	2	1.0%	0.29	0	0.0%	0.00	2	2.2%	1.50	0	0.0%	0.00	1	1.4%	0.42	0	0.0%	0.00	5	1.1%	0.29	598	1.8%	0.08
Nephrology	2	1.0%	0.57	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	1	1.4%	0.85	0	0.0%	0.00	3	0.7%	0.35	297	0.9%	0.04
Ophthalmology	2	1.0%	0.25	0	0.0%	0.00	1	1.1%	0.65	0	0.0%	0.00	0	0.0%	0.00	1	1.8%	0.50	4	0.9%	0.20	688	2.1%	0.09
Orthopedic Surgery	4	1.9%	0.40	1	9.1%	0.25	8	9.0%	4.19	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	13	2.9%	0.52	855	2.6%	0.11
Otolaryngology (Includes Allergy)	1	0.5%	0.28	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	2	3.6%	2.27	3	0.7%	0.34	301	0.9%	0.04
Pathology	1	0.5%	0.09	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	2	2.7%	0.55	1	1.8%	0.37	4	0.9%	0.15	919	2.8%	0.12
Pediatrics	21	10.0%	0.67	0	0.0%	0.00	8	9.0%	1.35	0	0.0%	0.00	8	10.8%	0.76	6	10.9%	0.77	43	9.7%	0.56	2,661	8.2%	0.33
Physical Medicine & Rehabilitation	4	1.9%	1.19	0	0.0%	0.00	2	2.2%	3.12	0	0.0%	0.00	1	1.4%	0.88	0	0.0%	0.00	7	1.6%	0.84	287	0.9%	0.04
Plastic Surgery	2	1.0%	0.70	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	2	0.4%	0.28	244	0.8%	0.03
Preventative Medicine	2	1.0%	0.41	0	0.0%	0.00	1	1.1%	1.09	0	0.0%	0.00	1	1.4%	0.61	0	0.0%	0.00	4	0.9%	0.33	412	1.3%	0.05
Psychiatry	8	3.8%	0.47	0	0.0%	0.00	5	5.6%	1.53	0	0.0%	0.00	8	10.8%	1.38	1	1.8%	0.23	22	4.9%	0.52	1,458	4.5%	0.18
Pulmonary	1	0.5%	0.19	0	0.0%	0.00	4	4.5%	3.93	0	0.0%	0.00	0	0.0%	0.00	3	5.5%	2.25	8	1.8%	0.61	455	1.4%	0.06
Radiology	6	2.9%	0.22	0	0.0%	0.00	1	1.1%	0.19	0	0.0%	0.00	3	4.1%	0.33	0	0.0%	0.00	10	2.2%	0.15	2,326	7.2%	0.29
Rheumatology	1	0.5%	0.54	0	0.0%	0.00	1	1.1%	2.85	0	0.0%	0.00	0	0.0%	0.00	0	0.0%	0.00	2	0.4%	0.44	157	0.5%	0.02
Surgery	4	1.9%	0.13	1	9.1%	0.08	2	2.2%	0.33	0	0.0%	0.00	5	6.8%	0.47	4	7.3%	0.51	16	3.6%	0.21	2,675	8.2%	0.34
Urology	0	0.0%	0.00	0	0.0%	0.00	1	1.1%	1.31	0	0.0%	0.00	0	0.0%	0.00	1	1.8%	1.00	2	0.4%	0.20	341	1.0%	0.04
Other	5	2.4%	1.42	0	0.0%	0.00	1	1.1%	1.49	0	0.0%	0.00	2	2.7%	1.68	2	3.6%	2.27	10	2.2%	1.15	301	0.9%	0.04
Not Board Certified	41	19.6%	4.06	2	18.2%	0.49	9	10.1%	4.67	1	14.3%	0.34	8	10.8%	2.34	8	14.5%	3.16	69	15.5%	2.76	863	2.7%	0.11
TOTAL	209	100.0%	0.55	11	100.0%	0.07	89	100.0%	1.22	7	100.0%	0.06	74	100.0%	0.57	55	100.0%	0.58	445	100.0%	0.47	32,511	100.0%	4.08

1. Some physicians are certified in more than one specialty. Each specialty is listed.

2. Zip Codes 23831, 23836, 23832, 23838

3. "Other" cities include Alberta, Blackstone, Boykins, Courtland, Dolphin, Emporia, Franklin, Lawrenceville, Newsoms, Spring Grove, Stony Creek, Surry, Wakefield and Waverly.

4. The state database did not separate out hepatology. As such, they are included in internal medicine.

Source: VA Dept. of Health and RKG Associates, Inc., 2010

Southside Regional Medical Center is located in Petersburg, however the City contains an index of specialties below the Commonwealth in most categories. Psychiatry (1.38), Emergency Medicine (1.04), Other (1.68), and Not Board Certified (2.34) are the few exceptions. As noted in the previous TRICARE Discharges section of this report, there are high numbers of psychiatric discharges, and the high demand for psychiatric care is likely fueling the psychiatry specialty index in this City. The comparatively high number of Emergency Medicine specialties in Petersburg and other Fort Lee Region communities may be related to a higher rate of emergency room demand, often found in communities with lower median incomes. Those without health insurance are often reliant on the Emergency Room for all medical care, which increases the demand for hospital ER services.

The City of Hopewell is home to the John Randolph Medical Center. Like Petersburg, despite the presence of a main hospital most specialties are lower than the Commonwealth index. Those specialties higher than the Commonwealth index slightly differ from the Petersburg categories and include Pulmonary (2.25), Emergency Medicine (1.96), Infectious Disease (1.42), Otolaryngology (2.27), Urology (1.0), Other (2.27), and Not Board Certified (3.16).

In some cases, specialties that may be under-represented in one community can be found a short drive away in another community within the Fort Lee Region. One example is orthopedic surgery. Although the Health Professions indicates there are 0 orthopedic specialties in Hopewell, Petersburg, or Dinwiddie; there are 8 orthopedic specialties located in Colonial Heights (which also has over 4 times the proportion of orthopedic surgeons as the Commonwealth), 4 located in Southern Chesterfield and 1 orthopedic surgeon located in Prince George County. In addition, although proportionally more physicians within the Fort Lee Region are not Board Certified, they may have self-designated specialties that are helping to fill some of the specialty demand. Medical services do not operate in a vacuum, and the specialty analysis needs to be taken into context with the surrounding community.

2. Southside Regional Medical Center (SRMC) Physician Needs Assessment

SRMC has developed a model for analyzing the physician needs of their service area, which includes Petersburg, Colonial Heights, Chester, Hopewell, Dinwiddie County, Prince George County, Southern Chesterfield County, Surry County, Sussex County and surrounding areas. The SRMC physician needs assessment shows a community need for most specialties (Table 17). However, there needs analysis indicates a current adequate supply of both cardiologists and nephrologists.

The community need is strongest for family practice physicians (23). Internal Medicine physicians also show a comparatively large need (15). The need for these types of physicians is not unique to the Fort Lee Region. There amount of family and internal medicine doctors has fallen nation-wide. According to the American Academy of Family Physicians (AAFP), the number of U.S. medical school students going into primary care has dropped 51.8% from 1997 to 2008. The AAFP is projecting a shortage of 40,000 family physicians by 2020. Many medical students are preferring specialties that pay better and offer more control over work hours. It will be important that more recruitment

**Table 17
SRMC Physician Needs Assessment
2010**

Specialty	Community Need
Cardiology	-4
Family Practice	23
Gastroenterology	4
General Surgery	3
Internal Medicine	15
Nephrology	-2
OB	6
Orthopedics	0
Pediatrics	3
Psychiatry	11
Pulmonary	4
Urology	2

Source: Southside Regional Medical Center and RKG Associates, Inc., 2010

efforts and programs that encourage students to become family physicians be developed in order to meet this important physician need.

G. RECRUITMENT OF FOREIGN PHYSICIANS

As a way to fill physician openings, many hospitals hire foreign doctors. There are two main visas that a foreign doctor can apply for. They are the H-1B Visa and the J-1 “Exchange” Visa. The H-1B Visa is for temporary workers in any specialty occupations. It allows for the physician to stay in the U.S. for up to 6 years. However, only 65,000 visas are issued per year in the United States. This includes all specialty occupations and not just physician occupations (the technology sector uses much of these slots).

The other type of visa is the J-1 Visa. An applicant for this visa would need to complete education at a U.S. institution and then return to the country of origin for two years prior to attaining permanency status in the U.S. However, a government agency can sponsor a waiver to the J-1 visa in exchange for practicing in an under-served area for three years. After fulfilling requirement, physician can practice anywhere in the country.

The requirements for both include having graduated from a school in the International Medical Education Directory (which can include a U.S. institution), passing the U.S. Licensing Exam, and entering a residency or fellowship program in the U.S. Interviews with health professionals indicate hiring foreign doctors is a good way to increase diversity while filling much needed physician positions. However it was also stated that there could be cultural sensitivity issues and that hiring foreign doctors may not be the “perfect” solution.

H. HEALTH FACILITY EXPANSION PLANS

The Central Virginia Health Services is an organization serving the Crater Region whose primary mission is to provide primary health care to patients regardless of their ability to pay. They provide medical, dental and behavioral health services and take patients with or without insurance. Payment is operated on a sliding scale for those who make under 200% of the federal poverty level. If one earns above 200%, there is no discount on services but a patient can work with the facility and set up a payment plan.

There are three medical facilities operated by Central VA Health Services in the Crater region. The Hopewell-Prince George Community Health Center is located near the Fort Lee base. There are also two centers in Petersburg (the Petersburg Health Care Alliance and the Appomattox Area Health and Wellness Center).

There are expansion plans in place to help better serve the growing demand for medical services. In Hopewell, an additional 4,500 square feet will be added to the Hopewell-Prince George Community Health Center (Table 18). There will be an increase of three staff including a dental hygienist, family practitioner, and psychologist. The Appomattox Center in Petersburg has a full-time family practitioner, a full-time dentist and a full-time internist, as well as a part-time pediatrician. The Appomattox Center plans to recruit another provider who will be a family practice physician or a nurse practitioner. They also have plans to recruit a full-time psychologist. The third site that is planned for expansion is the Health Care Alliance in Petersburg. They have two family practitioners who work part-time. The last planned expansion of medical services in the Fort Lee Region is at Poplar Springs Hospital (a private hospital not affiliated with the Central VA Health Services), which plans to add a 28-day military only substance abuse program at Poplar.

Table 18

**Health Care Facility Expansion Plans
Fort Lee Study Area**

Name of Facility	Location	Future Facility Improvements	Program Additions	Staff Increase	Type
Hopewell-Prince George Community Health Center	Hopewell	Additional 4,500 SF	--	3	Dental Hygienist, Family Practitioner, Psychologist
Appomattox Center	Petersburg	--	--	2	Family Practice, Psychologist
Ambulatory Service Center (John Randolph Medical Center Partnership with Surgeons)	Colonial Heights	New Facility	--	--	Surgeons
Poplar Springs	Petersburg	Subcommittee Continuously looks at expansion plans and will make improvements as needed	New 28-Day Military Only Substance Abuse Program	--	--

Source: RKG Associates, Inc., 2009

I. FORT LEE BASE REALIGNMENT AND CLOSURE WORKFORCE QUESTIONNAIRE HEALTH CHARACTERISTICS

1. Spouse Healthcare Issues

In 2006, Fort Lee’s BRAC Synchronization Office administered a survey to the existing personnel at Fort Lee. The survey was designed to understand the household characteristics of the population in anticipation of BRAC-related growth planned for the 2008-2013 period. RKG Associates was able to utilize this data in preparation of the Fort Lee Growth Management Plan, which was completed in February of 2008. In 2009, the survey was updated by the BRAC Synchronization Office and analyzed by RKG Associates. The following analysis identifies healthcare issues as they pertain to the 2009 survey.

The 2009 survey included questions about the health of dependents, including spouses and children. The results will help to identify the potential demand for healthcare services within the region. The data was separated into spouse health care issues and dependent (non-spouse) healthcare issues. It was assumed that the non-spouse dependents were children of the respondents, although could include other relatives.

Approximately 3.7% of military spouses reported having special healthcare needs (Table 19), or 7 out of 190 military spouses. Of those with conditions, the greatest number (3 of 7 persons) reported having asthma. Another 1% has potentially life threatening diseases and 1% requires adaptive equipment. Given the small number of military respondents, it’s very difficult to generalize to the larger population. Of the civilian respondents, almost 11% have special health conditions. About 5% have potentially life threatening diseases (such as cancer or diabetes). Another 2% have asthma. Just over 1% of civilian spouses require adaptive equipment. The total percent of contractor spouses with health condition is similar to the civilian percentage (10%). The top two conditions are potentially life threatening diseases (2.6%) and conditions requiring environmental/architectural considerations (3.3%).

Table 19
Health Conditions of Spouses; 2009 Survey Respondents

	Military % of Total Survey		Civilian % of Total Survey		Contractor % of Total Survey	
	Respondents	Count	Respondents	Count	Respondents	Count
Potentially life threatening disease (i.e. cancer, insulin-dependant diabetes)	1.1%	2	4.6%	20	2.6%	4
Chronic duration mental health condition (i.e. bi-polar, personality disorders)	0.0%	0	0.9%	4	1.3%	2
Asthma (i.e. uses an inhaler, history of acute asthma in the past year)	1.6%	3	2.3%	10	2.0%	3
Attention Deficit Disorder	0.0%	0	0.2%	1	0.0%	0
Requires adaptive equipment (i.e wheelchair, splint)	0.5%	1	1.6%	7	0.0%	0
Requires assistive technology device (i.e. communication device)	0.0%	0	0.5%	2	0.7%	1
Requires environmental/architectural considerations (i.e. limited steps, wheelchair accessible)	0.5%	1	0.5%	2	3.3%	5
Total With Conditions	3.7%	7	10.5%	46	9.9%	15
Total Spouses	-	190	-	438	-	152

Source: Fort Lee 2009 Survey and RKG Associates, Inc., 2010

2. CSA Healthcare Issues

In terms of non-spouse dependents, some of the special needs conditions would likely qualify for CSA support, including autism, attention deficit disorders, learning disabilities, clinical depression, developmental delays, other behavioral disorders, speech, and vision disorders. Other categories of conditions, including asthma, diabetes, cancer, and other physical ailments might not necessarily require CSA services, but are included in this analysis in order to provide a more complete picture of those dependents that might need extra social and health services from the community.

Of the 247 military respondents, just over 15% answered that they have a non-spouse dependent with special needs (Table 20). The greatest special need among the respondents is asthma/allergies (37%). Under general circumstances, this condition would not require CSA services. However, attention deficit disorder accounts for the second largest category of special needs. About 16% responded that they have a dependent with this disorder. Additional categories of conditions that would likely require CSA services include developmental delay (8%), learning disability (8%), and speech disorder (3%). Together, the number of dependents that could potentially require CSA services amounts to 17 cases.

Approximately the same percentage of contractors responded that they have a non-spouse dependent with a special need (16%). Asthma and allergies and clinical depression account for the largest amount of cases (16% each). There are also a comparatively high amount of cases in developmental delay (13%), speech disorder (13%), and learning disability (13%) conditions. There are approximately 22 contractor cases that are likely to qualify for CSA services.

Compared to the military and contractor respondents, a lesser percentage of civilians answered that they have a non-spouse dependent with a special need (7%). However, similar to the military respondents, the largest amount of cases was for asthma/allergy conditions (20%). Both learning disabilities and diabetes accounted for the second largest group of respondents (11% each). In all, about 21 of the total cases would likely qualify for CSA services.

Fort Lee staffing projections indicate that from 2006 to 2013, there will be an additional 2,563 military dependents, 2,021 civilian dependents, and 269 contractor dependents. Using data from the 2006 Fort Lee survey, RKG Associates estimated that this results in an approximate growth of 1,589 military children, 1,071 civilian children and 156 contractor children. The consultant then applied the survey percentages of children with special needs to the number of incoming children. RKG estimated that approximately 238 new military children, 74 new civilian children, and 25 new contractor children may have special needs. As mentioned, not all the conditions listed in the survey would necessarily qualify for CSA coverage. Applying the percentages from the survey of those that would likely qualify (non-asthma or other learning/behavioral disorders) results in an estimated total of 107 new military children, 35 new civilian children, and 18 new contractor children with CSA qualifying special needs.

It is important to note that not all of the incoming children that would qualify for CSA services would necessarily need to use them. CSA funds are only accessed when the individuals insurance (either TRICARE or a private provider) does not cover a particular CSA services. Therefore, the amount of actual respondents needing to access CSA funds will likely be much smaller than reported on the survey. Regardless, the responses show what the potential demand could be on the Fort Lee region jurisdictions. The data also indicates that learning disability and special education services account for a comparatively high amount of cases, and adequate services and funding must be in place to help support these special needs.

Table 20
Dependents with Special Needs
Fort Lee Survey; 2009

Condition Listed	MILITARY RESPONSES		CIVILIAN RESPONSES		CONTRACTOR RESPONSES	
	# of Cases	% of Cases	# of Cases	% of Cases	# of Cases	% of Cases
Asthma/Allergies	14	37%	9	20%	5	16%
Attention Deficit Disorder	6	16%	3	7%	2	6%
Autism	0	0%	3	7%	1	3%
Cancer	0	0%	1	2%	0	0%
Cerebral Palsy	0	0%	1	2%	1	3%
Clinical Depression (bipolar, etc)	1	3%	2	5%	5	16%
Developmental Delay	3	8%	1	2%	4	13%
Diabetes	1	3%	5	11%	1	3%
Epilepsy	1	3%	2	5%	1	3%
Heart Condition	1	3%	2	5%	0	0%
Learning Disability	3	8%	5	11%	4	13%
None of the Above	3	8%	0	0%	0	0%
Other Behavioral/Mental Disorder	2	5%	1	2%	1	3%
Sickle Cell Anemia	0	0%	0	0%	0	0%
Skin Condition	1	3%	3	7%	1	3%
Speech Disorder	1	3%	3	7%	4	13%
Traumatic Brain Injury	0	0%	0	0%	0	0%
Vision Impairment	1	3%	3	7%	1	3%
Total	38	100%	44	100%	31	100%
	Total Survey Respondents	% of Total Respondents with Special Needs	Total Survey Respondents	% of Total Respondents with Special Needs	Total Survey Respondents	% of Total Respondents with Special Needs
Total	247	15%	587	7%	197	16%

Source: Fort Lee 2009 Survey and RKG Associates, Inc., 2010

3. Location of Service Provider

The civilian and contractor personnel were asked where their dependents receive services for their listed diagnosis. The data in Table 21 indicates that the majority of both civilians and contractors receive services at the on-base clinic (23.8% and 25.0%, respectively) (Table 21). About 11% of civilians received services at John Randolph Medical Center and 6% received services at Southside Regional Medical Center. These are the two main off-post medical facilities serving the region. It is also important to note that 25% of civilian respondents go to healthcare providers outside of the region. This is likely because respondents are driving to Richmond, which contains has a much larger cluster of general and specialty healthcare providers.

Table 21
Health Conditions of Children; 2009 Survey Respondents

Response	Civilian		Contractor	
	%	Count	%	Count
On-Base Health Clinic	23.8%	15	25.0%	10
John Randolph Medical Center Behavioral Health Unit	11.1%	7	5.0%	2
Southside Reginal Medical Center Behavioral Health Unit	6.3%	4	5.0%	2
Poplar Springs Hospital	0.0%	0	5.0%	2
Other Residential Psychiatric Hospital	3.2%	2	5.0%	2
County Social Service Department	4.8%	3	17.5%	7
Outpatient Therapy Provider	9.5%	6	10.0%	4
Special Education Residential Program Provider	1.6%	1	0.0%	0
Special Education Non-Residential Service Provider in a Private School	1.6%	1	0.0%	0
Special Education Non-Residential Service Provider in a Public School	11.1%	7	7.5%	3
Intensive In-Home Service Provider (including in-home respite care)	1.6%	1	5.0%	2
Other Type of Care Provider	25.4%	16	15.0%	6
Total	100.0%	63	100.0%	40

Source: Fort Lee 2009 Survey and RKG Associates, Inc., 2010

In terms of contractors, 17.5% of dependents receive services from the County Social Service providers. The comparatively large number of contractor respondents receiving services at social service providers could place an increased strain on local jurisdictions. About 5% of respondents received services at John Randolph Medical Center and another 5% received services Southside Regional Medical Center. Although both contractors and civilians will likely increase demand for these two hospitals, interviews with representatives from both indicate that they have the capacity and have prepared for the increase in demand resulting from the increased personnel and their dependents.

J. CONCLUSIONS

The presence of Fort Lee in the Crater Region has largely influenced the medical needs of the communities. Although the Kenner Army Health Clinic provides a variety of services to military personnel and dependents, there is no emergency care or in-patient services offered on-base. That leaves the civilian health care partners to provide these types of services to the military personnel and dependents, as well as the general population.

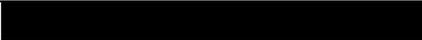
In terms of in-patient demand, there are certain diagnoses that have higher levels of discharge than others. Psychoses and childbirth services are discharge diagnoses that have the highest rates of discharge in almost all the Crater Region communities. Creation of new programs at Poplar Springs Hospital, and the addition of psychologists/psychiatrists at local community health centers as well as on-post have been in response to the high demand for mental health services. However, it is imperative that psychiatric needs of the Crater Region population are further studied in order to best address the population living within the community. In fact, the Central Virginia Health Planning Agency published a behavioral health study in 2009. It is an in-depth analysis of the behavioral health needs of the region and is available for download at www.cvhpa.org.

There are also a comparatively large number of childbirth related discharges in the Region. Many of these are planned pregnancies, however interviews with health care officials have indicated that there also is a teenage pregnancy problem. Programs put in place at Planned Parenthood have helped to reduce teenage pregnancies in Petersburg, and similar programs may need to be studied and implemented in order to reduce the number of childbirth related medical services in the region.

Based on the consultant's previous analysis of physician specialties, it is estimated that the Fort Lee Region is underserved in Board Certified specialties compared to the Commonwealth of Virginia. There are more than double the specialties in the Commonwealth (4.08 specialties per 1,000 population as compared to 1.93 specialties per 1,000 population). However, there is a medical cluster located in Richmond that provides many of the specialty services not directly located in the Crater Region. Regardless, the need to fill medical physician slots is an issue found in communities all across the country. The J-1 visa program is one way many communities are solving the physician shortage problems. However, the hiring of foreign medical graduates also could bring cultural sensitivity issues for both the patient and physician.

Other approaches to decreasing the physician shortage could lie in a "grow your own" method that encourages high school and college students from medically underserved areas to practice medicine. For example, The Pennsylvania Governor's School for Health Care, established in 1991, exposes advanced high school students to careers in a variety of health care fields. More than 100 disadvantaged and minority students from rural and urban underserved areas across the state participate in a five-week program in the summer between the junior and senior years of high school. A similar program in the Crater Region could help in filling local physician positions.

The most effective way to bring physicians to the Crater Region may be for the federal and state governments to increase Medicare, Medicaid and TRICARE reimbursement rates. Due to the high number of TRICARE participants in the area, many doctors are more dependent on this insurance program for payment for services. Increasing the reimbursement rates could attract more physicians which will help to provide better services for these insurance carriers. Health policy is a very complex issue, and it may take an array of approaches in order to best meet the needs of the Crater Region.



**COMPREHENSIVE SERVICES ACT
TECHNICAL MEMORANDUM**



Technical Memorandum

To: Community Services Task Force
 From: Russell A. Archambault, Vice President and Principal
 RKG Associates, Inc.
 Re: Comprehensive Services Act Issues
 Date: September 2010



A. INTRODUCTION

Providing adequate funding for social service programs is difficult for any jurisdiction or non-profit. In the Commonwealth of Virginia, the Comprehensive Services Act for At-Risk Youth and Families (CSA) dictates the funding responsibilities of Virginia local governments in meeting the social service needs of the community. The Comprehensive Services Act was created in 1993 as a state and local funding mechanism for meeting the needs of at-risk youth and their families. More specifically, the CSA is a collaborative system of services and funding that is child-centered, family-focused, and community-based. It is intended to be cost-effective when addressing the strengths and needs of troubled and at-risk youth and their families.

The new personnel at Fort Lee will likely add to the demand for social services provided under the CSA. The following technical memorandum provides an overview of the main issues that have arisen from CSA provision; a brief summary of main CSA highlights by each jurisdiction; and the Fort Lee response to the increase in social service demand within the Crater Region. This memorandum concludes with a description of a wrap-around service delivery approach being employed in another region of the Commonwealth, and how it might help alleviate some of the large costs associated with providing services for at-risk youth.

Although non-CSA social service programs will also be impacted by the incoming Fort Lee personnel, RKG Associates was charged with specifically looking at CSA-related programs. As such, the CSA is the main focus of this technical memorandum.

B. CSA SERVICE PROVISION INTERVIEW FINDINGS

RKG Associates conducted a series of interviews with the social service departments within the Fort Lee growth impact region in order to obtain a better understanding of the strengths and weaknesses of the CSA program and the challenges facing local municipalities. The following section highlights some of the main findings from those interviews.

1. Budget Uncertainty

Although there is statewide funding for CSA programs, there is a local match that must be met for CSA service provision. Social service departments must set a yearly budget for CSA matching needs without knowing the level of service, or the types of services, to be provided in a given year. The local match rate varies by jurisdiction and also varies by the type of service being

offered. The CSA summary tables located at the end of the memorandum detail the varying cost rates for each jurisdiction.

It should be noted there recently the Commonwealth of Virginia adopted changes in local match rate levels. Specifically, local match rates for community-based services were reduced by 50 percent from each locality's 2007 base rate. By January 2009, the local match rate for residential services will increase by 25 percent above each locality's base rate. These changes stem from the Commonwealth's desire to reduce the number of children in long-term residential care, which can be very expensive and may not meet the care needs of the child.

Interviews with social service department representatives indicate that meeting the match levels, especially for foster care or residential services, can be a difficult task. In addition, demand for CSA services are very hard to project on a monthly and annual basis. Some years, there may be no children with long-term residential needs, and other years there could be many with these types of needs.

Another CSA budgetary concern is that social service departments are legally obligated to provide services to at-risk youth. If a jurisdiction exceeds its the allotted CSA budget for a given year, local matching payments must be paid from other existing funding sources or newly authorized sources. The legal obligation to provide services can adversely impact local budgets, particularly for high cost services such as long-term residential services.

2. Army/Community Service Coordination

Coordination between local social service departments and the Army Community Services department is very important in providing services for at-risk military children. Some social service departments have mentioned that it is sometimes hard to locate the parents of CSA children. The fathers are often abroad and one interviewee said it can be difficult getting cooperation from the Army in locating them.

Also, there has been repeated turnover in the Army Community Services, which can make coordination difficult. It should be noted that at the time of the interviews, the Family Advocacy Manager position at the Army Community Services was vacant. This position has since been filled which has helped coordination with the social service departments.

In 2007, the Army unveiled the Army Family Covenant, which institutionalizes the Army's commitment to provide Soldiers and Families — Active, Guard, and Reserve — a quality of life commensurate with their level of service and sacrifice to the Nation. It commits the Army to improve Family readiness by:

- Standardizing Family programs and services
- Increasing accessibility to health care
- Improving Soldier and Family housing
- Ensuring excellence in child, youth and school services
- Expanding education and employment opportunities for Family members.

While service provision is improving inside the gate, local social service agencies are often the first option for services. In particular, many soldiers will turn to local service agencies rather than on-base programs if the nature of the service is sensitive in nature or would reflect poorly on the soldier or their careers.

Another issue for social service departments is the limited hours of operation of the Army Community Services office. Army Community Services is open Monday through Friday from 8 a.m.

to 5 p.m. and is closed on the weekends and holidays. It has been mentioned that it is sometimes important to get in touch with Army Community Services during the times they are closed. Longer operating hours or weekend operations were noted as ways to close this service gap.

3. Community Services Cost Escalation

Interviews with social service departments have indicated that there is little control over what non-profit or private service providers charge and there are limited options available to social services departments. Some needs are very specialized, and there may not be many service providers within the region to choose from. Residential services were cited as one example of where local social services departments may have to negotiate with residential providers located outside the region while trying to arrange an emergency placement of a child. The service providers understand the communities' financial obligation to provide services under CSA and they can exploit that circumstance. In addition, it was mentioned that service providers typically charge the same rates for all jurisdictions. As such, jurisdiction with small populations and budgets are charged the same amount as larger jurisdictions with substantially greater resources.

One possible solution to this issue would be for the Fort Lee region jurisdictions to pool resources together to create a regional residential care or non-residential service center for at-risk youth. As will be discussed in more detail later in this section, the counties within the New River Valley region of Southwest Virginia are creating a short-term residential facility that will provide wrap-around services for at-risk youth. Although this facility is still in the planning stages, interviews with representatives from New River Valley Community Services indicate that the new publically run facility will cut costs and give more pricing control and budget predictability to the jurisdictions.

C. CSA CASE LOAD AND EXPENDITURE TRENDS

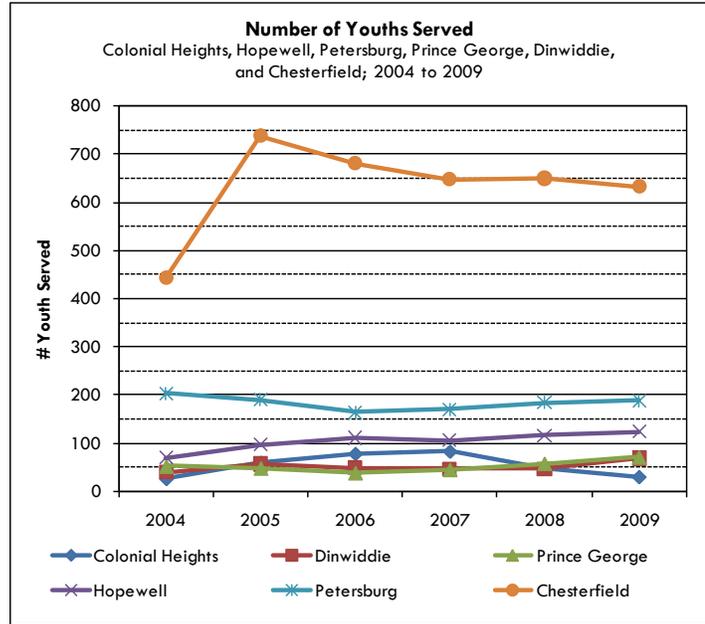
The Commonwealth of Virginia maintains annual data about CSA usage and payments. RKG Associates has obtained and organized this data into tables which are located in the Appendix Section of this report. Each table has data on the types of CSA services provided, the number of youth served, and CSA funds expended. In 2009, the State changed the locality reporting system. The 2009 CSA data is included in the Appendix; however it contains slightly different categorizations of service programs. Although it is not possible to discern the number of military children from this data, it does include information on the types of services provided and expenditures incurred for providing at-risk youth services.

1. City of Petersburg

Since 2004, there has been a comparatively high number of at-risk youth served in the City of Petersburg as compared to other jurisdictions within the region (excluding Chesterfield). The data in Figure 1 indicate that the number of youths served in Petersburg ranges from 170 to just over 200 per year. In fact, there has been a steady increase over the past four years in this jurisdiction.

Residential placements and special education day placement account for a large share of the services provided. In terms of cost, therapeutic foster homes incurred the largest charge in 2009 at \$1.12 million. However, group homes (\$1.11 million) and special education private day placement (\$741,208) also accounted for a large share of the costs. In particular, the cost for residential care and group homes is consistently above \$20,000 per youth. The high cost for these types of services places very high importance on prevention services and other services that focus on keeping children with families and out of residential care.

Figure 1



Source: VA Comprehensive Services Act and RKG Associates, Inc., 2009

2. Prince George County

The number of youths served in Prince George increased from 45 in 2007 to 71 in 2009. In this jurisdiction, special education is a primary service need. In fact, interviews with the social service department confirm this and indicate that Prince George has a good reputation throughout the region for providing special needs services. However, this jurisdiction is having difficulty keeping up with the demand for services. CSA costs for Prince George have increased from \$590,039 in 2007 to \$1,138,415 in 2009. Special education day placement and special education day services have accounted for a disproportionately large majority of those costs. It is likely that, with the additional need driven by the new personnel at Fort Lee, the costs for special needs programs will increase into the future and place further strain on the social services budget.

3. City of Hopewell

The number of youths served in Hopewell has also increased from 70 in 2004 to 124 in 2009. Special education day services account for the largest proportion of youths served. Although there was a spike in community based interventions in 2008 (18 youths served) the cost for these services is relatively low compared to other services covered under CSA. In fact, the cost for CSA services only increased about 9% from 2004 to 2008, despite the 77% increase in the amount of youth served.

4. City of Colonial Heights

Colonial Heights has very erratic amounts of at-risk youths served on a yearly basis. In 2007, a high of 83 children were served, which decreased to 29 in 2009. Likewise, CSA costs reached a high of \$752,645 in 2007 which decreased to \$246,629 in 2009. Currently, special education day placement and special education other day services account for the largest share of services provided. Similar to many other communities in the region, there is a high demand for special education services.

5. Dinwiddie County

Dinwiddie has a comparatively smaller population than other jurisdictions within the Fort Lee region, and as such there are less youth served under the CSA. Although there are a comparatively small number of youth served in Dinwiddie compared to the rest of the immediate region, the fiscal impacts of the CSA services have a large impact on the social services budget. In 2009, there were 69 youths served. These services cost a total of \$642,669. Interviews with social service departments indicate that even one or two more children in foster care or residential treatment facilities could severely impact their budget.

6. Chesterfield

The data for Chesterfield is for the entire county. Unfortunately, it was not possible to separate out data related to the southern portion of the County. However, the trends for Chesterfield indicate that the amount of at-risk youth served has ranged from 650 to 700 for the past three years. Residential treatment facility costs have been disproportionately high compared to other services. This service is the only CSA service that had costs over \$2 million.

D. FORT LEE SPECIAL NEEDS SURVEY RESULTS

In the fall of 2009, Fort Lee distributed a survey to the military, civilian and contractor personnel to assess household and demographic information. While it is likely there will be some differences between the 2009 population and the incoming personnel, RKG Associates assumed the incoming personnel will have similar characteristics to those currently working at Fort Lee.

The survey included questions about the special needs of military, civilian, and contractor dependents. Some of the special needs conditions would likely qualify for CSA support, including autism, attention deficit disorders, learning disabilities, clinical depression, developmental delays, other behavioral disorders, speech, and vision disorders. Other categories of conditions, including asthma, diabetes, cancer, and other physical ailments might not necessarily require CSA services, but are included in this analysis in order to provide a more complete picture of those dependents that might need extra social and health services from the community.

Of the 247 military respondents, just over 15% answered that they have a non-spouse dependent with special needs (Table 1). The greatest special need among the respondents is asthma/allergies (37%). Under general circumstances, this condition would not require CSA services. However, attention deficit disorder accounts for the second largest category of special needs. About 16% responded that they have a dependent with this disorder. Additional categories of conditions that would likely require CSA services include developmental delay (8%), learning disability (8%), and speech disorder (3%). Together, the number of dependents that could potentially require CSA services amounts to 17 cases.

Approximately the same percentage of contractors responded that they have a non-spouse dependent with a special need (16%). Asthma and allergies and clinical depression account for the largest amount of cases (16% each). There are also a comparatively high amount of cases in developmental delay (13%), speech disorder (13%), and learning disability (13%) conditions. There are approximately 22 contractor cases that are likely to qualify for CSA services.

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It is important to note that not all of the incoming children that would qualify for CSA services would necessarily need to use them. CSA funds are only accessed when the individuals insurance (either TRICARE or a private provider) does not cover a particular CSA services. Therefore, the amount of actual respondents needing to access CSA funds will likely be much smaller than reported on the survey. Regardless, the responses show what the potential demand could be on the Fort Lee region jurisdictions. The data also indicates that learning disability and special education services account for a comparatively high amount of cases, and adequate services and funding must be in place to help support these special needs.

Table 1
Dependents with Special Needs
Fort Lee Survey; 2009

Condition Listed	MILITARY RESPONSES		CIVILIAN RESPONSES		CONTRACTOR RESPONSES	
	# of Cases	% of Cases of Respondents with Special Needs	# of Cases	% of Cases	# of Cases	% of Cases
Asthma/Allergies	14	37%	9	20%	5	16%
Attention Deficit Disorder	6	16%	3	7%	2	6%
Autism	0	0%	3	7%	1	3%
Cancer	0	0%	1	2%	0	0%
Cerebral Palsy	0	0%	1	2%	1	3%
Clinical Depression (bipolar, etc)	1	3%	2	5%	5	16%
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Diabetes	1	3%	5	11%	1	3%
Epilepsy	1	3%	2	5%	1	3%
Heart Condition	1	3%	2	5%	0	0%
Learning Disability	3	8%	5	11%	4	13%
None of the Above	3	8%	0	0%	0	0%
Other Behavioral/Mental Disorder	2	5%	1	2%	1	3%
Sickle Cell Anemia	0	0%	0	0%	0	0%
Skin Condition	1	3%	3	7%	1	3%
Speech Disorder	1	3%	3	7%	4	13%
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Total	38	100%	44	100%	31	100%
	Total Survey Respondents	% of Total Respondents with Special Needs	Total Survey Respondents	% of Total Respondents with Special Needs	Total Survey Respondents	% of Total Respondents with Special Needs
Total	247	15%	587	7%	197	16%

Source: Fort Lee 2009 Survey and RKG Associates, Inc., 2010

E. FORT LEE SOCIAL SERVICE SUPPORT

There are a variety of referral services and programs available to military and civilian personnel and their families at Fort Lee Army Community Services (ACS). One of the services available is the Family Advocacy Program (FAP). The mission of this program is to “support readiness, builds healthy families, and sustains strong communities by providing comprehensive approaches to prevention, identification and intervention of child and spouse abuse in military families.”

There are core programs which fall under FAP. The New Parent Support Program (NPSP) offers services from a licensed professional to expectant parents and parents of newborns up to three years of age. The NPSP works with at-risk families or moms with premature babies, and do home site visits, parenting classes, individual work, trainings for parents and group trainings or activities. There is a training schedule available which includes baby basic training, anger management, baby safety, stress management, and 1,2,3,4 parenting. These prevention and training classes can often be a first step in preventing more dangerous issues and problems in the future.

Some social service agencies had mentioned coordination problems with the Army Community Services. At the time of the interviews, the Family Advocacy Program Manager position was vacant. Since the time of the interviews, the ACS has appointed a new FAP Manager. Much of the previous coordination issues were related to this position vacancy. In addition to filling the FAP Program Manager position, ACS has added three additional GS positions. These new positions were based on a military formula that takes into account population and a standard table of allowances.

Interviews with the ACS indicate that they hold regular meetings with the jurisdictions within the Crater Region. The various social service departments are invited to come in and talk about how they can partner together. There is also a memorandum of agreements with the counties. For the most part it is believed that there is a productive working relationship with the social service departments.

F. POPLAR SPRINGS HOSPITAL BEHAVIORAL HEALTH SERVICES

Short-term psychiatric care is available to CSA payers through Poplar Springs Hospital. Poplar Springs is Central Virginia's largest provider of inpatient psychiatric care and is located in Petersburg, Virginia. The facility currently has 75 acute beds (intensive treatment unit, adult, active military unit and adolescent), 108 residential treatment beds and 16 group home beds. Programs include psychological and behavioral treatment for adults and adolescents aged 11-18, extended adolescent acute treatment, residential, sexual abuse prevention and group homes.

Many at-risk youth who utilize the treatments at Poplar Springs Hospital are able to use other types of insurance to cover their services. However, there are cases where CSA funds can be used. Data gathered from Poplar Springs indicates that over the past five years, nine youth have used CSA to pay for their services (Table 2). Chesterfield accounts for the largest majority of patients (8). The City of Petersburg accounted for the one other CSA payer. It should be noted that the payer for the Petersburg case was listed as the City and not CSA. Discussions with Poplar Springs' representatives indicated that this may have been a clerical error.

It should be noted that there are two group homes currently at Poplar Springs. These homes are for boys ages 12 to 18 and give youth the opportunity to experience a step down residential treatment program while continuing to address their emotional and behavioral needs. It may be worthwhile for the Fort Lee region's jurisdictions to initiate an agreement with Poplar Springs in expanding this program, or tailoring it to better fit their needs.

Poplar Springs has stated that they would be willing to partner with the local jurisdictions in providing expanded services for the military population. The facility currently provides psychiatric care to military personnel, both officers and enlisted soldiers. The partnership could span different options such as creating or expanding their short-term residential programs for at-risk youth, constructing additional building facilities, to offering CSA payers a special rate or payment plan. Although CSA residential use is difficult to project, the consultant recommends holding meetings with Poplar Springs in order to assess the needs of the communities and how Poplar Springs can help to meet these needs.

Table 2
Poplar Springs CSA Payors
Crater Region; 2004 - Present

Admission	County	Zip	Insurance	Program
6/4/2004	Chesterfield	23832	CHESTERFIELD CSA	Adolescent Acute
7/9/2004	Chesterfield	23832	CHESTERFIELD CSA	Adolescent Acute
2/2/2007	Chesterfield	23832	CHESTERFIELD CSA	Adolescent Acute
6/10/2005	Petersburg	23803	CITY OF PETERSBURG	Adolescent Acute
3/15/2005	Chesterfield	23235	CHESTERFIELD CSA	Adult Acute
1/5/2005	Chesterfield	23114	CHESTERFIELD CSA	Boys Residential Treatment Center
3/7/2006	Chesterfield	23831	CHESTERFIELD CSA	Boys Residential Treatment Center
10/7/2004	Chesterfield	23112	CHESTERFIELD CSA	Daybreak Abuse Prevention Program
12/27/2004	Chesterfield	23112	CHESTERFIELD CSA	Daybreak Abuse Prevention Program

Source: Poplar Springs and RKG Associates, Inc., 2009

G. WRAPAROUND SERVICE DELIVERY

Due to sky-rocketing costs, growing attention is being focused on lowering residential care costs and increasing community based services. The local match rates for CSA programs that fall under community based services have therefore recently been reduced by approximately 50% from each counties baseline match rate. At the same time, as a disincentive to long-term residential placement, the local match rates for these services have increased by approximately 30%. Although there will likely always be a need for residential care placement, evidence suggests that providing more comprehensive services for at-risk youth can reduce the number placed in more restrictive environments (i.e., rehab centers, prisons, juvenile detention centers).

According to the National Wraparound Initiative, an organization located in Portland, OR, whose mission is to engage experts nationally in a process of defining standards and compiling specific strategies for delivering high-quality wraparound services. This approach is defined as,

A team-based planning process intended to provide individualized, coordinated, family-driven care to meet the complex needs of children who are involved with several child-and-family-serving systems (e.g. mental health, child welfare, juvenile justice, special education), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The wraparound process requires that families, providers, and key members of the family’s social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal wraparound process is no longer needed.

Communities across the nation, and in Virginia, are beginning to implement wraparound services. One such community in Virginia is the New River Valley located in Southwest Virginia. The

jurisdictions in New River Valley have created an organization called New River Valley Community Services (NRVCS), which is a public provider of behavior health services (including CSA) for residents in the counties of Floyd, Giles, Montgomery and Pulaski, and the City of Radford.

New River Valley Community Services has a variety of treatment programs and services available to both youth and adults. Like most communities around the country, the high costs of long-term residential care have become a very important issue. To help reduce the number of children in long term placement, the organization is currently in the process of establishing a short-term (90-day maximum) residential placement center. The goal of this center would be to return the children to their families, rather than placing them in longer-term residential care facility (e.g., foster home). Essentially, the 8 to 10-bed treatment center would be a place for children to stabilize and develop a plan and wraparound service program to support them before they are released back to their family, if appropriate.

The new facility is a place where children can begin the wraparound and goal setting process in a safe and secure environment. Once a child arrives at the new facility, a team of individuals (e.g., family members, other natural supports, service providers, and agency representatives) will develop an individualized plan of care for the child. The child will be able to remain at the facility for a maximum of 90 days.

The cost structure of the facility is yet to be determined. However, the funding of the new facility would be paid for largely by CSA and Medicaid sources. The localities would have to provide a local match, which would be approximately 21% of the administrative costs per year. It is estimated that the five communities would need to set aside funds for about \$100,000/year.

One of the possible allocation strategies is for each community to analyze how many residential placements they make, on average, in a given year. While this is difficult to do with certain, the jurisdiction would initially project their future use of the facility based on this historic usage. Larger jurisdictions would likely have more use of the facilities and therefore contribute more funding. In the future, the true usage share would be reassessed every 2 to 3 years based on actual use of the facility by each community.

A representative of New River Valley Community Services state that the main goal of creating this new facility would be to reduce the number of long-term residential placements. She stated that in the past, there have been some children that ended up in residential placement, when it could have been avoided. By creating a safe space for children and families to stabilize, it will be much easier to return the child to the family. The cost savings of avoiding residential treatment is a major benefit to New River Valley Community Services.

Unfortunately, it is not possible for some children to return to their parents or a family member. Those in the juvenile justice system, or those children without relatives would still need to go through the standard residential placement systems that are already in place. It should be noted that meetings with the CSA providers in the Fort Lee Region have indicated that a regionally coordinated residential placement facility, of any type, is not a desired recommendation. The description of the New River Valley facility is meant to serve as an example of what other communities are doing in response to their needs. However, each community is different, and programs need to be formed that cater to the specific needs of the Fort Lee Region communities.

H. CONCLUSIONS

The number of CSA services needed on a yearly basis is very difficult to project from year to year. However, certain steps can be taken to help bring down local matching costs.

- Coordination Among Crater Region Social Service Departments - It is recommended that the region's social service departments continue to coordinate with each other on their overlapping service needs. To a limited degree this is currently happening, but not sufficient to work through difficult CSA cases that might involve multiple jurisdictions. There may be an opportunity to create a partnership among the communities, similar to that found at New River Valley Community Services (NRVCS). Each of the five localities within the NRVCS set aside an annual amount of funding to NRVCS and appoints representatives to the agency's Board of Directors. There are 13-volunteer board members that are appointed by each of the five jurisdictions. This type of structure may be a viable option for the communities in the Fort Lee.
- Coordination Among Army Community Services – Interviews with social service departments indicate that they would like to have increased coordination with Army Community Services. It is recommended that Army Community Services and the Crater Region social service departments hold regular meetings to discuss service and informational needs.
- Streamline Tracking of CSA Youth From Military Families – As mentioned previously, projecting CSA usage into the future is a very difficult task. However, in order to better prepare for times when there is military growth, it is recommended that jurisdictions within the region streamline the tracking system of military children. Currently, there does not seem to be a consistent method used by jurisdictions to keep track of military children served. Having an easily accessible database with this information can give county social service department administrators a better sense of the likely increases in services they will need to prepare for.

One possible way to get a better sense of the military children that require services is to administer an end-of-the-year survey to the parents of all public school students that require special education services. This would not be an indicator of new military children entering the system; however it could provide a good sense of the baseline number of military children that would need services from year-to-year.

It can be assumed that the demand for CSA programs will continue to increase in the future. In order to keep matching costs down, new community-based interventions and techniques will be needed, as well higher levels of coordination among impacted communities. Increased communication between all the social service departments would help to begin the process of finding solutions to the potential CSA cost and funding issues. Similarly, closer coordination with Fort Lee would assist in meeting the needs of military households.



Appendix Section

Petersburg CSA CPMT Management Report Summary
Prince George CSA CPMT Management Report Summary
Hopewell CSA CPMT Management Report Summary
Colonial Heights CSA CPMT Management Report Summary
Dinwiddie CSA CPMT Management Report Summary
Chesterfield CSA CPMT Management Report Summary
2009 CSA Data Summary – All Jurisdictions

CSA CPMT Management Report
Petersburg; 2004 to 2008

	Family Foster Maintenance Only	Foster Care Maintenance & Other Services	Community Based Interventions	SPED Day Services	Other Specialized Foster Homes	Independent Living	Therapeutic Foster Home	Group Home	SPED Day Placement	Residential Treatment Facility	Psychiatric Hospital	TOTAL
# SERVICES												
Petersburg 04	18	28	20	5	1	3	33	33	38	25	2	206
State 04	1,724	3,172	5,906	1,027	690	350	2,665	1,385	1,982	2,988	113	22,002
Petersburg 05	13	21	16	3	1	4	40	34	35	25	1	193
State 05	1,900	3,555	6,950	1,178	695	419	3,042	1,706	2,150	3,085	100	24,780
Petersburg 06	4	6	10	2	1	5	42	31	36	27	1	165
State 06	2,084	4,416	9,349	1,420	721	564	3,457	1,970	2,645	3,395	83	30,104
Petersburg 07	2	11	9	1	4	5	35	32	43	29	0	171
State 07	2,411	4,794	9,755	1,504	583	573	3,553	1,975	2,798	3,213	79	31,238
Petersburg 08	5	17	14	0	3	6	36	33	34	36	1	185
State 08	2,857	4,924	9,433	1,629	525	763	3,938	2,147	3,150	3,301	104	32,771
% TOTAL CSA SERVICES												
Petersburg 04	9%	14%	10%	2%	0%	1%	16%	16%	18%	12%	1%	99%
State 04	8%	14%	27%	5%	3%	2%	12%	6%	9%	14%	1%	101%
Petersburg 05	7%	11%	8%	2%	1%	2%	21%	18%	18%	13%	1%	102%
State 05	8%	14%	28%	5%	3%	2%	12%	7%	9%	12%	0%	100%
Petersburg 06	2%	4%	6%	1%	1%	3%	25%	19%	22%	16%	1%	100%
State 06	7%	15%	31%	5%	2%	2%	11%	7%	9%	11%	0%	100%
Petersburg 07	1%	6%	5%	1%	2%	3%	20%	19%	25%	17%	0%	99%
State 07	8%	15%	31%	5%	2%	2%	11%	6%	9%	10%	0%	99%
Petersburg 08	3%	9%	8%	0%	2%	3%	19%	18%	18%	19%	1%	100%
State 08	9%	15%	29%	5%	2%	2%	12%	7%	10%	10%	0%	101%
# YOUTH SERVED												
Petersburg 04	18	28	20	5	1	3	33	31	37	25	2	203
State 04	1,708	3,120	5,772	1,008	683	347	2,639	1,365	1,958	2,908	110	21,618
Petersburg 05	13	21	16	3	1	4	40	33	34	24	1	190
State 05	1,893	3,520	6,855	1,151	691	418	2,993	1,687	2,132	2,998	98	24,436
Petersburg 06	4	6	10	2	1	5	42	31	36	26	1	164
State 06	1,911	3,478	6,985	1,279	694	518	3,196	1,800	2,452	3,084	78	25,475
Petersburg 07	2	11	9	1	4	5	35	32	43	28	0	170
State 07	2,231	3,728	7,594	1,357	558	524	3,351	1,863	2,603	2,971	79	26,859
Petersburg 08	5	17	14	0	3	6	36	33	33	36	1	184
State 08	2,093	3,712	7,162	1,486	508	688	3,697	1,938	2,684	3,006	104	27,078
GROSS CSA FUNDS POOL COSTS (\$) (35.35% LOCAL MATCH)												
Petersburg 04	\$70,700	\$131,008	\$85,574	\$59,536	\$15,108	\$16,537	\$644,432	\$999,144	\$657,845	\$606,084	\$21,275	\$3,307,243
State 04	\$4,657,341	\$10,228,911	\$26,742,279	\$10,855,136	\$3,348,832	\$3,565,217	\$52,008,924	\$30,371,286	\$41,897,553	\$100,740,504	\$1,668,323	\$286,084,306
Petersburg 05	\$54,151	\$92,014	\$78,234	\$66,600	\$10,950	\$93,501	\$921,480	\$988,354	\$676,544	\$487,848	\$29,779	\$3,499,455
State 05	\$3,958,083	\$8,377,753	\$25,512,339	\$11,478,233	\$3,387,319	\$4,414,345	\$49,968,018	\$35,787,817	\$43,469,861	\$95,538,070	\$1,611,986	\$283,503,824
Petersburg 06	\$7,391	\$9,912	\$87,618	\$62,800	\$4,080	\$315,016	\$1,199,816	\$922,668	\$806,759	\$737,445	\$82,069	\$4,235,574
State 06	\$3,950,510	\$8,381,286	\$28,622,878	\$14,499,961	\$3,444,434	\$5,424,649	\$52,109,158	\$39,237,642	\$52,655,842	\$97,493,180	\$1,335,789	\$307,155,329
Petersburg 07	\$7,920	\$95,177	\$36,319	\$7,875	\$24,994	\$198,115	\$949,153	\$1,001,256	\$977,149	\$889,775	\$0	\$4,187,733
State 07	\$5,969,883	\$11,269,399	\$31,309,878	\$17,090,648	\$3,031,653	\$5,960,729	\$65,183,029	\$42,894,953	\$63,223,682	\$105,137,477	\$1,699,593	\$352,770,924
Petersburg 08	\$11,742	\$73,646	\$50,779	\$0	\$21,816	\$21,104	\$917,704	\$899,501	\$821,127	\$1,072,707	\$7,280	\$3,897,406
State 08	\$5,072,083	\$10,813,679	\$34,088,059	\$18,233,472	\$3,047,612	\$6,450,804	\$84,215,115	\$44,607,247	\$71,558,671	\$108,885,985	\$1,692,656	\$388,665,383
CSA FUNDS MEDICAID COSTS (\$) (17.68% LOCAL MATCH)												
Petersburg 04	\$0	\$0	\$0	\$0	\$0	\$0	\$399,099	\$0	\$0	\$943,724	\$0	\$1,342,823
State 04	\$0	\$0	\$0	\$0	\$0	\$0	\$13,512,436	\$0	\$0	\$48,434,858	\$0	\$61,947,294
Petersburg 05	\$0	\$0	\$0	\$0	\$0	\$0	\$314,349	\$13,162	\$0	\$1,054,314	\$0	\$1,381,825
State 05	\$0	\$0	\$0	\$0	\$0	\$0	\$14,998,082	\$2,837,086	\$0	\$59,670,690	\$0	\$77,505,858
Petersburg 06	\$0	\$0	\$0	\$0	\$0	\$0	\$288,593	\$30,634	\$0	\$1,467,178	\$0	\$1,786,405
State 06	\$0	\$0	\$0	\$0	\$0	\$0	\$21,645,299	\$1,023,441	\$0	\$67,805,338	\$0	\$90,474,078
Petersburg 07	\$0	\$0	\$0	\$0	\$0	\$0	\$208,428	\$99,610	\$0	\$1,003,922	\$0	\$1,311,960
State 07	\$0	\$0	\$0	\$0	\$0	\$0	\$13,193,517	\$11,331,616	\$0	\$76,227,304	\$0	\$100,752,437
Petersburg 08*	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
State 08	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
CSA FUNDS TOTAL COSTS (\$) (POOL + MEDICAID)												
Petersburg 04	\$70,700	\$131,008	\$85,574	\$59,536	\$15,108	\$16,537	\$1,043,531	\$999,144	\$657,845	\$1,549,808	\$21,275	\$4,650,066
State 04	\$4,657,341	\$10,228,911	\$26,742,279	\$10,855,136	\$3,348,832	\$3,565,217	\$65,521,360	\$30,371,286	\$41,897,553	\$149,175,362	\$1,668,323	\$348,031,600
Petersburg 05	\$54,151	\$92,014	\$78,234	\$66,600	\$10,950	\$93,501	\$1,235,829	\$1,001,516	\$676,544	\$1,542,160	\$29,779	\$4,881,280
State 05	\$3,958,083	\$8,377,753	\$25,512,339	\$11,478,233	\$3,387,319	\$4,414,345	\$64,966,100	\$38,624,903	\$43,469,861	\$155,208,760	\$1,611,986	\$361,009,682
Petersburg 06	\$7,391	\$9,912	\$87,618	\$62,800	\$4,080	\$315,016	\$1,488,409	\$953,302	\$806,759	\$2,204,623	\$82,069	\$6,021,979
State 06	\$3,950,510	\$8,381,286	\$28,622,878	\$14,499,961	\$3,444,434	\$5,424,649	\$73,754,457	\$40,261,083	\$52,655,842	\$165,298,518	\$1,335,789	\$397,629,407
Petersburg 07	\$7,920	\$95,177	\$36,319	\$7,875	\$24,994	\$198,115	\$1,157,581	\$1,001,866	\$977,149	\$1,893,697	\$0	\$5,499,693
State 07	\$5,969,883	\$11,269,399	\$31,309,878	\$17,090,648	\$3,031,653	\$5,960,729	\$78,376,546	\$54,226,569	\$63,223,682	\$181,364,781	\$1,699,593	\$453,523,361
Petersburg 08	\$11,742	\$73,646	\$50,779	\$0	\$21,816	\$21,104	\$917,704	\$899,501	\$821,127	\$1,072,707	\$7,280	\$3,897,406
State 08	\$5,072,083	\$10,813,679	\$34,088,059	\$18,233,472	\$3,047,612	\$6,450,804	\$84,215,115	\$44,607,247	\$71,558,671	\$108,885,985	\$1,692,656	\$388,665,383
AVERAGE COST PER YOUTH (\$)												
Petersburg 04	\$3,928	\$4,679	\$4,279	\$11,908	\$15,108	\$5,513	\$19,529	\$32,231	\$17,780	\$24,244	\$10,638	-
State 04	\$2,727	\$3,278	\$4,633	\$10,769	\$4,903	\$10,274	\$24,829	\$22,251	\$21,398	\$51,299	\$15,167	-
Petersburg 05	\$4,166	\$4,382	\$4,890	\$22,200	\$10,950	\$23,376	\$23,037	\$29,951	\$19,899	\$20,327	\$29,779	-
State 05	\$2,091	\$2,380	\$3,722	\$9,972	\$4,902	\$10,561	\$16,695	\$21,214	\$20,389	\$31,867	\$16,449	-
Petersburg 06	\$1,848	\$1,652	\$8,762	\$31,400	\$4,080	\$63,004	\$28,568	\$29,764	\$22,410	\$28,364	\$82,069	-
State 06	\$2,067	\$2,410	\$4,098	\$11,337	\$4,963	\$10,472	\$23,078	\$22,368	\$21,475	\$53,599	\$17,126	-
Petersburg 07	\$3,960	\$8,653	\$4,036	\$7,875	\$6,249	\$39,623	\$27,119	\$31,290	\$22,725	\$31,778	\$0	-
State 07	\$2,676	\$3,023	\$4,123	\$12,594	\$5,433	\$11,375	\$23,390	\$29,108	\$24,289	\$61,046	\$21,514	-
Petersburg 08	\$2,349	\$4,333	\$3,628	\$0	\$7,272	\$3,518	\$25,492	\$27,258	\$24,883	\$29,798	\$7,280	-
State 08	\$2,423	\$2,913	\$4,760	\$12,270	\$5,999	\$9,376	\$22,780	\$23,018	\$24,986	\$36,223	\$16,276	-
% DSM-IV DIAGNOSIS												
Petersburg 04	0%	4%	55%	0%	0%	67%	73%	87%	46%	80%	100%	-
State 04	26%	29%	48%	56%	39%	47%	57%	52%	60%	70%	86%	-
Petersburg 05	0%	5%	38%	0%	0%	75%	50%	76%	32%	67%	100%	-
State 05	24%	25%	42%	60%	43%	47%	54%	60%	63%	74%	80%	-
Petersburg 06	0%	17%	30%	0%	0%	80%	40%	55%	31%	65%	100%	-
State 06	21%	23%	35%	64%	39%	45%	47%	57%	59%	68%	72%	-
Petersburg 07	0%	0%	56%	0%	25%	80%	43%	44%	42%	71%	0%	-
State 07	20%	21%	33%	63%	32%	41%	42%	52%	61%	65%	56%	-
Petersburg 08	0%	6%	43%	0%	33%	33%	28%	42%	48%	78%	100%	-
State 08	22%	24%	38%	60%	33%	40%	39%	54%	58%	65%	56%	-
PRIMARY SERVICE REASON												
Petersburg 04	Neglect	Neglect	Behavioral Issues	Special Education	Neglect	Behavioral Issues	Behavioral Issues	Behavioral Issues	Special Education	Behavioral Issues	Physical Aggression	-
State 04	Neglect	Neglect	Behavioral Issues	Special Education	Neglect	Caregiver Incapacity	Neglect	Behavioral Issues	Special Education	Behavioral Issues	Behavioral Issues	-
Petersburg 05	Neglect	Neglect	Court Involvement	Special Education	Neglect	Caregiver Incapacity	Neglect	Behavioral Issues	Special Education	Behavioral Issues	Physical Aggression	-
State 05	Neglect	Neglect	Caregiver Incapacity	Special Education	Neglect	Caregiver Incapacity	Neglect	Behavioral Issues	Special Education	Behavioral Issues	Behavioral Issues	-

	Family Foster Care Maintenance Only	Foster Care Maintenance & Other Services	Community Based Interventions	SPED Day Services	Other Day Services	Specialized Foster Homes	Independent Living	Therapeutic Foster Home	Group Home	SPED Day Placement	Residential Treatment Facility	Psychiatric Hospital	TOTAL
# SERVICES													
Prince George 04	8	7	9	17	0	1	0	1	8	1	0		52
State 04	1,724	3,172	5,906	1,027	690	350	2,665	1,385	1,982	2,988	113		22,002
Prince George 05	8	4	11	12	0	0	0	3	10	1	0		49
State 05	1,900	3,555	6,950	1,178	695	419	3,042	1,706	2,150	3,085	100		24,780
Prince George 06	1	2	5	12	0	2	0	3	11	3	0		39
State 06	2,084	4,416	9,349	1,420	721	564	3,457	1,970	2,645	3,395	83		30,104
Prince George 07	7	2	1	13	0	1	0	2	18	1	0		45
State 07	2,411	4,794	9,755	1,504	583	573	3,553	1,975	2,798	3,213	79		31,238
Prince George 08	4	2	8	23	0	1	0	3	15	3	0		59
State 08	2,857	4,924	9,433	1,629	525	763	3,938	2,147	3,150	3,301	104		32,771
% TOTAL CSA SERVICES													
Prince George 04	15%	13%	17%	33%	0%	2%	0%	2%	15%	2%	0%		99%
State 04	8%	14%	27%	5%	3%	2%	12%	6%	9%	14%	1%		101%
Prince George 05	16%	8%	22%	24%	0%	0%	0%	6%	20%	2%	0%		98%
State 05	8%	14%	28%	5%	3%	2%	12%	7%	9%	12%	0%		100%
Prince George 06	3%	5%	13%	31%	0%	5%	0%	8%	28%	8%	0%		101%
State 06	7%	15%	31%	5%	2%	2%	11%	7%	9%	11%	0%		100%
Prince George 07	16%	4%	2%	29%	0%	2%	0%	4%	40%	2%	0%		99%
State 07	8%	15%	31%	5%	2%	2%	11%	6%	9%	10%	0%		99%
Prince George 08	7%	3%	14%	39%	0%	2%	0%	5%	25%	5%	0%		100%
State 08	9%	15%	29%	5%	2%	2%	12%	7%	10%	10%	0%		101%
# YOUTH SERVED													
Prince George 04	8	7	9	17	0	1	0	1	8	1	0		52
State 04	1,708	3,120	5,772	1,008	683	347	2,639	1,365	1,958	2,908	110		21,618
Prince George 05	8	4	11	11	0	0	0	3	10	1	0		48
State 05	1,893	3,520	6,855	1,151	691	418	2,993	1,687	2,132	2,998	98		24,436
Prince George 06	1	2	5	12	0	2	0	3	10	3	0		38
State 06	1,911	3,478	6,985	1,279	694	518	3,196	1,800	2,452	3,084	78		25,475
Prince George 07	7	2	1	13	0	1	0	2	18	1	0		45
State 07	2,231	3,728	7,594	1,357	558	524	3,351	1,863	2,603	2,971	79		26,859
Prince George 08	4	2	8	22	0	1	0	3	15	3	0		58
State 08	2,093	3,712	7,162	1,486	508	688	3,697	1,938	2,684	3,006	104		27,078
GROSS CSA FUNDS POOL COSTS (\$) (37.16% LOCAL MATCH)													
Prince George 04	\$3,835	\$34,920	\$10,129	\$90,634	\$0	\$7,551	\$0	\$6,550	\$158,878	\$15,006	\$0		\$327,503
State 04	\$4,657,341	\$10,228,911	\$26,742,279	\$10,855,136	\$3,348,832	\$3,565,217	\$52,008,924	\$30,371,286	\$41,897,553	\$100,740,504	\$1,668,323		\$286,084,306
Prince George 05	\$4,549	\$16,197	\$25,694	\$109,788	\$0	\$0	\$0	\$73,696	\$136,778	\$14,965	\$0		\$381,667
State 05	\$3,958,083	\$8,377,753	\$25,512,339	\$11,478,233	\$3,387,319	\$4,414,345	\$49,968,018	\$35,787,817	\$43,469,861	\$95,538,070	\$1,611,986		\$283,503,824
Prince George 06	\$1,918	\$12,278	\$11,819	\$150,247	\$0	\$18,745	\$0	\$9,327	\$155,261	\$43,131	\$0		\$402,726
State 06	\$3,950,510	\$8,381,286	\$28,622,878	\$14,499,961	\$3,444,434	\$5,424,649	\$52,109,158	\$39,237,642	\$52,655,842	\$97,493,180	\$1,335,789		\$307,155,329
Prince George 07	\$7,178	\$8,531	\$4,480	\$187,726	\$0	\$3,144	\$0	\$18,016	\$284,902	\$8,880	\$0		\$522,857
State 07	\$5,969,883	\$11,269,399	\$31,309,878	\$17,090,648	\$3,031,653	\$5,960,729	\$65,183,029	\$42,894,953	\$63,223,682	\$105,137,477	\$1,699,593		\$352,770,924
Prince George 08	\$10,667	\$3,961	\$69,161	\$317,597	\$0	\$3,284	\$0	\$27,092	\$298,918	\$73,442	\$0		\$804,122
State 08	\$5,072,083	\$10,813,679	\$34,088,059	\$18,233,472	\$3,047,612	\$6,450,804	\$84,215,115	\$44,607,247	\$71,558,671	\$108,885,985	\$1,692,656		\$388,665,383
CSA FUNDS MEDICAID COSTS (\$) (18.58% LOCAL MATCH)													
Prince George 04	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$4,176	\$0		\$4,176
State 04	\$0	\$0	\$0	\$0	\$0	\$0	\$13,512,436	\$0	\$0	\$48,434,858	\$0		\$61,947,294
Prince George 05	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0		\$0
State 05	\$0	\$0	\$0	\$0	\$0	\$0	\$14,998,082	\$2,837,086	\$0	\$59,670,690	\$0		\$77,505,858
Prince George 06	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$56,887	\$0		\$56,887
State 06	\$0	\$0	\$0	\$0	\$0	\$0	\$21,645,299	\$1,023,441	\$0	\$67,805,338	\$0		\$90,474,078
Prince George 07	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$25,746	\$0	\$41,436	\$0		\$67,182
State 07	\$0	\$0	\$0	\$0	\$0	\$0	\$13,193,517	\$11,331,616	\$0	\$76,227,304	\$0		\$100,752,437
Prince George 08*	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0		\$0
State 08	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0		\$0
CSA FUNDS TOTAL COSTS (\$) (POOL + MEDICAID)													
Prince George 04	\$3,835	\$34,920	\$10,129	\$90,634	\$0	\$7,551	\$0	\$6,550	\$158,878	\$19,182	\$0		\$331,679
State 04	\$4,657,341	\$10,228,911	\$26,742,279	\$10,855,136	\$3,348,832	\$3,565,217	\$65,521,360	\$30,371,286	\$41,897,553	\$149,175,362	\$1,668,323		\$348,031,600
Prince George 05	\$4,549	\$16,197	\$25,694	\$109,788	\$0	\$0	\$0	\$73,696	\$136,778	\$14,965	\$0		\$381,667
State 05	\$3,958,083	\$8,377,753	\$25,512,339	\$11,478,233	\$3,387,319	\$4,414,345	\$64,966,100	\$38,624,903	\$43,469,861	\$155,208,760	\$1,611,986		\$361,009,682
Prince George 06	\$1,918	\$12,278	\$11,819	\$150,247	\$0	\$18,745	\$0	\$9,327	\$155,261	\$100,018	\$0		\$459,613
State 06	\$3,950,510	\$8,381,286	\$28,622,878	\$14,499,961	\$3,444,434	\$5,424,649	\$73,754,457	\$40,261,083	\$52,655,842	\$165,298,518	\$1,335,789		\$397,629,407
Prince George 07	\$7,178	\$8,531	\$4,480	\$187,726	\$0	\$3,144	\$0	\$43,762	\$284,902	\$50,316	\$0		\$590,039
State 07	\$5,969,883	\$11,269,399	\$31,309,878	\$17,090,648	\$3,031,653	\$5,960,729	\$78,376,546	\$54,226,569	\$63,223,682	\$181,364,781	\$1,699,593		\$453,523,361
Prince George 08	\$10,667	\$3,961	\$69,161	\$317,597	\$0	\$3,284	\$0	\$27,092	\$298,918	\$73,442	\$0		\$804,122
State 08	\$5,072,083	\$10,813,679	\$34,088,059	\$18,233,472	\$3,047,612	\$6,450,804	\$84,215,115	\$44,607,247	\$71,558,671	\$108,885,985	\$1,692,656		\$388,665,383
AVERAGE COST PER YOUTH (\$)													
Prince George 04	\$480	\$4,989	\$1,126	\$5,332	\$0	\$7,551	\$0	\$6,550	\$19,860	\$19,182	\$0		—
State 04	\$2,727	\$3,278	\$4,633	\$10,769	\$4,903	\$10,274	\$24,829	\$22,251	\$21,398	\$51,299	\$15,167		—
Prince George 05	\$569	\$4,050	\$2,336	\$9,981	\$0	\$0	\$0	\$24,566	\$13,678	\$14,965	\$0		—
State 05	\$2,091	\$2,380	\$3,722	\$9,972	\$4,902	\$10,561	\$16,695	\$21,214	\$20,389	\$31,867	\$16,449		—
Prince George 06	\$1,918	\$6,139	\$2,364	\$12,521	\$0	\$9,373	\$0	\$3,109	\$15,527	\$33,340	\$0		—
State 06	\$2,067	\$2,410	\$4,098	\$11,337	\$4,963	\$10,472	\$23,078	\$22,368	\$21,475	\$53,599	\$17,126		—
Prince George 07	\$1,026	\$4,266	\$4,480	\$14,441	\$0	\$3,144	\$0	\$21,881	\$15,828	\$50,316	\$0		—
State 07	\$2,676	\$3,023	\$4,123	\$12,594	\$5,433	\$11,375	\$23,390	\$29,108	\$24,289	\$61,046	\$21,514		—
Prince George 08	\$2,667	\$1,981	\$8,646	\$14,437	\$0	\$3,284	\$0	\$9,031	\$19,928	\$24,481	\$0		—
State 08	\$2,423	\$2,913	\$4,760	\$12,270	\$5,999	\$9,376	\$22,780	\$23,018	\$24,986	\$36,223	\$16,276		—
% DSM-IV DIAGNOSIS													
Prince George 04	0%	29%	44%	71%	0%	0%	0%	0%	88%	100%	0%		—
State 04	26%	29%	48%	56%	39%	47%	57%	52%	60%	70%	86%		—
Prince George 05	0%	25%	36%	91%	0%	0%	0%	0%	100%	100%	0%		—
State 05	24%	25%	42%	60%	43%	47%	54%	60%	63%	74%	80%		—
Prince George 06	100%	0%	100%	100%	0%	50%	0%	33%	90%	100%	0%		—
State 06	21%	23%	35%	64%	39%	45%	47%	57%	59%	68%	72%		—
Prince George 07	0%	0%	0%	31%	0%	0%	0%	100%	67%	100%	0%		—
State 07	20%	21%	33%	63%	32%	41%	42%	52%	61%	65%	56%		—
Prince George 08	0%	0%	25%	32%	0%	0%	0%	67%	33%	33%	0%		—
State 08	22%	24%	38%	60%	33%	40%	39%	54%	58%	65%	56%		—
PRIMARY SERVICE REASON													
Prince George 04	Neglect	Neglect	Physical Abuse	Special Education	-	Caregiver Absent	-	Runaway	Special Education	Neglect	-		—
State 04	Neglect	Neglect	Behavioral Issues	Education	Neglect	Incapacity	Neglect	Issues	Education	Issues	Issues		—
Prince George 05	Neglect	Neglect	Physical Abuse	Special Education	-	-	-	Neglect	Special Education	Neglect	-		—
State 05	Neglect	Neglect	Caregiver Incapacity	Education	Neglect	Incapacity	Neglect	Behavioral Issues	Education	Issues	Issues		—
Prince George 06	Neglect	Neglect	Special Education	Special Education	-	Neglect	-	Caregiver Incapacity	Special Education	Neglect	-		

CSA CPMT Management Report
Hopewell; 2004 to 2008

	Family Foster Maintenance Only	Foster Care Maintenance & Other Services	Community Based Interventions	SPED Other Day Services	Specialized Foster Homes	Independent Living	Therapeutic Foster Home	Group Home	SPED Day Placement	Residential Treatment Facility	Psychiatric Hospital	TOTAL
# SERVICES												
Hopewell 04	4	6	5	2	0	0	10	12	24	5	2	70
State 04	1,724	3,172	5,906	1,027	690	350	2,665	1,385	1,982	2,988	113	22,002
Hopewell 05	5	6	9	2	0	0	12	11	37	11	5	98
State 05	1,900	3,555	6,950	1,178	695	419	3,042	1,706	2,150	3,085	100	24,780
Hopewell 06	15	6	5	3	1	0	6	10	58	8	0	112
State 06	2,084	4,416	9,349	1,420	721	564	3,457	1,970	2,645	3,395	83	30,104
Hopewell 07	11	9	7	5	1	0	3	13	49	8	0	106
State 07	2,411	4,794	9,755	1,504	583	573	3,553	1,975	2,798	3,213	79	31,238
Hopewell 08	6	17	18	7	0	4	6	8	42	9	0	117
State 08	2,857	4,924	9,433	1,629	525	763	3,938	2,147	3,150	3,301	104	32,771
% TOTAL CSA SERVICES												
Hopewell 04	6%	9%	7%	3%	0%	0%	14%	17%	34%	7%	3%	100%
State 04	8%	14%	27%	5%	3%	2%	12%	6%	9%	14%	1%	101%
Hopewell 05	5%	6%	9%	2%	0%	0%	12%	11%	38%	11%	5%	99%
State 05	8%	14%	28%	5%	3%	2%	12%	7%	9%	12%	0%	100%
Hopewell 06	13%	5%	4%	3%	1%	0%	5%	9%	52%	7%	0%	99%
State 06	7%	15%	31%	5%	2%	2%	11%	7%	9%	11%	0%	100%
Hopewell 07	10%	8%	7%	5%	1%	0%	3%	12%	46%	8%	0%	100%
State 07	8%	15%	31%	5%	2%	2%	11%	6%	9%	10%	0%	99%
Hopewell 08	5%	15%	15%	6%	0%	3%	5%	7%	36%	8%	0%	100%
State 08	9%	15%	29%	5%	2%	2%	12%	7%	10%	10%	0%	101%
# YOUTH SERVED												
Hopewell 04	4	6	5	2	0	0	10	12	24	5	2	70
State 04	1,708	3,120	5,772	1,008	683	347	2,639	1,365	1,958	2,908	110	21,618
Hopewell 05	5	6	9	2	0	0	12	10	37	11	5	97
State 05	1,893	3,520	6,855	1,151	691	418	2,993	1,687	2,132	2,998	98	24,436
Hopewell 06	15	6	5	3	1	0	6	10	57	8	0	111
State 06	1,911	3,478	6,985	1,279	694	518	3,196	1,800	2,452	3,084	78	25,475
Hopewell 07	11	9	7	5	1	0	3	13	49	8	0	106
State 07	2,231	3,728	7,594	1,357	558	524	3,351	1,863	2,603	2,971	79	26,859
Hopewell 08	6	17	18	7	0	4	6	8	41	9	0	116
State 08	2,093	3,712	7,162	1,486	508	688	3,697	1,938	2,684	3,006	104	27,078
GROSS CSA FUNDS POOL COSTS (\$) (26.67% LOCAL MATCH)												
Hopewell 04	\$21,827	\$73,634	\$10,208	\$23,931	\$0	\$0	\$355,583	\$678,254	\$467,116	\$345,359	\$57,309	\$2,033,221
State 04	\$4,657,341	\$10,228,911	\$26,742,279	\$10,855,136	\$3,348,832	\$3,565,217	\$52,008,924	\$30,371,286	\$41,897,553	\$100,740,504	\$1,668,323	\$286,084,306
Hopewell 05	\$8,270	\$71,020	\$24,819	\$28,620	\$0	\$0	\$410,705	\$351,856	\$642,279	\$365,440	\$103,204	\$2,006,213
State 05	\$3,958,083	\$8,377,753	\$25,512,339	\$11,478,233	\$3,387,319	\$4,414,345	\$49,968,018	\$35,787,817	\$43,469,861	\$95,538,070	\$1,611,986	\$283,503,824
Hopewell 06	\$34,788	\$73,734	\$77,858	\$42,185	\$4,292	\$0	\$157,367	\$441,981	\$1,008,345	\$687,266	\$0	\$2,527,816
State 06	\$3,950,510	\$8,381,286	\$28,622,878	\$14,499,961	\$3,444,434	\$5,424,649	\$52,109,158	\$39,237,642	\$52,655,842	\$97,493,180	\$1,335,789	\$307,155,329
Hopewell 07	\$57,207	\$75,216	\$14,633	\$100,356	\$3,054	\$0	\$71,747	\$543,230	\$1,006,985	\$488,334	\$0	\$2,360,762
State 07	\$5,969,883	\$11,269,399	\$31,309,878	\$17,090,648	\$3,031,653	\$5,960,729	\$65,183,029	\$42,894,953	\$63,223,682	\$105,137,477	\$1,699,593	\$352,770,924
Hopewell 08	\$57,233	\$148,897	\$109,723	\$130,977	\$0	\$178,819	\$191,226	\$254,123	\$923,402	\$508,465	\$0	\$2,502,865
State 08	\$5,072,083	\$10,813,679	\$34,088,059	\$18,233,472	\$3,047,612	\$6,450,804	\$84,215,115	\$44,607,247	\$71,558,671	\$108,885,985	\$1,692,656	\$388,665,383
CSA FUNDS MEDICAID COSTS (\$) (13.34% LOCAL MATCH)												
Hopewell 04	\$0	\$0	\$0	\$0	\$0	\$0	\$24,432	\$0	\$0	\$370,181	\$0	\$394,613
State 04	\$0	\$0	\$0	\$0	\$0	\$0	\$13,512,436	\$0	\$0	\$48,434,858	\$0	\$61,947,294
Hopewell 05	\$0	\$0	\$0	\$0	\$0	\$0	\$26,651	\$108,867	\$0	\$790,058	\$0	\$925,576
State 05	\$0	\$0	\$0	\$0	\$0	\$0	\$14,998,082	\$2,837,086	\$0	\$59,670,690	\$0	\$77,505,858
Hopewell 06	\$0	\$0	\$0	\$0	\$0	\$0	\$98,907	\$9,854	\$0	\$372,333	\$0	\$481,094
State 06	\$0	\$0	\$0	\$0	\$0	\$0	\$21,645,299	\$1,023,441	\$0	\$67,805,338	\$0	\$90,474,078
Hopewell 07	\$0	\$0	\$0	\$0	\$0	\$0	\$35,122	\$203,113	\$0	\$308,544	\$0	\$546,779
State 07	\$0	\$0	\$0	\$0	\$0	\$0	\$13,193,517	\$11,331,616	\$0	\$76,227,304	\$0	\$100,752,437
Hopewell 08*	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
State 08	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
CSA FUNDS TOTAL COSTS (\$) (POOL + MEDICAID)												
Hopewell 04	\$21,827	\$73,634	\$10,208	\$23,931	\$0	\$0	\$380,015	\$678,254	\$467,116	\$715,540	\$57,309	\$2,427,834
State 04	\$4,657,341	\$10,228,911	\$26,742,279	\$10,855,136	\$3,348,832	\$3,565,217	\$65,521,360	\$30,371,286	\$41,897,553	\$149,175,362	\$1,668,323	\$348,031,600
Hopewell 05	\$8,270	\$71,020	\$24,819	\$28,620	\$0	\$0	\$437,356	\$460,723	\$642,279	\$1,155,498	\$103,204	\$2,931,789
State 05	\$3,958,083	\$8,377,753	\$25,512,339	\$11,478,233	\$3,387,319	\$4,414,345	\$64,966,100	\$38,624,903	\$43,469,861	\$155,208,760	\$1,611,986	\$361,009,682
Hopewell 06	\$34,788	\$73,734	\$77,858	\$42,185	\$4,292	\$0	\$256,274	\$451,835	\$1,008,345	\$1,059,599	\$0	\$3,008,910
State 06	\$3,950,510	\$8,381,286	\$28,622,878	\$14,499,961	\$3,444,434	\$5,424,649	\$73,754,457	\$40,261,083	\$52,655,842	\$165,298,518	\$1,335,789	\$397,629,407
Hopewell 07	\$57,207	\$75,216	\$14,633	\$100,356	\$3,054	\$0	\$106,869	\$746,343	\$1,006,985	\$796,878	\$0	\$2,907,541
State 07	\$5,969,883	\$11,269,399	\$31,309,878	\$17,090,648	\$3,031,653	\$5,960,729	\$78,376,546	\$54,226,569	\$63,223,682	\$181,364,781	\$1,699,593	\$453,523,361
Hopewell 08	\$57,233	\$148,897	\$109,723	\$130,977	\$0	\$178,819	\$191,226	\$254,123	\$923,402	\$508,465	\$0	\$2,502,865
State 08	\$5,072,083	\$10,813,679	\$34,088,059	\$18,233,472	\$3,047,612	\$6,450,804	\$84,215,115	\$44,607,247	\$71,558,671	\$108,885,985	\$1,692,656	\$388,665,383
AVERAGE COST PER YOUTH (\$)												
Hopewell 04	\$5,457	\$12,273	\$2,042	\$11,966	\$0	\$0	\$38,002	\$56,522	\$19,464	\$143,108	\$28,655	-
State 04	\$2,727	\$3,278	\$4,633	\$10,769	\$4,903	\$10,274	\$24,829	\$22,251	\$21,398	\$51,299	\$15,167	-
Hopewell 05	\$1,654	\$11,837	\$2,758	\$14,310	\$0	\$0	\$36,447	\$46,073	\$17,359	\$105,046	\$20,641	-
State 05	\$2,091	\$3,380	\$3,722	\$9,972	\$4,902	\$10,561	\$16,695	\$21,214	\$20,389	\$31,867	\$16,449	-
Hopewell 06	\$2,320	\$12,289	\$15,572	\$14,062	\$4,292	\$0	\$42,713	\$45,184	\$17,691	\$132,450	\$0	-
State 06	\$2,067	\$2,410	\$4,098	\$11,337	\$4,963	\$10,472	\$23,078	\$22,368	\$21,475	\$53,599	\$17,126	-
Hopewell 07	\$5,201	\$8,358	\$2,091	\$20,072	\$3,054	\$0	\$35,623	\$57,411	\$20,551	\$99,610	\$0	-
State 07	\$2,676	\$3,023	\$4,123	\$12,594	\$5,433	\$11,375	\$23,390	\$29,108	\$24,289	\$61,046	\$21,514	-
Hopewell 08	\$9,539	\$8,759	\$6,096	\$18,711	\$0	\$44,705	\$31,871	\$31,766	\$22,522	\$56,497	\$0	-
State 08	\$2,423	\$2,913	\$4,760	\$12,270	\$5,999	\$9,376	\$22,780	\$23,018	\$24,986	\$36,223	\$16,276	-
% DSM-IV DIAGNOSIS												
Hopewell 04	0%	33%	0%	0%	0%	0%	10%	42%	8%	60%	50%	-
State 04	26%	29%	48%	56%	39%	47%	57%	52%	60%	70%	86%	-
Hopewell 05	0%	33%	0%	0%	0%	0%	17%	60%	8%	55%	40%	-
State 05	24%	25%	42%	60%	43%	47%	54%	60%	63%	74%	80%	-
Hopewell 06	0%	33%	0%	33%	0%	0%	0%	40%	4%	63%	0%	-
State 06	21%	23%	35%	64%	39%	45%	47%	57%	59%	68%	72%	-
Hopewell 07	9%	11%	14%	20%	0%	0%	0%	31%	2%	75%	0%	-
State 07	20%	21%	33%	63%	32%	41%	42%	52%	61%	65%	56%	-
Hopewell 08	0%	6%	11%	14%	0%	50%	17%	38%	2%	56%	0%	-
State 08	22%	24%	38%	60%	33%	40%	39%	54%	58%	65%	56%	-
PRIMARY SERVICE REASON												
Hopewell 04	Caregiver Incapacity	Neglect	Caregiver Incapacity	Special Education	-	-	Caregiver Incapacity	Physical Abuse	Special Education	Neglect	Caregiver Absent	-
State 04	Neglect	Neglect	Behavioral Issues	Special Education	Neglect	Caregiver Incapacity	Neglect	Behavioral Issues	Special Education	Behavioral Issues	Behavioral Issues	-
Hopewell 05	Caregiver Incapacity	Neglect	Caregiver Incapacity	Behavioral Issues	-	-	Neglect	Physical Abuse	Special Education	Caregiver Absent	Caregiver Incapacity	-
State 05	Neglect	Neglect	Caregiver Incapacity	Behavioral Issues	Neglect	Caregiver Incapacity	Neglect	Behavioral Issues	Special Education	Behavioral Issues	Behavioral Issues	-
Hopewell 06	Neglect	Neglect	Caregiver Incapacity	Behavioral Issues	Caregiver Incapacity	-	Abuse	Physical Abuse	Special Education	Caregiver Absent	-	-
State 0												

CSA CPMT Management Report
Colonial Heights; 2004 to 2008

	Family Foster Maintenance Only	Foster Care Maintenance & Other Services	Community Based Interventions	SPED Other Day Services	Specialized Foster Homes	Independent Living	Therapeutic Foster Home	Group Home	SPED Day Placement	Residential Treatment Facility	Psychiatric Hospital	TOTAL
# SERVICES												
Colonial Heights 04	1	3	4	3	0	0	3	0	10	1	0	25
State 04	1,724	3,172	5,906	1,027	690	350	2,665	1,385	1,982	2,988	113	22,002
Colonial Heights 05	8	10	7	13	0	0	5	0	9	7	0	59
State 05	1,900	3,555	6,950	1,178	695	419	3,042	1,706	2,150	3,085	100	24,780
Colonial Heights 06	8	37	7	16	0	0	8	0	13	17	0	106
State 06	2,084	4,416	9,349	1,420	721	564	3,457	1,970	2,645	3,395	83	30,104
Colonial Heights 07	5	22	13	21	0	3	9	3	15	19	0	110
State 07	2,411	4,794	9,755	1,504	583	573	3,553	1,975	2,798	3,213	79	31,238
Colonial Heights 08	2	10	13	11	0	6	2	0	12	5	0	61
State 08	2,857	4,924	9,433	1,629	525	763	3,938	2,147	3,150	3,301	104	32,771
% TOTAL CSA SERVICES												
Colonial Heights 04	4%	12%	16%	12%	0%	0%	12%	0%	40%	4%	0%	100%
State 04	8%	14%	27%	5%	3%	2%	12%	6%	9%	14%	1%	101%
Colonial Heights 05	14%	17%	12%	22%	0%	0%	8%	0%	15%	12%	0%	100%
State 05	8%	14%	28%	5%	3%	2%	12%	7%	9%	12%	0%	100%
Colonial Heights 06	8%	35%	7%	15%	0%	0%	8%	0%	12%	16%	0%	101%
State 06	7%	15%	31%	5%	2%	2%	11%	7%	9%	11%	0%	100%
Colonial Heights 07	5%	20%	12%	19%	0%	3%	8%	3%	14%	17%	0%	101%
State 07	8%	15%	31%	5%	2%	2%	11%	6%	9%	10%	0%	99%
Colonial Heights 08	3%	16%	21%	18%	0%	10%	3%	0%	20%	8%	0%	99%
State 08	9%	15%	29%	5%	2%	2%	12%	7%	10%	10%	0%	101%
# YOUTH SERVED												
Colonial Heights 04	1	3	4	3	0	0	3	0	10	1	0	25
State 04	1,708	3,120	5,772	1,008	683	347	2,639	1,365	1,958	2,908	110	21,618
Colonial Heights 05	8	10	7	13	0	0	5	0	9	7	0	59
State 05	1,893	3,520	6,855	1,151	691	418	2,993	1,687	2,132	2,998	98	24,436
Colonial Heights 06	7	18	5	14	0	0	8	0	12	14	0	78
State 06	1,911	3,478	6,985	1,279	694	518	3,196	1,800	2,452	3,084	78	25,475
Colonial Heights 07	3	12	9	16	0	3	9	3	12	16	0	83
State 07	2,231	3,728	7,594	1,357	558	524	3,351	1,863	2,603	2,971	79	26,859
Colonial Heights 08	2	7	8	9	0	5	2	0	10	5	0	48
State 08	2,093	3,712	7,162	1,486	508	688	3,697	1,938	2,684	3,006	104	27,078
GROSS CSA FUNDS POOL COSTS (\$) (40.27% LOCAL MATCH)												
Colonial Heights 04	\$35,316	\$2,789	\$37,965	\$22,832	\$0	\$0	\$63,893	\$0	\$114,792	\$39,300	\$0	\$316,887
State 04	\$4,657,341	\$10,228,911	\$26,742,279	\$10,855,136	\$3,348,832	\$3,565,217	\$52,008,924	\$30,371,286	\$41,897,553	\$100,740,504	\$1,668,323	\$286,084,306
Colonial Heights 05	\$13,946	\$5,921	\$27,206	\$122,075	\$0	\$0	\$61,546	\$0	\$109,649	\$61,390	\$0	\$401,733
State 05	\$3,958,083	\$8,377,753	\$25,512,339	\$11,478,233	\$3,387,319	\$4,414,345	\$49,968,018	\$35,787,817	\$43,469,861	\$95,538,070	\$1,611,986	\$283,503,824
Colonial Heights 06	\$15,083	\$13,120	\$14,312	\$137,911	\$0	\$0	\$41,132	\$0	\$102,899	\$122,218	\$0	\$446,675
State 06	\$3,950,510	\$8,381,286	\$28,622,878	\$14,499,961	\$3,444,434	\$5,424,649	\$52,109,158	\$39,237,642	\$52,655,842	\$97,493,180	\$1,335,789	\$307,155,329
Colonial Heights 07	\$5,337	\$9,411	\$29,086	\$85,835	\$0	\$22,096	\$131,952	\$44,805	\$183,039	\$146,469	\$0	\$658,030
State 07	\$5,969,883	\$11,269,399	\$31,309,878	\$17,090,648	\$3,031,653	\$5,960,729	\$65,183,029	\$42,894,953	\$63,223,682	\$105,137,477	\$1,699,593	\$352,770,924
Colonial Heights 08	\$885	\$6,693	\$49,109	\$73,636	\$0	\$45,768	\$4,933	\$0	\$141,010	\$101,607	\$0	\$423,641
State 08	\$5,072,083	\$10,813,679	\$34,088,059	\$18,233,472	\$3,047,612	\$6,450,804	\$84,215,115	\$44,607,247	\$71,558,671	\$108,885,985	\$1,692,656	\$388,665,383
CSA FUNDS MEDICAID COSTS (\$) (20.13% LOCAL MATCH)												
Colonial Heights 04	\$0	\$0	\$0	\$0	\$0	\$0	\$11,300	\$0	\$0	\$50,773	\$0	\$62,073
State 04	\$0	\$0	\$0	\$0	\$0	\$0	\$13,512,436	\$0	\$0	\$48,434,858	\$0	\$61,947,294
Colonial Heights 05	\$0	\$0	\$0	\$0	\$0	\$0	\$33,035	\$22,727	\$0	\$140,765	\$0	\$196,527
State 05	\$0	\$0	\$0	\$0	\$0	\$0	\$14,998,082	\$2,837,086	\$0	\$59,670,690	\$0	\$77,505,858
Colonial Heights 06	\$0	\$0	\$0	\$0	\$0	\$0	\$92,806	\$4,768	\$0	\$90,501	\$0	\$188,075
State 06	\$0	\$0	\$0	\$0	\$0	\$0	\$21,645,299	\$1,023,441	\$0	\$67,805,338	\$0	\$90,474,078
Colonial Heights 07	\$0	\$0	\$0	\$0	\$0	\$0	\$33,252	\$38,621	\$0	\$22,742	\$0	\$94,615
State 07	\$0	\$0	\$0	\$0	\$0	\$0	\$13,193,517	\$11,331,616	\$0	\$76,227,304	\$0	\$100,752,437
Colonial Heights 08*	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
State 08	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
CSA FUNDS TOTAL COSTS (\$) (POOL + MEDICAID)												
Colonial Heights 04	\$35,316	\$2,789	\$37,965	\$22,832	\$0	\$0	\$75,193	\$0	\$114,792	\$90,073	\$0	\$378,960
State 04	\$4,657,341	\$10,228,911	\$26,742,279	\$10,855,136	\$3,348,832	\$3,565,217	\$65,521,360	\$30,371,286	\$41,897,553	\$149,175,362	\$1,668,323	\$348,031,600
Colonial Heights 05	\$13,946	\$5,921	\$27,206	\$122,075	\$0	\$0	\$94,581	\$0	\$109,649	\$202,155	\$0	\$575,533
State 05	\$3,958,083	\$8,377,753	\$25,512,339	\$11,478,233	\$3,387,319	\$4,414,345	\$64,966,100	\$38,624,903	\$43,469,861	\$155,208,760	\$1,611,986	\$361,009,682
Colonial Heights 06	\$15,083	\$13,120	\$14,312	\$137,911	\$0	\$0	\$133,938	\$0	\$102,899	\$121,719	\$0	\$629,982
State 06	\$3,950,510	\$8,381,286	\$28,622,878	\$14,499,961	\$3,444,434	\$5,424,649	\$73,754,457	\$40,261,083	\$52,655,842	\$165,298,518	\$1,335,789	\$397,629,407
Colonial Heights 07	\$5,337	\$9,411	\$29,086	\$85,835	\$0	\$22,096	\$165,204	\$83,426	\$183,039	\$169,211	\$0	\$752,645
State 07	\$5,969,883	\$11,269,399	\$31,309,878	\$17,090,648	\$3,031,653	\$5,960,729	\$78,376,546	\$54,226,569	\$63,223,682	\$181,364,781	\$1,699,593	\$453,523,361
Colonial Heights 08	\$885	\$6,693	\$49,109	\$73,636	\$0	\$45,768	\$4,933	\$0	\$141,010	\$101,607	\$0	\$423,641
State 08	\$5,072,083	\$10,813,679	\$34,088,059	\$18,233,472	\$3,047,612	\$6,450,804	\$84,215,115	\$44,607,247	\$71,558,671	\$108,885,985	\$1,692,656	\$388,665,383
AVERAGE COST PER YOUTH (\$)												
Colonial Heights 04	\$35,316	\$930	\$9,492	\$7,611	\$0	\$0	\$25,065	\$0	\$11,480	\$90,073	\$0	—
State 04	\$2,727	\$3,278	\$4,633	\$10,769	\$4,903	\$10,274	\$24,829	\$22,251	\$21,398	\$51,299	\$15,167	—
Colonial Heights 05	\$1,744	\$593	\$3,887	\$9,391	\$0	\$0	\$18,917	\$0	\$12,184	\$28,880	\$0	—
State 05	\$2,091	\$2,380	\$3,722	\$9,972	\$4,902	\$10,561	\$16,695	\$21,214	\$20,389	\$31,867	\$16,449	—
Colonial Heights 06	\$2,155	\$729	\$2,863	\$9,851	\$0	\$0	\$16,743	\$0	\$8,575	\$15,195	\$0	—
State 06	\$2,067	\$2,410	\$4,098	\$11,337	\$4,963	\$10,472	\$23,078	\$22,368	\$21,475	\$53,599	\$17,126	—
Colonial Heights 07	\$1,779	\$785	\$3,232	\$5,365	\$0	\$7,366	\$18,356	\$27,809	\$15,254	\$10,576	\$0	—
State 07	\$2,676	\$3,023	\$4,123	\$12,594	\$5,433	\$11,375	\$23,390	\$29,108	\$24,289	\$61,046	\$21,514	—
Colonial Heights 08	\$443	\$957	\$6,139	\$8,182	\$0	\$9,154	\$2,467	\$0	\$14,101	\$20,322	\$0	—
State 08	\$2,423	\$2,913	\$4,760	\$12,270	\$5,999	\$9,376	\$22,780	\$23,018	\$24,986	\$36,223	\$16,276	—
% DSM-IV DIAGNOSIS												
Colonial Heights 04	100%	100%	100%	100%	0%	0%	100%	0%	90%	100%	0%	—
State 04	26%	29%	48%	56%	39%	47%	57%	52%	60%	70%	86%	—
Colonial Heights 05	50%	60%	71%	92%	0%	0%	60%	0%	100%	57%	0%	—
State 05	24%	25%	42%	60%	43%	47%	54%	60%	63%	74%	80%	—
Colonial Heights 06	43%	28%	60%	79%	0%	0%	38%	0%	92%	29%	0%	—
State 06	21%	23%	34%	64%	39%	45%	47%	57%	59%	68%	72%	—
Colonial Heights 07	33%	25%	44%	69%	0%	33%	11%	67%	83%	50%	0%	—
State 07	20%	21%	33%	63%	32%	41%	42%	52%	61%	65%	56%	—
Colonial Heights 08	0%	43%	63%	56%	0%	20%	50%	0%	70%	100%	0%	—
State 08	22%	24%	38%	60%	33%	40%	39%	54%	58%	65%	56%	—
PRIMARY SERVICE REASON												
Colonial Heights 04	Caregiver Absent	Caregiver Absent	Behavioral Issues	Behavioral Issues	-	-	Caregiver Absent	-	Special Education	Caregiver Absent	-	—
State 04	Neglect	Neglect	Behavioral Issues	Special Education	Neglect	Caregiver Incapacity	Neglect	Behavioral Issues	Special Education	Behavioral Issues	Behavioral Issues	—
Colonial Heights 05	Caregiver Incapacity	Caregiver Incapacity	Caregiver Incapacity	Special Education	-	-	Behavioral Issues	-	Special Education	Caregiver Incapacity	-	—
State 05	Neglect	Neglect	Caregiver Incapacity	Special Education	Neglect	Caregiver Incapacity	Neglect	Behavioral Issues	Special Education	Behavioral Issues	Behavioral Issues	—
Colonial Heights 06	Caregiver Incapacity	Caregiver Incapacity	Caregiver Incapacity	Special Education	-	-	Caregiver Incapacity	-	Special Education	Caregiver Incapacity	-	—
State 06	Neglect	Neglect	Behavioral Issues	Special Education	Neglect	Caregiver Incapacity	Neglect	Behavioral Issues	Special Education	Behavioral Issues	Behavioral Issues	—
Colonial Heights 07	Caregiver Incapacity	Caregiver										

CSA CPMT Management Report
Dinwiddie; 2004 to 2008

	Family Foster Maintenance Only	Foster Care Care Maintenance & Other Services	Community Based Interventions	SPED Day Services	Other Specialized Foster Homes	Independent Living	Therapeutic Foster Home	Group Home	SPED Day Placement	Residential Treatment Facility	Psychiatric Hospital	TOTAL
# SERVICES												
Dinwiddie 04	1	3	15	3	1	0	0	4	13	1	0	41
State 04	1,724	3,172	5,906	1,027	690	350	2,665	1,385	1,982	2,988	113	22,002
Dinwiddie 05	1	7	15	10	0	1	1	7	11	4	0	57
State 05	1,900	3,555	6,950	1,178	695	419	3,042	1,706	2,150	3,085	100	24,780
Dinwiddie 06	1	5	10	7	0	1	3	7	11	3	0	48
State 06	2,084	4,416	9,349	1,420	721	564	3,457	1,970	2,645	3,395	83	30,104
Dinwiddie 07	1	4	9	5	0	1	8	6	7	7	0	48
State 07	2,411	4,794	9,755	1,504	583	573	3,553	1,975	2,798	3,213	79	31,238
Dinwiddie 08	7	3	4	3	0	4	3	1	8	12	1	46
State 08	2,857	4,924	9,433	1,629	525	763	3,938	2,147	3,150	3,301	104	32,771
% TOTAL CSA SERVICES												
Dinwiddie 04	2%	7%	37%	7%	2%	0%	0%	10%	32%	2%	0%	99%
State 04	8%	14%	27%	5%	3%	2%	12%	6%	9%	14%	1%	101%
Dinwiddie 05	2%	12%	26%	18%	0%	2%	2%	12%	19%	7%	0%	100%
State 05	8%	14%	28%	5%	3%	2%	12%	7%	9%	12%	0%	100%
Dinwiddie 06	2%	10%	21%	15%	0%	2%	6%	15%	23%	6%	0%	100%
State 06	7%	15%	31%	5%	2%	2%	11%	7%	9%	11%	0%	100%
Dinwiddie 07	2%	8%	19%	10%	0%	2%	17%	13%	15%	15%	0%	101%
State 07	8%	15%	31%	5%	2%	2%	11%	6%	9%	10%	0%	99%
Dinwiddie 08	15%	7%	9%	7%	0%	9%	7%	2%	17%	26%	2%	101%
State 08	9%	15%	29%	5%	2%	2%	12%	7%	10%	10%	0%	101%
# YOUTH SERVED												
Dinwiddie 04	1	3	13	3	1	0	0	4	13	1	0	39
State 04	1,708	3,120	5,772	1,008	683	347	2,639	1,365	1,958	2,908	110	21,618
Dinwiddie 05	1	7	15	10	0	1	1	7	11	4	0	57
State 05	1,893	3,520	6,855	1,151	691	418	2,993	1,687	2,132	2,998	98	24,436
Dinwiddie 06	1	5	10	7	0	1	3	7	11	3	0	48
State 06	1,911	3,478	6,985	1,279	694	518	3,196	1,800	2,452	3,084	78	25,475
Dinwiddie 07	1	4	8	5	0	1	7	6	7	7	0	46
State 07	2,231	3,728	7,594	1,357	558	524	3,351	1,863	2,603	2,971	79	26,859
Dinwiddie 08	7	3	4	3	0	4	3	1	8	12	1	46
State 08	2,093	3,712	7,162	1,486	508	688	3,697	1,938	2,684	3,006	104	27,078
GROSS CSA FUNDS POOL COSTS (\$) (33.58% LOCAL MATCH)												
Dinwiddie 04	\$463	\$41,894	\$26,374	\$21,515	\$2,508	\$0	\$0	\$66,063	\$167,506	\$1,920	\$0	\$328,243
State 04	\$4,657,341	\$10,228,911	\$26,742,279	\$10,855,136	\$3,348,832	\$3,565,217	\$52,008,924	\$30,371,286	\$41,897,553	\$100,740,504	\$1,668,323	\$286,084,306
Dinwiddie 05	\$4,348	\$28,247	\$51,249	\$91,938	\$0	\$22,140	\$28,244	\$59,986	\$168,608	\$69,983	\$0	\$524,743
State 05	\$3,958,083	\$8,377,753	\$25,512,339	\$11,478,233	\$3,387,319	\$4,414,345	\$49,968,018	\$35,787,817	\$43,469,861	\$95,538,070	\$1,611,986	\$283,503,824
Dinwiddie 06	\$5,758	\$2,049	\$62,332	\$86,488	\$0	\$66,998	\$77,040	\$94,767	\$121,382	\$32,008	\$0	\$548,822
State 06	\$3,950,510	\$8,381,286	\$28,622,878	\$14,499,961	\$3,444,434	\$5,424,649	\$52,109,158	\$39,237,642	\$52,655,842	\$97,493,180	\$1,335,789	\$307,155,329
Dinwiddie 07	\$2,903	\$12,621	\$45,291	\$61,930	\$0	\$34,916	\$79,867	\$32,645	\$118,639	\$91,237	\$0	\$480,049
State 07	\$5,969,883	\$11,269,399	\$31,309,878	\$17,090,648	\$3,031,653	\$5,960,729	\$65,183,029	\$42,894,953	\$63,223,682	\$105,137,477	\$1,699,593	\$352,770,924
Dinwiddie 08	\$13,686	\$1,497	\$10,044	\$21,815	\$0	\$86,582	\$71,566	\$4,512	\$118,126	\$251,500	\$2,750	\$582,078
State 08	\$5,072,083	\$10,813,679	\$34,088,059	\$18,233,472	\$3,047,612	\$6,450,804	\$84,215,115	\$44,607,247	\$71,558,671	\$108,885,985	\$1,692,656	\$388,665,383
CSA FUNDS MEDICAID COSTS (\$) (16.79% LOCAL MATCH)												
Dinwiddie 04	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$108,308	\$0	\$108,308
State 04	\$0	\$0	\$0	\$0	\$0	\$0	\$13,512,436	\$0	\$0	\$48,434,858	\$0	\$61,947,294
Dinwiddie 05	\$0	\$0	\$0	\$0	\$0	\$0	\$9,695	\$3,655	\$0	\$190,625	\$0	\$203,975
State 05	\$0	\$0	\$0	\$0	\$0	\$0	\$14,998,082	\$2,837,086	\$0	\$59,670,690	\$0	\$77,505,858
Dinwiddie 06	\$0	\$0	\$0	\$0	\$0	\$0	\$62,414	\$0	\$0	\$111,495	\$0	\$173,909
State 06	\$0	\$0	\$0	\$0	\$0	\$0	\$21,645,299	\$1,023,441	\$0	\$67,805,338	\$0	\$90,474,078
Dinwiddie 07	\$0	\$0	\$0	\$0	\$0	\$0	\$34,749	\$0	\$0	\$382,780	\$0	\$417,529
State 07	\$0	\$0	\$0	\$0	\$0	\$0	\$13,193,517	\$11,331,616	\$0	\$76,227,304	\$0	\$100,752,437
Dinwiddie 08	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
State 08	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
CSA FUNDS TOTAL COSTS (\$) (POOL + MEDICAID)												
Dinwiddie 04	\$463	\$41,894	\$26,374	\$21,515	\$2,508	\$0	\$0	\$66,063	\$167,506	\$110,228	\$0	\$436,551
State 04	\$4,657,341	\$10,228,911	\$26,742,279	\$10,855,136	\$3,348,832	\$3,565,217	\$65,521,360	\$30,371,286	\$41,897,553	\$149,175,362	\$1,668,323	\$348,031,600
Dinwiddie 05	\$4,348	\$28,247	\$51,249	\$91,938	\$0	\$22,140	\$37,939	\$63,641	\$168,608	\$260,608	\$0	\$728,718
State 05	\$3,958,083	\$8,377,753	\$25,512,339	\$11,478,233	\$3,387,319	\$4,414,345	\$64,966,100	\$38,624,903	\$43,469,861	\$155,208,760	\$1,611,986	\$361,009,682
Dinwiddie 06	\$5,758	\$2,049	\$62,332	\$86,488	\$0	\$66,998	\$139,454	\$94,767	\$121,382	\$143,503	\$0	\$722,731
State 06	\$3,950,510	\$8,381,286	\$28,622,878	\$14,499,961	\$3,444,434	\$5,424,649	\$73,754,457	\$40,261,083	\$52,655,842	\$165,298,518	\$1,335,789	\$397,629,407
Dinwiddie 07	\$2,903	\$12,621	\$45,291	\$61,930	\$0	\$34,916	\$114,616	\$32,645	\$118,639	\$474,017	\$0	\$897,578
State 07	\$5,969,883	\$11,269,399	\$31,309,878	\$17,090,648	\$3,031,653	\$5,960,729	\$78,376,546	\$54,226,569	\$63,223,682	\$181,364,781	\$1,699,593	\$453,523,361
Dinwiddie 08	\$13,686	\$1,497	\$10,044	\$21,815	\$0	\$86,582	\$71,566	\$4,512	\$118,126	\$251,500	\$2,750	\$582,078
State 08	\$5,072,083	\$10,813,679	\$34,088,059	\$18,233,472	\$3,047,612	\$6,450,804	\$84,215,115	\$44,607,247	\$71,558,671	\$108,885,985	\$1,692,656	\$388,665,383
AVERAGE COST PER YOUTH (\$)												
Dinwiddie 04	\$463	\$13,965	\$2,029	\$7,172	\$2,508	\$0	\$0	\$16,516	\$12,886	\$1,920	\$0	--
State 04	\$2,727	\$3,278	\$4,633	\$10,769	\$4,903	\$10,274	\$24,829	\$22,251	\$21,398	\$51,299	\$15,167	--
Dinwiddie 05	\$4,348	\$4,036	\$3,417	\$9,194	\$0	\$22,140	\$28,244	\$8,570	\$15,328	\$17,496	\$0	--
State 05	\$2,091	\$2,380	\$3,722	\$9,972	\$4,902	\$10,561	\$16,695	\$21,214	\$20,389	\$31,867	\$16,449	--
Dinwiddie 06	\$5,758	\$410	\$6,234	\$12,356	\$0	\$66,998	\$46,485	\$13,539	\$11,035	\$47,835	\$0	--
State 06	\$2,067	\$2,410	\$4,098	\$11,337	\$4,963	\$10,472	\$23,078	\$22,368	\$21,475	\$53,599	\$17,126	--
Dinwiddie 07	\$2,903	\$3,156	\$5,662	\$12,386	\$0	\$34,916	\$11,410	\$5,441	\$16,949	\$13,034	\$0	--
State 07	\$2,676	\$3,023	\$4,123	\$12,594	\$5,433	\$11,375	\$23,390	\$29,108	\$24,289	\$61,046	\$21,514	--
Dinwiddie 08	\$1,956	\$499	\$2,511	\$7,272	\$0	\$21,646	\$23,856	\$4,512	\$14,766	\$20,959	\$2,750	--
State 08	\$2,423	\$2,913	\$4,760	\$12,270	\$5,999	\$9,376	\$22,780	\$23,018	\$24,986	\$36,223	\$16,276	--
% DSM-IV DIAGNOSIS												
Dinwiddie 04	0%	67%	85%	67%	0%	0%	0%	25%	92%	100%	0%	--
State 04	26%	29%	48%	56%	39%	47%	57%	52%	60%	70%	86%	--
Dinwiddie 05	0%	43%	67%	90%	0%	100%	0%	57%	82%	75%	0%	--
State 05	24%	25%	42%	60%	43%	47%	54%	60%	63%	74%	80%	--
Dinwiddie 06	0%	40%	80%	57%	0%	100%	0%	57%	91%	100%	0%	--
State 06	21%	23%	35%	64%	39%	45%	47%	57%	59%	68%	72%	--
Dinwiddie 07	100%	50%	75%	80%	0%	100%	29%	67%	86%	100%	0%	--
State 07	20%	21%	33%	63%	32%	41%	42%	52%	61%	65%	56%	--
Dinwiddie 08	29%	0%	75%	67%	0%	50%	33%	100%	88%	75%	100%	--
State 08	22%	24%	38%	60%	33%	40%	39%	54%	58%	65%	56%	--
PRIMARY SERVICE REASON												
Dinwiddie 04	Caregiver Absent	Behavioral Issues	Special Education	Special Education	Neglect	-	-	Neglect	Special Education	Behavioral Issues	-	--
State 04	Neglect	Neglect	Behavioral Issues	Special Education	Neglect	Caregiver Incapacity	Neglect	Behavioral Issues	Special Education	Behavioral Issues	Behavioral Issues	--
Dinwiddie 05	Caregiver Absent	Caregiver Incapacity	Special Education	Special Education	-	Sexual Abuse Victim	Caregiver Incapacity	Neglect	Special Education	Behavioral Issues	-	--
State 05	Neglect	Neglect	Caregiver Incapacity	Special Education	Neglect	Caregiver Incapacity	Neglect	Behavioral Issues	Special Education	Behavioral Issues	Behavioral Issues	--
Dinwiddie 06	Caregiver Absent	Caregiver Incapacity	Emotional Issues	Behavioral Issues	-	Sexual Abuse Victim	Caregiver Incapacity	Caregiver Incapacity	Special Education	Behavioral Issues	-	--
State 06	Neglect	Neglect	Behavioral Issues	Special Education	Neglect	Caregiver						

CSA CPMT Management Report
Chesterfield; 2004 to 2008

	Family Foster Maintenance Only	Foster Care Maintenance & Other Services	Community Based Interventions	SPED Other Day Services	Specialized Foster Homes	Independent Living	Therapeutic Foster Home	Group Home	SPED Day Placement	Residential Treatment Facility	Psychiatric Hospital	TOTAL
# SERVICES												
Chesterfield 04	49	78	63	96	0	14	47	1	25	70	0	443
State 04	1,724	3,172	5,906	1,027	690	350	2,665	1,385	1,982	2,988	113	22,002
Chesterfield 05	108	141	115	118	2	18	61	42	46	87	0	738
State 05	1,900	3,555	6,950	1,178	695	419	3,042	1,706	2,150	3,085	100	24,780
Chesterfield 06	125	265	133	124	0	19	54	13	60	121	0	914
State 06	2,084	4,416	9,349	1,420	721	564	3,457	1,970	2,645	3,395	83	30,104
Chesterfield 07	70	248	119	124	0	16	44	20	76	120	0	837
State 07	2,411	4,794	9,755	1,504	583	573	3,553	1,975	2,798	3,213	79	31,238
Chesterfield 08	56	222	137	95	1	25	50	40	98	124	0	848
State 08	2,857	4,924	9,433	1,629	525	763	3,938	2,147	3,150	3,301	104	32,771
% TOTAL CSA SERVICES												
Chesterfield 04	11%	18%	14%	22%	0%	3%	11%	0%	6%	16%	0%	101%
State 04	8%	14%	27%	5%	3%	2%	12%	6%	9%	14%	1%	101%
Chesterfield 05	15%	19%	16%	16%	0%	2%	8%	6%	6%	12%	0%	100%
State 05	8%	14%	28%	5%	3%	2%	12%	7%	9%	12%	0%	100%
Chesterfield 06	14%	29%	15%	14%	0%	2%	6%	1%	7%	13%	0%	101%
State 06	7%	15%	31%	5%	2%	2%	11%	7%	9%	11%	0%	100%
Chesterfield 07	8%	30%	14%	15%	0%	2%	5%	2%	9%	14%	0%	99%
State 07	8%	15%	31%	5%	2%	2%	11%	6%	9%	10%	0%	99%
Chesterfield 08	7%	26%	16%	11%	0%	3%	6%	5%	12%	15%	0%	101%
State 08	9%	15%	29%	5%	2%	2%	12%	7%	10%	10%	0%	101%
# YOUTH SERVED												
Chesterfield 04	49	78	63	96	0	14	47	1	25	70	0	443
State 04	1,708	3,120	5,772	1,008	683	347	2,639	1,365	1,958	2,908	110	21,618
Chesterfield 05	108	141	115	118	2	18	61	42	46	87	0	738
State 05	1,893	3,520	6,855	1,151	691	418	2,993	1,687	2,132	2,998	98	24,436
Chesterfield 06	105	139	98	107	0	16	51	13	55	97	0	681
State 06	1,911	3,478	6,985	1,279	694	518	3,196	1,800	2,452	3,084	78	25,475
Chesterfield 07	67	141	92	110	0	15	44	20	67	92	0	648
State 07	2,231	3,728	7,594	1,357	558	524	3,351	1,863	2,603	2,971	79	26,859
Chesterfield 08	54	134	99	83	1	20	50	35	76	98	0	650
State 08	2,093	3,712	7,162	1,486	508	688	3,697	1,938	2,684	3,006	104	27,078
GROSS CSA FUNDS POOL COSTS (\$) (38.53% LOCAL MATCH)												
Chesterfield 04	\$190,015	\$210,398	\$501,582	\$2,039,526	\$0	\$167,820	\$1,438,919	\$290	\$579,454	\$3,838,696	\$0	\$8,966,700
State 04	\$4,657,341	\$10,228,911	\$26,742,279	\$10,855,136	\$3,348,832	\$3,565,217	\$52,008,924	\$30,371,286	\$41,897,553	\$100,740,504	\$1,668,323	\$286,084,306
Chesterfield 05	\$264,293	\$200,239	\$406,742	\$1,893,247	\$8,168	\$120,088	\$709,552	\$680,923	\$707,314	\$2,784,079	\$0	\$7,774,645
State 05	\$3,958,083	\$8,377,753	\$25,512,339	\$11,478,233	\$3,387,319	\$4,414,345	\$49,968,018	\$35,787,817	\$43,469,861	\$95,538,070	\$1,611,986	\$283,503,824
Chesterfield 06	\$298,898	\$211,857	\$392,910	\$2,115,661	\$0	\$233,651	\$695,813	\$239,391	\$814,024	\$2,634,552	\$0	\$7,636,757
State 06	\$3,950,510	\$8,381,286	\$28,622,878	\$14,499,961	\$3,444,434	\$5,424,649	\$52,109,158	\$39,237,642	\$52,655,842	\$97,493,180	\$1,335,789	\$307,155,329
Chesterfield 07	\$156,552	\$207,516	\$259,691	\$1,477,360	\$0	\$226,406	\$566,845	\$489,250	\$1,152,952	\$3,367,206	\$0	\$7,903,778
State 07	\$5,969,883	\$11,269,399	\$31,309,878	\$17,090,648	\$3,031,653	\$5,960,729	\$65,183,029	\$42,894,953	\$63,223,682	\$105,137,477	\$1,699,593	\$352,770,924
Chesterfield 08	\$165,959	\$206,206	\$398,592	\$560,211	\$20	\$153,421	\$1,018,966	\$694,805	\$1,891,440	\$2,887,734	\$0	\$7,977,354
State 08	\$5,072,083	\$10,813,679	\$34,088,059	\$18,233,472	\$3,047,612	\$6,450,804	\$84,215,115	\$44,607,247	\$71,558,671	\$108,885,985	\$1,692,656	\$388,665,383
CSA FUNDS MEDICAID COSTS (\$) (19.27% LOCAL MATCH)												
Chesterfield 04	\$0	\$0	\$0	\$0	\$0	\$0	\$398,179	\$0	\$0	\$1,706,676	\$0	\$2,104,855
State 04	\$0	\$0	\$0	\$0	\$0	\$0	\$13,512,436	\$0	\$0	\$48,434,858	\$0	\$61,947,294
Chesterfield 05	\$0	\$0	\$0	\$0	\$0	\$0	\$346,954	\$160,519	\$0	\$1,803,891	\$0	\$2,311,364
State 05	\$0	\$0	\$0	\$0	\$0	\$0	\$14,998,082	\$2,837,086	\$0	\$59,670,690	\$0	\$77,505,858
Chesterfield 06	\$0	\$0	\$0	\$0	\$0	\$0	\$534,444	\$16,211	\$0	\$2,100,257	\$0	\$2,650,912
State 06	\$0	\$0	\$0	\$0	\$0	\$0	\$21,645,299	\$1,023,441	\$0	\$67,805,338	\$0	\$90,474,078
Chesterfield 07	\$0	\$0	\$0	\$0	\$0	\$0	\$200,195	\$289,848	\$0	\$2,032,772	\$0	\$2,522,815
State 07	\$0	\$0	\$0	\$0	\$0	\$0	\$13,193,517	\$11,331,616	\$0	\$76,227,304	\$0	\$100,752,437
Chesterfield 08*	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
State 08	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
CSA FUNDS TOTAL COSTS (\$) (POOL + MEDICAID)												
Chesterfield 04	\$190,015	\$210,398	\$501,582	\$2,039,526	\$0	\$167,820	\$1,837,098	\$290	\$579,454	\$5,545,372	\$0	\$11,071,555
State 04	\$4,657,341	\$10,228,911	\$26,742,279	\$10,855,136	\$3,348,832	\$3,565,217	\$65,521,360	\$30,371,286	\$41,897,553	\$149,175,362	\$1,668,323	\$348,031,600
Chesterfield 05	\$264,293	\$200,239	\$406,742	\$1,893,247	\$8,168	\$120,088	\$1,056,506	\$841,442	\$707,314	\$4,587,970	\$0	\$10,086,009
State 05	\$3,958,083	\$8,377,753	\$25,512,339	\$11,478,233	\$3,387,319	\$4,414,345	\$64,966,100	\$38,624,903	\$43,469,861	\$155,208,760	\$1,611,986	\$361,009,682
Chesterfield 06	\$298,898	\$211,857	\$392,910	\$2,115,661	\$0	\$233,651	\$1,230,257	\$255,602	\$814,024	\$4,734,809	\$0	\$10,287,669
State 06	\$3,950,510	\$8,381,286	\$28,622,878	\$14,499,961	\$3,444,434	\$5,424,649	\$73,754,457	\$40,261,083	\$52,655,842	\$165,298,518	\$1,335,789	\$397,629,407
Chesterfield 07	\$156,552	\$207,516	\$259,691	\$1,477,360	\$0	\$226,406	\$767,040	\$779,098	\$1,152,952	\$5,399,978	\$0	\$10,426,593
State 07	\$5,969,883	\$11,269,399	\$31,309,878	\$17,090,648	\$3,031,653	\$5,960,729	\$78,376,546	\$54,226,569	\$63,223,682	\$181,364,781	\$1,699,593	\$453,523,361
Chesterfield 08	\$165,959	\$206,206	\$398,592	\$560,211	\$20	\$153,421	\$1,018,966	\$694,805	\$1,891,440	\$2,887,734	\$0	\$7,977,354
State 08	\$5,072,083	\$10,813,679	\$34,088,059	\$18,233,472	\$3,047,612	\$6,450,804	\$84,215,115	\$44,607,247	\$71,558,671	\$108,885,985	\$1,692,656	\$388,665,383
AVERAGE COST PER YOUTH (\$)												
Chesterfield 04	\$3,878	\$2,698	\$7,962	\$21,246	\$0	\$11,988	\$39,088	\$290	\$23,179	\$79,220	\$0	--
State 04	\$2,727	\$3,278	\$4,633	\$10,769	\$4,903	\$10,274	\$24,829	\$22,251	\$21,398	\$51,299	\$15,167	--
Chesterfield 05	\$2,448	\$1,421	\$3,537	\$16,045	\$4,084	\$6,672	\$17,320	\$20,035	\$15,377	\$52,736	\$0	--
State 05	\$2,091	\$2,380	\$3,722	\$9,972	\$4,902	\$10,561	\$16,695	\$21,214	\$20,389	\$31,867	\$16,449	--
Chesterfield 06	\$2,847	\$1,525	\$4,010	\$19,773	\$0	\$14,604	\$24,123	\$19,662	\$14,801	\$48,813	\$0	--
State 06	\$2,067	\$2,410	\$4,098	\$11,337	\$4,963	\$10,472	\$23,078	\$22,368	\$21,475	\$53,599	\$17,126	--
Chesterfield 07	\$2,337	\$1,472	\$2,823	\$13,431	\$0	\$15,094	\$17,433	\$38,955	\$17,209	\$58,696	\$0	--
State 07	\$2,676	\$3,023	\$4,123	\$12,594	\$5,433	\$11,375	\$23,390	\$29,108	\$24,289	\$61,046	\$21,514	--
Chesterfield 08	\$3,074	\$1,539	\$4,027	\$6,750	\$20	\$7,672	\$20,380	\$19,852	\$24,888	\$29,467	\$0	--
State 08	\$2,423	\$2,913	\$4,760	\$12,270	\$5,999	\$9,376	\$22,780	\$23,018	\$24,986	\$36,223	\$16,276	--
% DSM-IV DIAGNOSIS												
Chesterfield 04	76%	87%	89%	94%	0%	86%	77%	100%	92%	90%	0%	--
State 04	26%	29%	48%	56%	39%	47%	57%	52%	60%	70%	86%	--
Chesterfield 05	43%	53%	55%	94%	100%	89%	69%	86%	91%	86%	0%	--
State 05	24%	25%	42%	60%	43%	47%	54%	60%	63%	74%	80%	--
Chesterfield 06	24%	40%	48%	92%	0%	69%	57%	77%	89%	67%	0%	--
State 06	21%	23%	35%	64%	39%	45%	47%	57%	59%	68%	72%	--
Chesterfield 07	36%	35%	57%	93%	0%	47%	45%	65%	93%	77%	0%	--
State 07	20%	21%	33%	63%	32%	41%	42%	52%	61%	65%	56%	--
Chesterfield 08	33%	34%	52%	67%	0%	70%	40%	57%	78%	69%	0%	--
State 08	22%	24%	38%	60%	33%	40%	39%	54%	58%	65%	56%	--
PRIMARY SERVICE REASON												
Chesterfield 04	Behavioral Issues	Behavioral Issues	Behavioral Issues	Behavioral Issues	-	Behavioral Issues	Behavioral Issues	Emotional Issues	Special Education	Behavioral Issues	-	--
State 04	Neglect	Neglect	Behavioral Issues	Special Education	Neglect	Caregiver Incapacity	Neglect	Behavioral Issues	Special Education	Behavioral Issues	Behavioral Issues	--
Chesterfield 05	Caregiver Incapacity	Caregiver Incapacity	Caregiver Incapacity	Special Education	Court Involvement	Behavioral Issues	Behavioral Issues	Behavioral Issues	Special Education	Behavioral Issues	-	--
State 05	Neglect	Neglect	Caregiver									

CSA Data Set
FY09- QTR 4

	Chesterfield		Petersburg		Hopewell		Dinwiddie		Colonial Heights		Prince George	
	Count	Expenditure	Count	Expenditure	Count	Expenditure	Count	Expenditure	Count	Expenditure	Count	Expenditure
Alternative Day Placement/Special Education Private Day Placement	98	\$3,221,375	36	\$741,208	37	\$814,165	10	\$204,709	8	\$141,139	24	\$560,484
Community Service	107	\$333,905	18	\$80,519	22	\$206,744	16	\$12,116	7	\$19,643	2	\$5,683
Community Transition Services	16	\$80,841	0	\$0	0	\$0	1	\$1,851	0	\$0	\$0	\$0
Congregate Educational Services - for Medicaid Funded Placements	25	\$331,999	23	\$347,675	0	\$0	9	\$128,655	0	\$0	3	\$65,580
Congregate Educational Services - for Non-Medicaid Funded Placements	13	\$265,191	1	\$6,984	0	\$0	0	\$0	0	\$0	1	\$27,848
Family Foster Care Basic Maintenance Payments Only	49	\$112,578	15	\$25,939	2	\$16,515	2	\$8,028	1	\$6,642	10	\$29,927
Foster Care Basic Maintenance & Basic Activities Payments	65	\$67,224	8	\$37,601	14	\$68,768	2	\$8,594	3	\$1,216	8	\$32,904
Group Home (Congregate Care Setting)	13	\$110,643	28	\$1,106,941	15	\$428,530	4	\$22,525	0	\$0	1	\$33,581
Independent Living Arrangement	6	\$91,295	9	\$446,142	2	\$111,577	3	\$2,800	1	\$7,140	0	\$0
Independent Living Stipend	6	\$69,475	0	\$0	0	\$0	1	\$1,300	0	\$0	1	\$3,625
Intensive Care Coordination	2	\$9,600	0	\$0	0	\$0	2	\$7,539	0	\$0	\$0	\$0
Intensive In-Home	25	\$130,517	3	\$15,592	1	\$1,695	0	\$0	2	\$2,520	2	\$25,145
Psychiatric Hospital/Crisis Stabilization Unit	0	\$0	0	\$0	1	\$14,160	0	\$0	0	\$0	1	\$10,985
Residential Treatment Facility(Congregate Care Setting)	54	\$730,157	4	\$176,240	7	\$347,974	5	\$70,728	0	\$0	1	\$55,696
Services in Public Schools	28	\$237,538	1	\$7,983	8	\$110,310	6	\$94,883	5	\$32,629	15	\$241,534
Specialized Foster Home	70	\$208,497	1	\$16,776	1	\$14,364	2	\$19,919	1	\$4,358	1	\$20,779
Temporary Care Facility and Services (Congregate Care Setting)	8	\$27,596	5	\$7,121	1	\$5,790	3	\$5,552	0	\$0	0	\$0
Therapeutic Foster Home	48	\$1,141,336	36	\$1,125,261	13	\$506,505	3	\$53,470	1	\$31,342	1	\$24,644
Totals	633	\$7,169,767	188	\$4,141,982	124	\$2,647,097	69	\$642,669	29	\$246,629	71	\$1,138,415

Source: Virginia CSA and RKG Associates, Inc., 2010



**CHILDCARE SUMMIT
TECHNICAL MEMORANDUM**



Technical Memorandum

To: Childcare Task Force
From: Russell A. Archambault, Vice President and Principal
RKG Associates, Inc.
Re: Summary of Childcare Summit
Date: September 2010

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A. PURPOSE AND NEED

The expansion of Fort Lee increased the demand for childcare within the Crater region. At the same time, the need for improving the quality of childcare remains an important issue not only in the Crater region but also throughout the Commonwealth of Virginia as a whole. The purpose of the Childcare Summit was to inform providers of the associated impacts of the Fort Lee expansion on childcare, as well as providing information and resources to providers on ways they can improve services, expand, or build new facilities.

Continuing education credit, which is an annual requirement of state licensed childcare providers in Virginia, was offered to those that attended the Childcare Summit. The Summit was held October 3rd, 2009 and there were over 150 attendees at the Hilton Garden Inn in Colonial Heights.

B. SUMMIT PROGRAM TOPICS

The Childcare Summit covered a variety of topics that are pertinent to Crater Region childcare providers. Below is a summary of the topics that were discussed at the summit. The PowerPoint presentations of the Childcare Summit are attached following this summary.

Fort Lee Growth and the Need for Childcare

Scott Brown, with the Fort Lee BRAC Synchronization team, discussed the current and planned supply of childcare spaces on Fort Lee. RKG Associates will brief childcare providers on the projected impacts on childcare facilities due to the Fort Lee expansion. The overview included increased demand projections.

Speakers:

Scott Brown, Fort Lee BRAC Synchronization Team
(Update on Facilities)

Russell Archambault, Vice President – RKG Associates, Inc.
(Fort Lee Impacts)

Caring for Special Needs Children in a Childcare Setting

Caring for children with special needs is an important issue facing childcare providers at all levels. This information session helped inform childcare providers on the full range of issues that must be addressed to properly care for special needs children.

Speakers:

Novella J. Ruffin, Ph.D., NCSP, CFLE, Assistant Professor and Extension Specialist, Child Development and Parenting -Virginia State University
Dr. Badiyyah Waajid, Assistant Professor, Child, Family and Community Studies – Virginia State University

Caring for Military Children

Military personnel and their children require specific care needs due to the emotional stress caused by the deployment of one or more parents and the general stress encountered by military households during wartime. Military personnel also have work schedules that don't always conform to typical operating hours of most daycare centers. This session provided an overview of the special needs that military personnel and their children require in a childcare setting.

Speakers:

Karen McComas, Director Army Community Service

Childcare Business Planning

This session is for those looking to expand their business or open a new daycare. Ways for childcare providers to better market, expand, and finance their businesses were discussed.

Speakers:

Pat Hood, Director Crater Small Business Development Center
(The importance of business planning and marketing)

Overview of Virginia's QRIS Program and Marketing Opportunities

The QRIS update session informed childcare providers on the details of the QRIS program, benefits, and how to participate. This session also included information on a new state-sponsored enhanced childcare website that includes QRIS ratings, childcare provider profiles, and other enhanced features.

Speakers:

Zelda Boyd, Office of Virginia Early Childhood Development
(QRIS update and state-level marketing opportunities)

FORT LEE Army Community Service
Karen McComas - Director

Caring for Military Children

Soldier and Parent

When Specialist Jones returned home after 12 months in Iraq, a new set of children awaited her.

Her son, John, 9, who had moved in with his grandmother, switching towns and schools, was angry and depressed. His grades had plummeted and his weight had ballooned by 60 pounds. Her 4-year-old daughter, Donna, scarcely knew her. And in Specialist Jones's absence, new rules had taken hold - chocolate syrup on waffles, Mountain Dew with dinner. Any hint of a return to the old order met with tirades and tantrums.

Specialist Jones, a single mother, had changed profoundly, too. The violence of war had staked a claim on her patience, her tenderness and her resilience. She snapped at her children routinely, at times harshly.

 Army Community Service - "Putting Soldiers and Families First!" 

FORT LEE Army Community Service

Caring for Military Children

- Overview
- Military Parent – Meeting their child care needs
 - * Extended work schedules
 - * 24/7 Child care needs
 - * Flexibility for emergencies

 Army Community Service - "Putting Soldiers and Families First!" 

FORT LEE Army Community Service

Caring for Military Children

- Military Children's Needs
 - * Emotional
 - * Caregivers understanding the military environment

 Army Community Service - "Putting Soldiers and Families First!" 

FORT LEE Army Community Service

Karen J. McComas
Director,
Fort Lee Army Community Service (ACS)

- 24 years assisting Soldiers and their Families with ACS services and childcare
- Served in Europe and throughout the United States
- A retired military spouse

 Army Community Service - "Putting Soldiers and Families First!" 

CHILD CARE SUMMIT

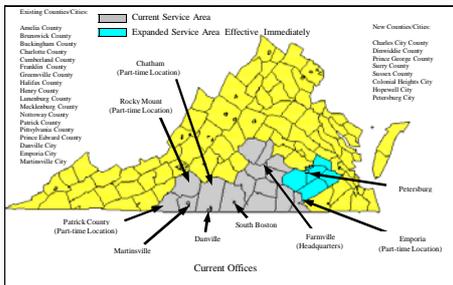
Pat Hood, Director
Longwood Small Business Development Center

October 3, 2009

Longwood SBDC Services

- Capital Formation
- Business Planning
- Workshops
- Information & Research
- Federal Procurement Assistance
- Export Assistance

Longwood SBDC Territory

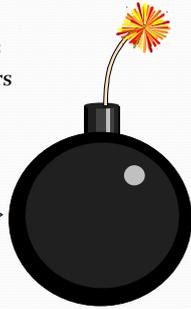
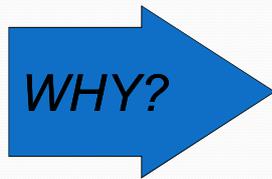


Why Do People Go Into Business?

- To achieve independence (78%)
- To “make a living”
- To supplement income & prepare for retirement
- To have control over their own lives
- To accept a challenge
- To gain emotional rewards (status, creativity)
- To get rich

Of the Over 1 Million Businesses Started Each Year:

- 35 % Fail Within 3 Years
- 55 % Fail Within 5 Years
- 80 % Fail Within 10 Years



Money Problems

- Shoestring Start-up
- Don't Know the True Costs of Selling
- Business Grows Too Fast



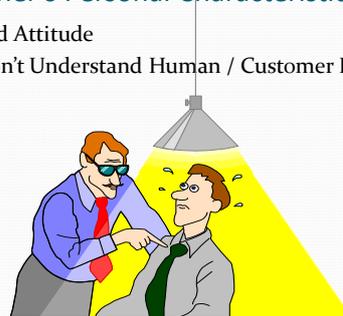
Managerial Incompetence

- Lack Management Skills
- Poor Business Planning



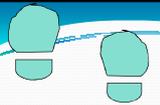
Owner's Personal Characteristics

- Bad Attitude
- Don't Understand Human / Customer Relations



No Business Plan!!

- Lack of Information
- No Market Research



FIRST STEPS



What Does It Take to Be Successful?

- It all starts with an idea!
- It Finishes With a Plan!



Old Lady That Lived In A Shoe

- Marketing Strategies
- Selling Strategies



From An Idea to Research ...

Clarify The Service:

- Determine The Need:

Childcare Center
Local childcare centers
have long waiting lists

- Identify The Target Market:

**Children 0-5 within 10
miles of Fort Lee**

- Research the Industry,
Competition, Target Market:

**Approx. 450 childcare
slots within 10 miles
0 certified centers**

- Determine Your Competitive Edge:

**3 Star Rating. Extended
hours of operation.
Accept infants under 18
months**



From Research to A Business Plan

- Executive Summary

1 - 2 Pages

Who You Are

What You Do

Why You Are Qualified

How You Will Accomplish Your Goal

Description of The Business

- Business Name: **Kiddie Care Day School**
- Legal Entity: **Non-Profit Organization**
- Who Are Business Owners: **Jane Smith**
- How Long In Business: **New Business**

Industry

- What Does the Business Represent?
Provides childcare and pre-schooling to children 0-5 years old
- How Will You Enter the Industry?
Will provide licensed in-home childcare services until sufficient capital can be raised to open childcare center
- Conditions of the Industry?
Very competitive market conditions and pricing. Lack of star-rated centers in region

Target Market

- Who Are Your Customers
Parents working at Fort Lee with children under 5 years old
- Where Are The Customers
Located within 10 miles of Fort Lee's main gate
- Customers Needs
Extended hours of operation and care of infants under 18 months old

Competition

- Who Else Offers Your Services
25 childcare providers within 10 miles providing 450 childcare slots
- Strengths & Weaknesses
**Strengths: Only 3-star rated program in region
Infant care not offer by competitors.
Extended hours of operation**
Weakness: Staff not trained to care for special needs
- How Will You Stand Out
3-star rated program. Opening hours 5:30 a.m.

Advertising & Promotion

- How Will You Reach Your Customers
Open house events, networking through Fort Lee, website and e-mail marketing, QRIS rating and link to state site
- How Do They Obtain Childcare Services
Parent referrals, web research, church affiliation
- What Are Your Marketing Efforts
No organized marketing effort
- How To Measure Success
Grow from 6 childcare slots to 15 in 5 years. Increase to 4-star QRIS rating

Establish a Web Presence to Market your Business

Who are you and what do you offer?

Who's involved in your organization and what are their qualifications?

Communicate With Parents and Potential Customers about Your Facility

What Great Things are you Doing for Your Children?

Picture Gallery 37

Let Parents Tour Your Facility From the Comfort of Their Homes.

More People are Relying on the Internet to do Their Initial Research

Location

- Where
South Crater Road, Petersburg
- Special Zoning
None required
- Features of The Location
Convenient access, located along main commuting route, close to Fort Lee, 5,000 households located within 5 miles, playground on property

Management Team

- Your Background & Experience
- Key Advisors
 - Lawyer
 - Banker
 - CPA
- **Other Key Positions & Experience

Financial Plan

- Capital Needed
- Capital Raised
- Capital Used For

2 – 3 Years Financial Statements
Income Statement, Cash Flow

Supporting Documents

- Licenses
- Certificates
- Resumes

Money, Money Money!!!!

Where You Gonna Get IT??

Loan Sources

The Superior Loan Program

Loans from 5,000 – 25,000

www.superiorfg.com

Pat Hood – 804-518-2003

hoodpa@longwood.edu

504 Loan Program & Other SBA Loans

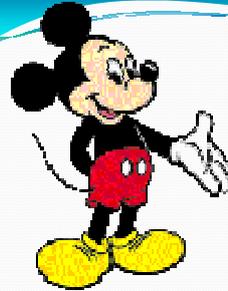
Jim McClure 804-861-1666 Ext. 228

jmclure@craterpdc.org

Micro Loans up to \$35,000

Wayne Crew 804-732-8543

wcrew@redcommunitycapital.org



*"You don't build it for yourself....
You ask the customer what they want
and you build it for them!"* Walt Disney

Free On-Line Training Classes For Entrepreneurs

Steps to Enrolling:

- Step 1: Go to <http://knowledge.elementk.com> and register as a New Student
- Step 2: Type In the Access Key Number: 6548-sbdc1-1179
- Step 3: Complete the Enrollment Information
- Step 4: Select your courses from the Recommended Course Tracks or go to the catalog and choose from the 100 available courses

End

Ten Years Ago...



- Where Are You?
- Who Are You?
- Where Would Like You To Be?

Business Owner Statistics

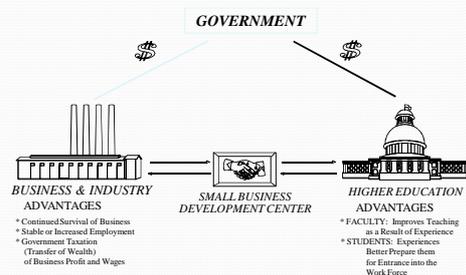
- 31% over the age of 55
- 29% between 45 and 54
- 24% between 35 and 44
- 12% between 25 and 34
- 2% under 25

• Info based on 2002 census reports

Longwood Small Business Development Center

“Providing education, counseling, and economic research for potential and existing businesses.”

The Small Business Development Center Model



Children With Special Needs

CHILD CARE SUMMIT
October 3, 2009

Dr. Novella Ruffin
Dr. Badiyyah Waajid

Defining

Inclusiveness

Rationale for Inclusion



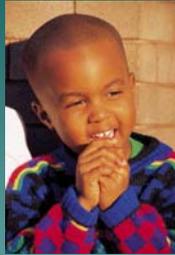
Inclusion

RESEARCH

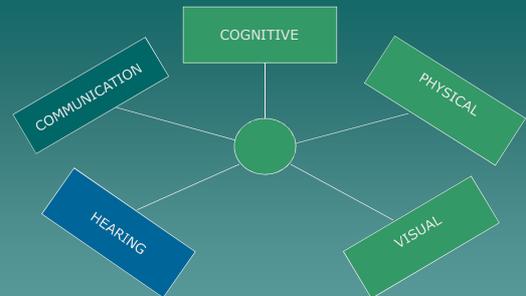
ALL

Children benefit
from inclusion

Children are more
alike than different



DISABILITIES



INCLUSION

Refers to *MODIFICATIONS* in:

- ◆ Physical environments
- ◆ Teaching Strategies

...to meet the needs of children with
various disabilities

MODIFICATIONS

...for each are needed...

- Indoor
- Out door
- Teaching Strategies
- Interactions

INDICATORS
OF
A
HIGH QUALITY INCLUSIVE
EARLY CHILDHOOD PROGRAM

Summary



QUESTIONS ????



**VIRGINIA
STAR QUALITY
INITIATIVE**
Committed to Quality Early Learning

*A Quality Rating and
Improvement System
(QRIS) for Early Care
and Education Settings*

 SMART
BEGINNINGS

www.smartbeginnings.org/QRIS

What is QRIS?

- 
- ★ A quality rating and improvement system (QRIS) is a method to assess, improve, and communicate the level of quality in early care and education settings.

- ★ QRIS is **voluntary**

Why QRIS?

- Defines standards for early childhood education
- Creates a framework for accountability
- Establishes a network of support
- Provides incentives
- Acts as a consumer education tool

Quality Matters

- ★ Early childhood experiences set the stage for all future learning.
- ★ High quality care means that children are engaging in meaningful learning and play, guided by qualified caregivers in an enrich educational environment.

Benefits & Expectations

- ★ Observation & rating
- ★ Feedback report
- ★ Parent resources
- ★ On-site mentoring
- ★ Quality improvement plan
- ★ Quarterly goals & incentives
- ★ Networking opportunities



Partners

- ★ The **Virginia Early Childhood Foundation** and the **Virginia Office of Early Childhood Development** work in partnership to serve as the hub and coordinate state-level activities for the Virginia Star Quality Initiative
- ★ **Local early childhood coalitions** or organizations work with the hub to coordinate local activities, like mentoring and community education.



Participants

- ★ Private licensed child day centers (for-profit and non-profit)
- ★ Private faith-based preschools and other preschools exempt from licensure
- ★ Public programs, like the Virginia Preschool Initiative and Head Start



Standard 1: Education, Qualifications, & Training

- ★ Assessed by documentation collected by programs
- ★ Indicators include:
 - Education level and qualifications of directors, teachers, and assistants
 - Ongoing training and professional development
 - Other professional development activities,



Standard 2: Interactions



- ★ Assessed by rater observation:
 - ★ **CLASS** (Classroom Assessment Scoring System) developed by the University of Virginia
 - ★ Measured across 3 domains: emotional support, classroom organization, and instructional support
 - ★ Weighted more than the other standards due to the strong correlation between high quality teacher-to-child and child-to-child interactions and positive child outcomes.



Standard 3: Structure

- ★ Assessed by documentation review
- ★ Examines maximum class sizes and child to staff ratios
- ★ Differentiated by the age of the children served, from infants to school-age children



Standard 4: Environment and Instructions



- Assessed by rater observations
- ★ **Environment Rating Scale**
 - ★ Measured across seven subscales: Space & Furnishings; Personal Care Routines; Language-reasoning; Activities; Interaction; Program Structure; and Parents & Staff
 - ★ Separate scales for each age group: ECERS-R or ITERS-R
 - ★ Also includes transition practices, such as parent meetings, transfer of records, related professional development, and program orientation for families



Consumer Education & Marketing

- ★ **Informational Materials**
 - ★ For the Community
 - ★ For Parents
- ★ **Publicity**
 - ★ Star Rating Certificate
 - ★ Use of Logo and Graphics
- ★ **Electronic information**
 - ★ Website



Does One Star Matter?

- ★ A program with a one-star rating:
 - ★ Is on a quality improvement path and is committed to continued quality improvement;
 - ★ Distinguishes itself for exceeding standards and expectations required of it;
 - ★ Assures parents of its focus on producing a high quality experience for their child;
 - ★ Reflects a culture of commitment to excellence among administrators, staff and families; and
 - ★ Has a distinctive vision and articulated plan for achieving quality benchmarks.



More Information...

- ★ For more information about the Virginia Star Quality Initiative in the Greater Richmond & Petersburg area, please contact:

Morgan Green
Smart Beginnings Greater Richmond
804-225-7917
greenm@yourunitedway.org






Fort Lee

Base Realignment and Closure (BRAC) Update



Crater Regional Childcare Summit
3 October 2009

BRAC Synchronization Office
U.S. ARMY GARRISON, FORT LEE, VIRGINIA




FORT LEE 2009



- Home of:
 - Sustainment Center of Excellence (SCoE)
 - Combined Arms Support Command (CASCOM)
 - Army Logistics Management College (ALMC)
 - U.S. Army Garrison, Fort Lee
 - U.S. Army Quartermaster Center and School (USAQMC&S)
 - 49th Quartermaster Group
 - Defense Commissary Agency HQ
- Demographics (4th Qtr FY09 Data)
 - Current military population = 4799
 - Civilian Employees = 3181
 - Contractor Employees = 1237
 - Military Family Members = 17,142
 - Average Student Daily Load = 6921

5907 Acres
7.5 Million SF of Facilities

Baseline from FY08 Data

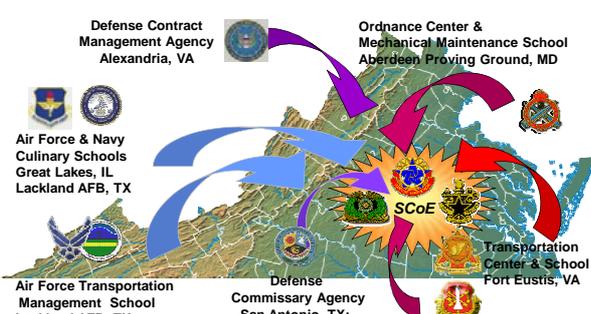



Fort Lee, VA BRAC Moves

Defense Contract Management Agency
Alexandria, VA

Air Force & Navy Culinary Schools
Great Lakes, IL
Lackland AFB, TX

Air Force Transportation Management School
Lackland AFB, TX



Ordnance Center & Mechanical Maintenance School
Aberdeen Proving Ground, MD

Transportation Center & School
Fort Eustis, VA

Ordnance Munitions & Electronic Maintenance School
Redstone Arsenal, AL

Defense Commissary Agency
San Antonio, TX;
Hopewell, VA; & Virginia Beach, VA

UNCLASSIFIED




FORT LEE 2011



- Home of:**
 - U.S. Army Combined Arms Support Command (CASCOM)
 - U.S. Army Garrison, Fort Lee
 - U.S. Army Quartermaster Center and School
 - 49th Quartermaster Group
 - Defense Commissary Agency HQ
 - Sustainment Center of Excellence (SCoE)
 - Army Logistics University (ALU)
 - U.S. Army Ordnance Center and School
 - U.S. Army Transportation Center and School
 - USAF Transportation Management School
 - USAF Culinary School
 - USN Culinary School
 - Defense Contract Management Agency HQ
- 2011 Demographics:**
 - Military population = 5,991
 - Civilian Employees = 4,993
 - Contractor Employees = 1,884
 - Family Members = 22,811
 - Average Daily Student Load = 11,061

5907 Acres
14 Million SF of Facilities

(739 USAF/USN additions worked in conjunction with 2Q FY 09 edit - being processed by HQDA ASIP Managers)
Does not include Retirees or Family Members of Retirees, Civilian, or Contractors
Data as of Jul 09

Ft. Lee Population Growth by Qtr/FY

Income Assignment	2QFY09*	3QFY09	4QFY09	1QFY10	2QFY10	3QFY10	4QFY10	1QFY11	2QFY11	3QFY11	4QFY11	END STATE
Military Permanent Party	0	64	123	0	4	181	434	0	145	2	426	1379
Civilian	4612	4676	4799	4799	4803	4984	5418	5418	5563	5565	5591	5591
Contractor	0	32	140	280	77	90	163	52	32	43	676	1586
Student Average Daily Load**	3407	3440	3580	3860	3937	4027	4190	4242	4274	4317	4393	4393
Family Members***	0	14	51	93	100	64	114	55	65	29	127	752
TOTAL POPULATION	1132	1140	1237	1330	1430	1494	1688	1663	1728	1751	1884	1884
Student Average Daily Load**	0	0	574	0	0	0	1545	0	719	0	1872	5914
Family Members***	6947	6947	6921	6921	6921	6921	8470	8470	9189	9189	11,061	11,061
Family Members***	0	201	594	688	296	692	1234	174	439	121	2135	6464
TOTAL POPULATION	16,347	16,548	17,142	17,750	18,048	18,648	19,342	20,116	20,552	20,876	22,811	22,811
TOTAL POPULATION	31,545	31,857	33,679	34,660	35,137	36,074	36,628	36,309	41,300	41,504	46,740	46,740

*FY09 Starting populations come from (29 Aug 08) ASDP Report.
 **Student Average Daily Load comes from FY10 ATRRS and MARL data. AIT & ALU transit Soldiers
 ***Family member projections are based on existing Fort Lee statistics applied to incoming populations.

Fort Lee Workforce Survey 2006 Overall Results

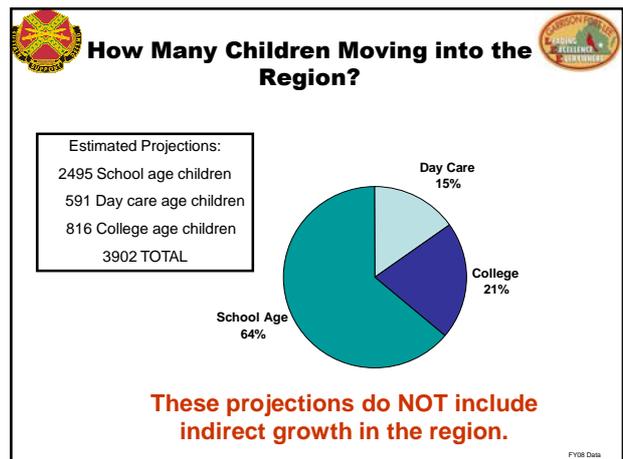
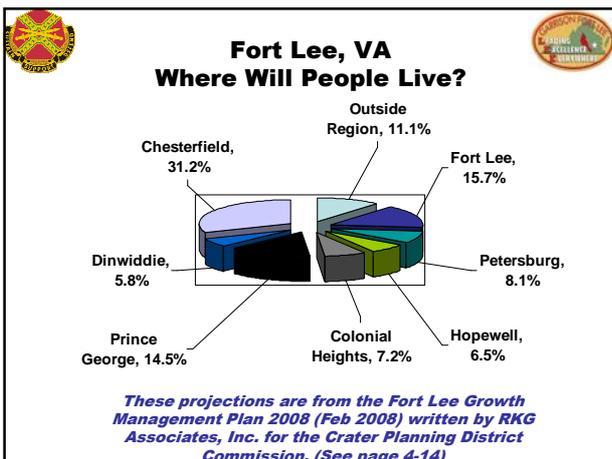
- 3801 out of 7888 possible
 - 48% response rate
- Military 1759 (46%)
- Civ/Cont 2052 (54%)
- 58% own their homes
- 17% live in military housing
- 25% rent or lease
- 51% have school age children
- 17% have kids in day care
- 27% have college age children

- 69% married
- 23% have no dependents
- 27% have one dependent
- 19% have two dependents
- 20% have three dependents
- 12% have four or more dependents

WHERE DO YOU LIVE?

Fort Lee (17%)	Petersburg (10.2%)	Hopewell (6.7%)
Colonial Heights (8.3%)	Prince George Co (15.2%)	Dinwiddie Co (5.7%)
Chesterfield Co (26.5%)	Other (10.8%)	

Data from Fort Lee Workforce Survey, June 2006



**CHILD, YOUTH & SCHOOL SERVICES**
FORT LEE, VIRGINIA



**“PROVIDING THE BEST
FOR THOSE WE SERVE”**

**CHILD, YOUTH & SCHOOL SERVICES**
FORT LEE, VIRGINIA

CHILD CARE SPACES

- Current Capability: 467 spaces**
 - Facility Spaces (2 Child Development Centers) = 269
 - Family Child Care Spaces (33 homes) = 198
- Capability (end state): 746-815 spaces**
 - Facility Spaces (4 Child Development Centers) = 530
 - Family Child Care Spaces (appx. 57 homes) = 216-285



**Modular Child Development Center**
Opened 6 April, 2009



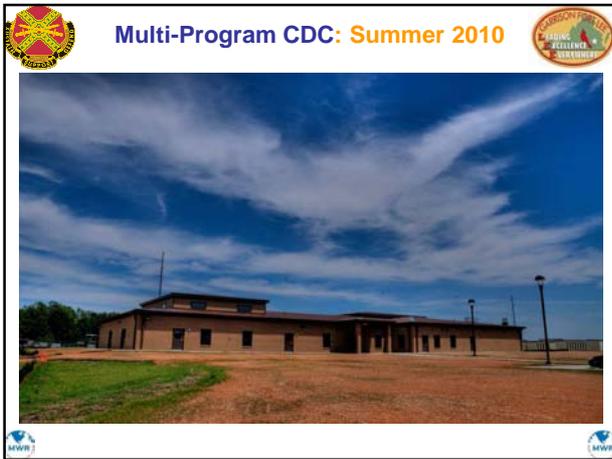


**CHILD, YOUTH & SCHOOL SERVICES**
FORT LEE, VIRGINIA

CHILD CARE CONSTRUCTION PROJECTS

- Multi-Program CDC: 135 capacity. Projected to be completed summer 2010.**
- SISISKY CDC: 126 capacity. Projected to be completed winter 2010.**





**CHILD, YOUTH & SCHOOL SERVICES
FORT LEE, VIRGINIA**

2009 QUICK FACTS

- 23.2% of patrons are sole parents
- 85.5% of patrons are military
- 62.4% of patrons are enlisted
- 57% of families live on-post
- 7% of children/youth enrolled have validated special needs



Information

- Fort Lee website
www.lee.army.mil
- To find housing for sale or rent
www.ahrn.army.mil
- Crater Planning District Commission
www.craterpdc.state.va.us




Questions?









Together, we can make Ft Lee the Best Home in the Army!





Back up Slides




Prince George County Schools Impact Aid

Each fiscal year includes prior year payments:

- 2005-2006 **\$2,536,603**
- 2006-2007 **\$2,198,753** (payments not complete on 2005-2006 survey)
- 2007-2008 **\$2,777,932** (payments not complete on 2006-2007 survey)
- 2008-2009 **\$1,920,196** (payments not complete on 2007-2008 survey)
- Four (4) year total *to date* **\$9,433,484**

FY 09 per child (based on 2007-2008 survey):

- On-post (A) **\$1,657.61** *to date*
- Extra Special Ed. On-post **\$900.00** *to date*
- Off-post (B) **\$304.49** *to date*
- Extra Special Ed. Off-post **\$450.17** *to date*

Additional funding received:

- DoD FY 08 Impact Aid \$30M grant School District Recipient, 20% total pop. federally connected, Prince George County Schools Awarded **\$283,045.93**

Data provided by PG Finance Director 2 Feb 09




Exceptional Family Member Program (EFMP)

- Objectives:
 - To provide certain medically related services to children with disabilities
 - To assess the needs for consideration during the assignment process
 - To assign soldiers where needs can be accommodated; provided there is a valid personnel requirement for that soldier's position
- Definition of Special Medical Needs:
 - Potentially life threatening disease (i.e. cancer; insulin-dependant diabetes)
 - Chronic duration mental health condition (i.e. bi-polar; personality disorders)
 - Asthma (i.e. uses an inhaler; history of acute asthma in past year)
 - Attention Deficit Disorder (i.e. with psychological diagnosis; requires multiple medications; requires mental health provider)
 - Requires adaptive equipment (i.e. wheelchair; splints)
 - Requires assistive technology device (i.e. communication device)
 - Requires environmental/architectural considerations (i.e. limited steps; wheelchair accessible)
- There is no such thing as an "EFMP Designated Installation"

Source: AR 608-75; Exceptional Family Member Program; 22 Nov 2006



***SURVEY RESULTS ANALYSIS
TECHNICAL MEMORANDUM***



Technical Memorandum

To: Dennis Morris, Crater Planning District Commission
 From: Russell A. Archambault, Vice President and Principal
 RKG Associates, Inc.
 Re: Fort Lee Base Realignment and Closure Workforce Questionnaire Analysis
 Date: September 2010

A. INTRODUCTION

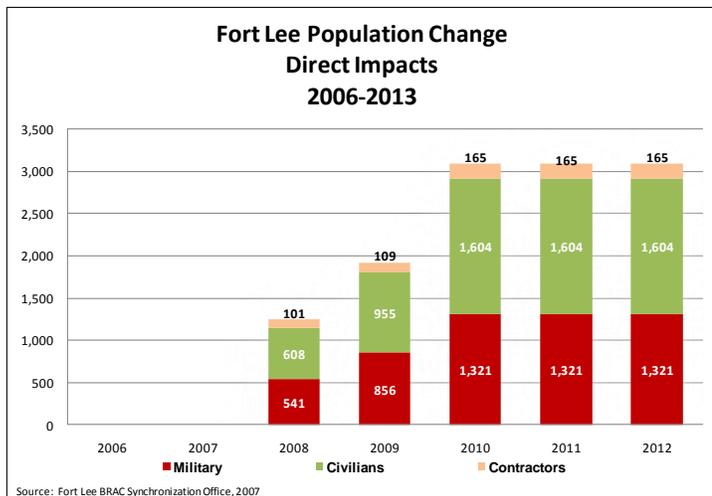
In 2006, Fort Lee’s BRAC Synchronization Office administered a survey to the existing personnel at Fort Lee. The survey was designed to understand the household characteristics of the population in anticipation of BRAC-related growth planned for the 2008-2013 period. RKG Associates was able to utilize this data in preparation of the Fort Lee Growth Management Plan, which was completed in February of 2008. RKG generated household and demographic profiles of the military, civilian, and contractor personnel. It was assumed that the incoming personnel would have very similar characteristics to the survey respondents. As such, this survey was instrumental in assisting the planning, recommendations, and implementation strategies for the 2008 *Fort Lee Growth Management Plan*. In 2009, the survey was updated by the BRAC Synchronization Office and analyzed by RKG Associates. The following analysis identifies the changes, if any, between the 2006 and 2009 survey populations. Results from new questions added in 2009 are also included in this analysis.

It should be noted that there were significantly less survey respondents to the 2009 survey compared to the 2006. This survey included 247 military, 587 civilian, and 197 contractor responses for a total of 1,031 completed surveys. In comparison, the 2006 survey included 1,749 military, 1,581 civilian, and 471 contractor responses, for a total of 3,801 completed surveys. Although the 2009 survey provides important information about the current personnel at Fort Lee, it had a comparatively small response rate which needs to be taken into context with the analysis.

B. INCOMING PERSONNEL

According to the Fort Lee Growth Management Plan (2008) approximately 3,090 new personnel were anticipated during the 2006-2013 projection period. This expansion consisted of 1,321 full-time military, 1,604 civilian government, and 165 federal contract employees (Figure 1). However, since the release of the plan in early 2008, Fort Lee has announced changes in the personnel forecasts that will reduce the number of permanent party military from 1,321 to 645. These changes reflect

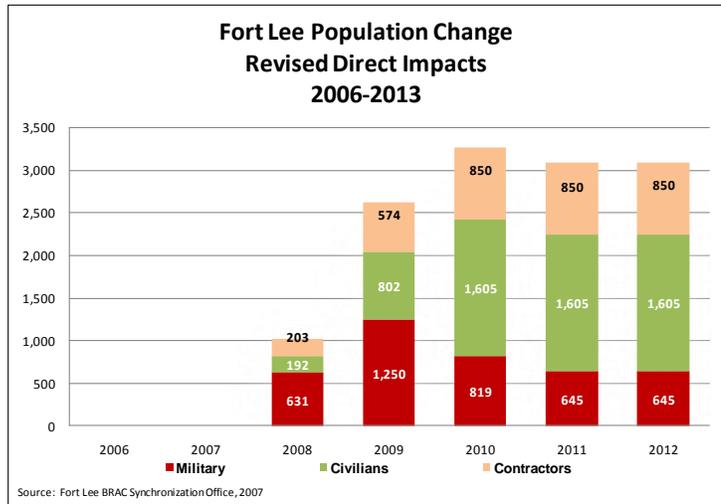
Figure 1



the loss of soldiers from the 49th Quartermaster Group during 2011 and 2012.

In addition, the number of federal contractors is projected to change from 165 to 850, for an increase of 685 (Figure 2). Overall, it is anticipated that 3,100 new personnel will be stationed at Fort Lee by 2013, for an increase of 10 over previous projections.

Figure 2



C. PAYROLL

RKG estimates that the changes in personnel by 2013, will increase the annual payroll by roughly \$12 million, from \$216.6 million to \$228.8 million, largely due to the reduction of lower paid military personnel and the increase contractor personnel. By 2013, increased contractor payroll will account for 29.7% of total new payroll (\$67 million), up from 6.1% previously.

D. RANKS OF MILITARY RESPONDENTS

A comparison of 2006 and 2009 survey data by rank indicates that a much larger percentage of 2009 survey respondents were military officers (46%) (Table1). Military Officers tend to be older and more advanced in their careers. As such, their lifestyle, incomes, and household characteristics tend to differ from lower ranking personnel. Due to the large number of officers responding to the survey, RKG does not believe that the 2009 survey

Table 1
Military Rank; 2006 and 2009 Survey Respondents

Personnel	2006		2009	
	Respondents	Percent	Respondents	Percent
Military Officers	407	23.3%	112	45.5%
E7-E9	415	23.7%	67	27.2%
<E6	927	53.0%	67	27.2%
Total	1,749	100.0%	246	100.0%

Source: Fort Lee 2006 and 2009 Survey and RKG Associates, Inc., 2010

results are representative of the larger military population at Fort Lee. As mentioned, the 2006 survey had a much higher response rate and is more indicative of the current and future composition of the Fort Lee personnel. Although the two surveys are not directly comparable, important information can still be ascertained from the 2009 survey and is included in this report.

E. PLACE OF RESIDENCE

The 2006 and 2009 survey respondents have very similar place of residence characteristics (Table 2). The main difference, in regards to the military personnel, is that in 2009 about 13% more of the respondents lived in Chesterfield, and about 12% less lived in Fort Lee. This is likely due to the fact that the 2009 survey was composed of a much larger percent of military officers. These higher ranking military officials tend to locate to Chesterfield and do not find the County’s higher housing prices a barrier to entry. The rest of the 2009 responses were within 4% or 5% of the original 2006 survey. The data shows that the majority of military respondents live in Chesterfield (33%) or Fort Lee

(23%). Prince George is home to 13% of the respondents, with the rest of the jurisdictions containing less than 10% each of the remaining military respondents.

In terms of civilians, the 2009 respondents are within 3% of the 2006 percentage. The data show that just about one-third live in Chesterfield, about 22% live in Prince George, and 15.6% live outside the immediate region. Dinwiddie (8.3%), Petersburg (7.4%), Colonial Heights (7.3%), and Hopewell (5.8%) comprise the balance of civilian personnel. Most significant is the apparent loss of civilian population from Petersburg and a gain in Dinwiddie. The contractor 2009 survey data is also very similar to the original 2006 results. However, in 2009 about 7% more of the contractors responded that they live in Chesterfield and more than 4% indicated that they did not live outside the region. The rest of the results are all within a couple percentages of the 2006 responses. The contractors primarily live in Chesterfield (34%), Prince George (19%) and Colonial Heights (9%).

Table 2
Residence of Fort Lee Personnel; 2006 and 2009 Survey Respondents

Location	Military		Civilian		Contractor	
	2006	2009	2006	2009	2006	2009
Fort Lee	34.8%	22.8%	0.9%	1.1%	2.2%	2.1%
Petersburg	11.8%	8.3%	9.3%	7.4%	6.8%	7.9%
Hopewell	7.3%	6.1%	5.6%	5.8%	8.7%	8.4%
Colonial Heights	7.5%	6.1%	8.7%	7.3%	9.5%	9.4%
Prince George (includes Disputanta, Spring Grove, and Carson)	9.7%	12.7%	20.0%	21.6%	20.1%	19.4%
Dinwiddie County	3.7%	5.7%	7.6%	8.3%	6.5%	4.2%
Chester or Chesterfield County	19.0%	32.5%	34.0%	32.9%	27.4%	34.0%
Other, please specify	6.2%	5.7%	13.8%	15.6%	19.0%	14.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Fort Lee 2006 and 2009 Survey and RKG Associates, Inc., 2010

F. RATE OF HOME OWNERSHIP

The statistics for home ownership from 2006 to 2009 did not change significantly except for military respondents. In 2006, approximately 31% of the military respondents were identified as homeowners. However, in 2009 approximately 44% of military respondents identified themselves as homeowners. This is likely due to the fact that the 2009 survey had a higher response rate from military officers. Military officers are generally older and make higher salaries, on average, than other pay grades, which allows for a higher rate of home ownership. In both 2006 and in 2009, civilians responded that 87% owned their homes. Lastly, contractors responded in 2006 that 80% owned their home, as compared to 83% of contractors responding that they own their home in 2009.

G. SCHOOL AGE CHILDREN

The consultant was able to break-out the number of school age children by type of school (elementary, middle, or high school) and jurisdiction in the 2006 survey. This information helped inform the future school enrollment forecasts for each community within the Crater Region for the 2008 Growth Management Plan. Unfortunately, the 2009 results for the number of school age children by type of school were reported in aggregate form and not by jurisdiction. This made it difficult to compare the composition of school age children by each community to the 2006 results.

Additionally, the higher response rate of military officers skews the 2009 data. Military officers tend to have older children and live in different locations than lower ranked military. As such, the 2009 data would not provide the best proxy for where the children of incoming Fort Lee personnel would go to school. However, the results from the 2009 survey is included in order to provide additional context for the 2009 survey population.

In order to better understand the location of where the 2009 survey respondent children will be attending school, RKG Associates tallied responses to the question “Where will your children attend school in the Fall?” This allows for a general sense of the break-out of where school age children might locate. The data in Table 3 shows that the majority of military children will attend school in Prince George (42%). Approximately 32% of children will attend school in Chesterfield and 11% will attend in Petersburg. As for children of civilian respondents, the largest number will attend school in Chesterfield (41%), 23% of civilian children will attend schools in Prince George, and 21% will attend schools in Petersburg. In terms of contractor personnel, approximately 43% of children will also attend school in Chesterfield. Compared to military and civilian personnel, a higher percentage of contractor children will attend school in Colonial Heights (12.3%).

Table 3
Location of Where Children Will Attend School; 2009 Survey Respondents

Location	Military	Civilian	Contractor
Petersburg	10.7%	21.2%	17.8%
Hopewell	6.7%	3.2%	5.5%
Colonial Heights	3.4%	3.2%	12.3%
Prince George (includes Disputanta, Spring Grove, and Carson)	41.6%	22.5%	19.2%
Dinwiddie County	6.0%	9.0%	2.7%
Chester or Chesterfield County	31.5%	41.0%	42.5%

Fort Lee 2009 Survey and RKG Associates, Inc., 2010

The percentage of military children attending pre-school, elementary school, middle school, and high school were somewhat similar to the 2006 survey, with a few exceptions (Table 4). In 2006, approximately 20% of military children were identified as “pre-schoolers.” In 2009, there were only 5.7% of children enrolled in pre-school. This likely reflects the fact that officers tend to have older children. This is supported by the fact that military respondents to the 2009 survey show a higher percentage of college-age children than in 2006.

The 2009 responses contained slightly more children in elementary school (48% compared to 42%), middle school (24% compared to 19%), and high school (22% compared to 19%). The civilian data indicates that the respondents also had fewer children that were pre-school age (10% compared to 15%) and middle school age (22% compared to 35%). However, the number of high school students was both about 35% of the total children for 2006 and 2009. Lastly, the number of pre-school age contractor children was less percentage of the total in 2009 (10%) than in 2006 (19%). The data in 2009 indicates that there is a slightly older population of children in the 2009 survey; however it is important to keep in mind that the number who responded to the survey in 2009 was also much smaller than the number who responded in 2006.

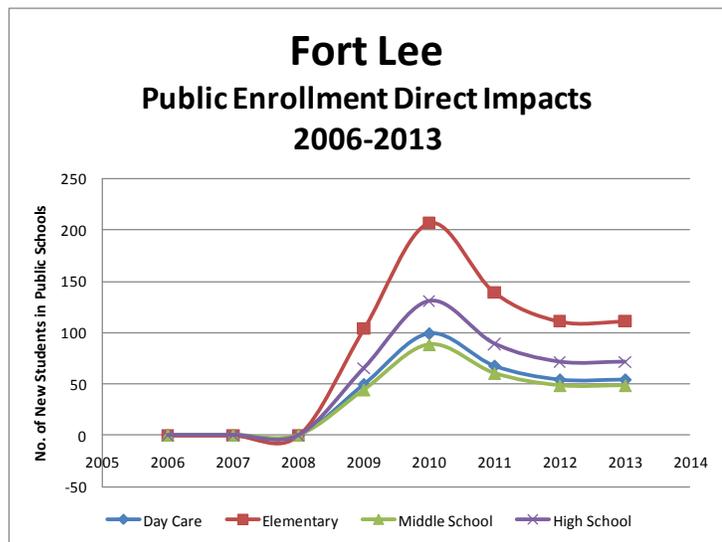
Table 4
Location of Where Children Will Attend School; 2009 Survey Respondents

Location	Military	Civilian	Contractor
Petersburg	10.7%	21.2%	17.8%
Hopewell	6.7%	3.2%	5.5%
Colonial Heights	3.4%	3.2%	12.3%
Prince George (includes Disputanta, Spring Grove, and Carson)	41.6%	22.5%	19.2%
Dinwiddie County	6.0%	9.0%	2.7%
Chester or Chesterfield County	31.5%	41.0%	42.5%

Fort Lee 2009 Survey and RKG Associates, Inc., 2010

Given the significant shifts in personnel projections from military to federal contractors, it is anticipated that the reduction in military children will put less stress on Prince George County’s school system, which educates the largest share of military school-age children in the region. The number of new military personnel are projected to drop from 1,250 in 2010 to 650 by 2013 (Figure 3). The increase in federal contractor employees will increase the total population due to their slightly larger average household size. However, since contractor households have a higher percentage of older children than military households, the number of school-age children is likely to decline slightly and the impact should be more pronounced in the Chesterfield County school system where 42.5% of contract children attend school.

Figure 3



H. HEALTH AND SOCIAL SERVICE NEEDS

1. Spouse Healthcare Issues

The 2009 survey included questions about the health of dependents, including spouses and children. The results will help to identify the potential demand for healthcare services within the region. The data was separated into spouse health care issues and dependent (non-spouse) healthcare issues. It was assumed that the non-spouse dependents were children of the respondents, although could include other relatives.

Approximately 3.7% of military spouses reported having special healthcare needs (Table 5), or 7 out of 190 military spouses. Of those with conditions, the greatest number (3 of 7 persons) reported having asthma. Another 1% has potentially life threatening diseases and 1% requires adaptive equipment. Given the small number of military respondents, it’s very difficult to generalize to the larger population. Of the civilian respondents, almost 11% have special health conditions. About 5% have potentially life threatening diseases (such as cancer or diabetes). Another 2% have asthma. Just

over 1% of civilian spouses require adaptive equipment. The total percent of contractor spouses with health condition is similar to the civilian percentage (10%). The top two conditions are potentially life threatening diseases (2.6%) and conditions requiring environmental/architectural considerations (3.3%).

Table 5
Health Conditions of Spouses; 2009 Survey Respondents

	Military		Civilian		Contractor	
	% of Total Survey	Count	% of Total Survey	Count	% of Total Survey	Count
Potentially life threatening disease (i.e. cancer, insulin-dependant diabetes)	1.1%	2	4.6%	20	2.6%	4
Chronic duration mental health condition (i.e. bi-polar, personality disorders)	0.0%	0	0.9%	4	1.3%	2
Asthma (i.e. uses an inhaler, history of acute asthma in the past year)	1.6%	3	2.3%	10	2.0%	3
Attention Deficit Disorder	0.0%	0	0.2%	1	0.0%	0
Requires adaptive equipment (i.e wheelchair, splint)	0.5%	1	1.6%	7	0.0%	0
Requires assistive technology device (i.e. communication device)	0.0%	0	0.5%	2	0.7%	1
Requires environmental/architectural considerations (i.e. limited steps, wheelchair accessible)	0.5%	1	0.5%	2	3.3%	5
Total With Conditions	3.7%	7	10.5%	46	9.9%	15
Total Spouses	--	190	--	438	--	152

Source: Fort Lee 2009 Survey and RKG Associates, Inc., 2010

2. CSA Healthcare Issues

In terms of non-spouse dependents, some of the special needs conditions would likely qualify for CSA support, including autism, attention deficit disorders, learning disabilities, clinical depression, developmental delays, other behavioral disorders, speech, and vision disorders. Other categories of conditions, including asthma, diabetes, cancer, and other physical ailments might not necessarily require CSA services, but are included in this analysis in order to provide a more complete picture of those dependents that might need extra social and health services from the community.

Of the 247 military respondents, just over 15% answered that they have a non-spouse dependent with special needs (Table 6). The greatest special need among the respondents is asthma/allergies (37%). Under general circumstances, this condition would not require CSA services. However, attention deficit disorder accounts for the second largest category of special needs. About 16% responded that they have a dependent with this disorder. Additional categories of conditions that would likely require CSA services include developmental delay (8%), learning disability (8%), and speech disorder (3%). Together, the number of dependents that could potentially require CSA services amounts to 17 cases.

Approximately the same percentage of contractors responded that they have a non-spouse dependent with a special need (16%). Asthma and allergies and clinical depression account for the largest amount of cases (16% each). There are also a comparatively high amount of cases in developmental delay (13%), speech disorder (13%), and learning disability (13%) conditions. There are approximately 22 contractor cases that are likely to qualify for CSA services.

Compared to the military and contractor respondents, a lesser percentage of civilians answered that they have a non-spouse dependent with a special need (7%). However, similar to the military respondents, the largest amount of cases was for asthma/allergy conditions (20%). Both learning disabilities and diabetes accounted for the second largest group of respondents (11% each). In all, about 21 of the total cases would likely qualify for CSA services.

Fort Lee staffing projections indicate that from 2006 to 2013, there will be an additional 2,563 military dependents, 2,021 civilian dependents, and 269 contractor dependents. Using data from the 2006 Fort Lee survey, RKG Associates estimated that this results in an approximate growth of 1,589

military children, 1,071 civilian children and 156 contractor children. The consultant then applied the survey percentages of children with special needs to the number of incoming children. RKG estimated that approximately 238 new military children, 74 new civilian children, and 25 new contractor children may have special needs. As mentioned, not all the conditions listed in the survey would necessarily qualify for CSA coverage. Applying the percentages from the survey of those that would likely qualify (non-asthma or other learning/behavioral disorders) results in an estimated total of 107 new military children, 35 new civilian children, and 18 new contractor children with CSA qualifying special needs.

It is important to note that not all of the incoming children that would qualify for CSA services would necessarily need to use them. CSA funds are only accessed when the individuals insurance (either TRICARE or a private provider) does not cover a particular CSA services. Therefore, the amount of actual respondents needing to access CSA funds will likely be much smaller than reported on the survey. Regardless, the responses show what the potential demand could be on the Fort Lee region jurisdictions. The data also indicates that learning disability and special education services account for a comparatively high amount of cases, and adequate services and funding must be in place to help support these special needs.

Table 6
Dependents with Special Needs
Fort Lee Survey; 2009

Condition Listed	MILITARY RESPONSES		CIVILIAN RESPONSES		CONTRACTOR RESPONSES	
	# of Cases	% of Cases	# of Cases	% of Cases	# of Cases	% of Cases
Asthma/Allergies	14	37%	9	20%	5	16%
Attention Deficit Disorder	6	16%	3	7%	2	6%
Autism	0	0%	3	7%	1	3%
Cancer	0	0%	1	2%	0	0%
Cerebral Palsy	0	0%	1	2%	1	3%
Clinical Depression (bipolar, etc)	1	3%	2	5%	5	16%
Developmental Delay	3	8%	1	2%	4	13%
Diabetes	1	3%	5	11%	1	3%
Epilepsy	1	3%	2	5%	1	3%
Heart Condition	1	3%	2	5%	0	0%
Learning Disability	3	8%	5	11%	4	13%
None of the Above	3	8%	0	0%	0	0%
Other Behavioral/Mental Disorder	2	5%	1	2%	1	3%
Sickle Cell Anemia	0	0%	0	0%	0	0%
Skin Condition	1	3%	3	7%	1	3%
Speech Disorder	1	3%	3	7%	4	13%
Traumatic Brain Injury	0	0%	0	0%	0	0%
Vision Impairment	1	3%	3	7%	1	3%
Total	38	100%	44	100%	31	100%
		% of Total Respondents		% of Total Respondents		% of Total Respondents
	Total Survey Respondents	with Special Needs	Total Survey Respondents	with Special Needs	Total Survey Respondents	with Special Needs
Total	247	15%	587	7%	197	16%

Source: Fort Lee 2009 Survey and RKG Associates, Inc., 2010

3. Location of Service Provider

The civilian and contractor personnel were asked where their dependents receive services for their listed diagnosis. The data in Table 7 indicates that the majority of both civilians and contractors receive services at the on-base clinic (23.8% and 25.0%, respectively). About 11% of civilians received services at John Randolph Medical Center and 6% received services at Southside Regional Medical Center. These are the two main off-post medical facilities serving the region. It is also important to note that 25% of civilian respondents go to healthcare providers outside of the region.

This is likely because respondents are driving to Richmond, which contains has a much larger cluster of general and specialty healthcare providers.

In terms of contractors, 17.5% of dependents receive services from the County Social Service providers. The comparatively large number of contractor respondents receiving services at social service providers could place an increased strain on local jurisdictions. About 5% of respondents received services at John Randolph Medical Center and another 5% received services Southside Regional Medical Center. Although both contractors and civilians will likely increase demand for these two hospitals, interviews with representatives from both indicate that they have the capacity and have prepared for the increase in demand resulting from the increased personnel and their dependents.

Table 7
Health Conditions of Children; 2009 Survey Respondents

Response	Civilian		Contractor	
	%	Count	%	Count
On-Base Health Clinic	23.8%	15	25.0%	10
John Randolph Medical Center Behavioral Health Unit	11.1%	7	5.0%	2
Southside Regional Medical Center Behavioral Health Unit	6.3%	4	5.0%	2
Poplar Springs Hospital	0.0%	0	5.0%	2
Other Residential Psychiatric Hospital	3.2%	2	5.0%	2
County Social Service Department	4.8%	3	17.5%	7
Outpatient Therapy Provider	9.5%	6	10.0%	4
Special Education Residential Program Provider	1.6%	1	0.0%	0
Special Education Non-Residential Service Provider in a Private School	1.6%	1	0.0%	0
Special Education Non-Residential Service Provider in a Public School	11.1%	7	7.5%	3
Intensive In-Home Service Provider (including in-home respite care)	1.6%	1	5.0%	2
Other Type of Care Provider	25.4%	16	15.0%	6
Total	100.0%	63	100.0%	40

Source: Fort Lee 2009 Survey and RKG Associates, Inc., 2010

Fort Lee Base Realignment and Closure Workforce Questionnaire

AR 611-3 SURVEY CONTROL NUMBER: TAPC-ARI-PS-2009-Fort Lee BRAC

Purpose. In order to prepare for the Base Realignment and Closure (BRAC) actions and subsequent growth in the Fort Lee community, we (the Fort Lee BRAC Synchronization Office) are asking the current workforce (Military, civilian, and contractor) to provide us with some demographic information.

Directions. Please answer each question as accurately and thoroughly as possible. You may change your answers at any time before submitting the survey. The survey should take approximately 10 minutes to complete.

This information is confidential; however, it will be tabulated to provide Fort Lee leadership and the local communities with data to assist us in the planning and implementation process for BRAC. If you have any questions, or would like to request a copy of the results of this survey, please email alexia.n.anderson@us.army.mil.

Are you currently performing your military/civilian duties on Fort Lee?

- Yes
- No

What is your current employment status?

- Military
- Federal Government Civilian
- Contractor

What is your current rank?

- General Officer
- COL- MAJ
- CPT-2LT
- CW5-CW4
- CW3-WO1
- CSM-SFC
- SSG-CPL
- SPC-PV1

What is your marital status?

- Married
- Separated
- Unmarried (includes single, divorced, widow, widower)

What is your civilian status?

- Department of the Army Civilian
- Department of the Air Force Civilian
- Department of the Navy Civilian (includes Marine Corps)
- Department of Defense Civilian
- AAFES or NAF Worker
- Other, please specify _____

What is your current grade? (If you are under NSPS and know the GS equivalent position, please select the GS position.)

- GS1-4
- GS5-8
- GS9-11
- GS12-13
- GS14-15
- NSPS Pay Band One
- NSPS Pay Band Two
- NSPS Pay Band Three
- WG1-5
- WG6-12
- WS1-5
- WS6-12
- NF1-2
- NF3-5
- NA1-5
- NL1-5
- NS1-5
- Other, please specify _____

What is your marital status?

- Married
- Separated
- Unmarried (includes divorced/not married/widow/widower)

Does your spouse have any special medical needs?

- Yes
- No

My spouse has the following special medical needs. (Choose all that apply)

- Potentially Life Threatening Disease (i.e. cancer, insulin-dependant diabetes)
- Chronic Duration Mental Health Condition (i.e. bi-polar, personality disorders)
- Asthma (i.e. uses an inhaler, history of acute asthma in the past year)

- Attention Deficit Disorder (i.e. with psychological diagnosis; requires multiple medications; requires mental health provider)
- Requires Adaptive Equipment (i.e wheelchair, splint)
- Requires Assistive Technology Device (i.e. communication device)
- Requires Environmental/Architectural Considerations (i.e. limited steps, wheelchair accessible)
- My spouse does not have special needs
- Other, please specify _____

Do you have any dependents (not including a spouse) living with you that have special medical needs?

- Yes
- No

My dependent (s) has the following special medical needs. (Choose all that apply)

- Potentially Life Threatening Disease (i.e. cancer, insulin-dependent diabetes)
- Chronic Duration Mental Health Condition (i.e. bi-polar, personality disorders)
- Asthma (i.e. uses an inhaler, history of acute asthma in the past year)
- Attention Deficit Disorder (i.e. with psychological diagnosis; requires multiple medications; requires mental health provider)
- Requires Adaptive Equipment (i.e wheelchair, splint)
- Requires Assistive Technology Device (i.e. communication device)
- Requires Environmental/Architectural Considerations (i.e. limited steps, wheelchair accessible)
- I choose not to provide this information
- My spouse does not have special medical needs
- Other, please specify _____

From the list of medical diagnoses indicated below; Identify the diagnosis that pertain to your dependent (s). Provide the number of dependents who fall into the particular diagnosis category and their ages. (Only fill in spaces that pertain to your dependent (s) diagnosis). OPTIONAL

Number of Dependents with Diagnosis

	1	2	3	4	5 or more
Autism	<input type="radio"/>				
Developmental Delay	<input type="radio"/>				
Learning Disability	<input type="radio"/>				
Speech Disorder	<input type="radio"/>				
Clinical Depression (bipolar, etc)	<input type="radio"/>				
Other Behavioral/Mental Disorder	<input type="radio"/>				
Cerebral Palsy	<input type="radio"/>				
Traumatic Brain Injury	<input type="radio"/>				

- Vision Impairment
- Attention Order Deficit Disorder
- Diabetes
- Asthma/Allergies
- Epilepsy
- Cancer
- Heart Condition
- Sickle Cell Anemia
- Skin Condition

Ages of Dependents with Special Needs

- Autism _____
- Developmental Delay _____
- Learning Disability _____
- Speech Disorder _____
- Clinical Depression (bipolar, etc) _____
- Other Behavioral/Mental Disorder _____
- Cerebral Palsy _____
- Traumatic Brain Injury _____
- Vision Impairment _____
- Attention Order Deficit Disorder _____
- Diabetes _____
- Asthma/Allergies _____
- Epilepsy _____
- Cancer _____
- Heart Condition _____
- Sickle Cell Anemia _____
- Skin Condition _____

For the above diagnoses, which of the following care providers have you sought assistance? (Choose all that apply) OPTIONAL

- On-Base Health Clinic
- John Randolph Medical Center Behavioral Health Unit
- Southside Regional Medical Center Behavioral Health Unit
- Poplar Springs Hospital
- Other Residential Psychiatric Hospital
- County Social Service Department
- Outpatient Therapy Provider
- Special Education Residential Program Provider
- Special Education Non-Residential Service Provider in a **Private** School
- Special Education Non-Residential Service Provider in a **Public** School
- Intensive In-Home Service Provider (including in-home respite care)
- Other Type of Care Provider, please specify _____

What is your marital status?

- Married
- Separated
- Unmarried (includes divorced/not married/widow/widower)

What is your spouse's primary language?

- English
- German
- Spanish
- French
- Korean
- Chinese
- Japanese
- Other, please specify _____

What is your spouse's secondary language?

- None
- English
- Spanish
- German
- French
- Japanese
- Chinese
- Korean
- Other, please specify _____

Is your spouse registered in the Exceptional Family Member Program (EFMP)?

- Yes
- No

My spouse is registered in EFMP for the following: (select all that apply)

- Potentially life threatening disease (i.e. cancer, insulin-dependant diabetes)
- Chronic duration mental health condition (i.e. bi-polar, personality disorders)
- Asthma (i.e. uses an inhaler, history of acute asthma in the past year)
- Attention Deficit Disorder (i.e. with psychological diagnosis; requires multiple medications; requires mental health provider)
- Requires adaptive equipment (i.e wheelchair, splint)
- Requires assistive technology device (i.e. communication device)
- Requires environmental/architectural considerations (i.e. limited steps, wheelchair accessible)
- I choose not to provide this information
- Other, please specify _____

Please select the diagnoses that best describes your spouse's medical situation. OPTIONAL (You may choose more than one)

Diagnosis of my

Spouse

- | | |
|------------------------------------|--------------------------|
| Autism | <input type="checkbox"/> |
| Developmental Delay | <input type="checkbox"/> |
| Learning Disability | <input type="checkbox"/> |
| Speech Disorder | <input type="checkbox"/> |
| Clinical Depression (bipolar, etc) | <input type="checkbox"/> |
| Other Behavioral/Mental Disorder | <input type="checkbox"/> |
| Cerebral Palsy | <input type="checkbox"/> |
| Traumatic Brain Injury | <input type="checkbox"/> |
| Vision Impairment | <input type="checkbox"/> |
| Attention Order Deficit Disorder | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> |
| Asthma/Allergies | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> |
| Heart Condition | <input type="checkbox"/> |
| Sickle Cell Anemia | <input type="checkbox"/> |
| Skin Condition | <input type="checkbox"/> |
| None of the Above | <input type="checkbox"/> |

Do you have any other dependents?

- Yes
- No

How many dependents live with you? (include spouse, children, and other adults)

- 0
- 1
- 2

- 3
- 4
- 5
- 6
- 7 or more

Are any of your dependants (not including a spouse) registered in the EFMP?

- Yes
- No

How many dependents (not including a spouse) are registered in EFMP?

- 1
- 2
- 3
- 4 or more

My dependent (s) (not including my spouse) are registered in EFMP for the following:

- Potentially life threatening disease (i.e. cancer, insulin-dependant diabetes)
- Chronic duration mental health condition (i.e. bi-polar, personality disorders)
- Asthma (i.e. uses an inhaler, history of acute asthma in the past year)
- Attention Deficit Disorder (i.e. with psychological diagnosis; requires multiple medications; requires mental health provider)
- Requires adaptive equipment (i.e wheelchair, splint)
- Requires assistive technology device (i.e. communication device)
- Requires environmental/architectural considerations (i.e. limited steps, wheelchair accessible)
- I choose not to provide this information
- Other, please specify _____

From the list of medical diagnoses indicated below; Identify the diagnosis that pertain to your dependent (s). Provide the number of dependents who fall into the particular diagnosis category and their ages. (Only fill in spaces that pertain to your dependent (s) diagnosis). OPTIONAL

Number of Dependents with the Diagnosis

	1	2	3	4	5 or more
Autism	<input type="radio"/>				
Developmental Delay	<input type="radio"/>				
Learning Disability	<input type="radio"/>				
Speech Disorder	<input type="radio"/>				
Clinical Depression (bipolar, etc)	<input type="radio"/>				
Other Behavioral/Mental Disorder	<input type="radio"/>				
Cerebral Palsy	<input type="radio"/>				
Traumatic Brain Injury	<input type="radio"/>				

- Vision Impairment
- Attention Order Deficit Disorder
- Diabetes
- Asthma/Allergies
- Epilepsy
- Cancer
- Heart Condition
- Sickle Cell Anemia
- Skin Condition
- None of the Above

Age of Dependents with the Diagnosis

Autism _____

Developmental Delay _____

Learning Disability _____

Speech Disorder _____

Clinical Depression (bipolar, etc) _____

Other Behavioral/Mental Disorder _____

Cerebral Palsy _____

Traumatic Brain Injury _____

Vision Impairment _____

Attention Order Deficit Disorder _____

Diabetes _____

Asthma/Allergies _____

Epilepsy _____

Cancer _____

Heart Condition _____

Sickle Cell Anemia _____

Skin Condition _____

None of the Above _____

What is your current living status?

- Own the home I live in
- Rent or Lease the home I live in
- Live in government quarters
- Other, please specify _____

Where do you currently live?

- Fort Lee
- Petersburg
- Hopewell
- Colonial Heights
- Prince George (includes Disputanta, Spring Grove, and Carson)
- Dinwiddie County
- Chester or Chesterfield County
- Other, please specify _____

Petersburg Schools

Where will your children attend school in the Fall of 2009? (select all that apply)

- I don't have school age children
- 21st Century Academy
- A.P. Hill Elementary School
- Blandford Elementary School
- J.E.B. Stuart Elementary School
- Peabody Middle School
- Robert E. Lee Elementary School
- Vernon Johns Middle School
- Virginia Avenue Elementary School
- Walnut Hill Elementary School
- Westview Elementary School
- Petersburg High School
- Private School
- Home School
- Other, please specify _____

Hopewell Schools

Where will your children attend school in the Fall of 2009? (select all that apply)

- I don't have school-age children
- Carter G. Woodson Middle School
- Dupont Elementary School
- Harry E. James Elementary School
- Hopewell High School
- Patrick Copeland Elementary School
- Private School
- Home School
- Other, please specify _____

Chester/Chesterfield Schools

Where will your children attend school in the Fall of 2009? (select all that apply)

- I don't have school-age children
- Alberta Smith Elementary School
- A.M. Davis Elementary School
- Bailey Bridge Middle School
- Bellwood Elementary School
- Bensley Elementary School
- Bettie Weaver Elementary School
- Beulah Elementary School
- Bon Air Elementary School
- Carver Middle School
- C.C. Wells
- Chalkley Elementary School
- Chester Middle School
- Chesterfield Community High School
- Chesterfield Technical Center
- Clover Hill Elementary School
- Crestwood Elementary School
- C. E. Curtis Elementary School
- Ecoff Elementary School
- Enon Elementary School
- Ettrick Elementary School
- Evergreen Elementary School
- Falling Creek Elementary School
- Falling Creek Middle School
- Grange Hall Elementary School
- Greenfield Elementary School
- Harrowgate Elementary School
- J.G. Hening Elementary School
- Hopkins Elementary School
- Jacobs Road Elementary School
- James River High School

- Lloyd C. Bird High School
- Manchester High School
- Manchester Middle School
- Marguerite Christian Elementary School
- Matoaca Elementary School
- Matoaca High School
- Matoaca Middle School
- Meadowbrook High School
- Midlothian High School
- Midlothian Middle School
- Monacan High School
- O. B. Gates Elementary School
- Perrymount School
- Providence Elementary School
- Providence Middle School
- Reams Road Elementary School
- Robius Elementary School
- Robius Middle School
- Salem Church Elementary School
- Salem Church Middle School
- Spring Run Elementary School
- Swift Creek Elementary School
- Swift Creek Middle School
- Thelma Crenshaw Elementary School
- Thomas Dale High School
- J.B. Watkins Elementary School
- W.W. Gordon Elementary School
- Woolridge Elementary School
- Private School
- Home School
- Other, please specify _____

Colonial Heights Schools

Where will your children attend school in the Fall of 2009? (select all that apply)

- I don't have school-age children
- Community Day School
- Colonial Heights Middle School
- Colonial Heights High School
- Lakeview Elementary School
- North
- Elementary School
- Tussing Elementary School
- Private School
- Home School
- Other, please specify _____

Dinwiddie County Schools

Where will your children attend school in the Fall of 2009? (select all that apply)

- I don't have school-age children
- Dinwiddie High School
- Dinwiddie Middle School
- Midway Elementary School
- Rohoic Elementary School
- Southside Elementary School
- Sunnyside Elementary School
- Private School
- Home School
- Other, please specify _____

Prince George Schools

Where will your children attend school in the Fall of 2009? (select all that apply)

- I don't have school-age children
- Harrison Elementary School
- J.E.J. Moore Middle School
- L. L. Beazley Elementary School
- N. B. Clements Junior High School
- North Elementary School
- Prince George High School
- Private School
- South Elementary School
- Walton Elementary School
- Home School
- Other, please specify _____

How many children do you have in pre-school (any school before kindergarten)?

- 0
- 1
- 2
- 3
- 4 or more

Where are they cared for?

- Day Care Center in the Local Community
- Child Development Center on Fort Lee
- Home Care Provider on Fort Lee
- Home Care Provider in the Local Community
- Family Member
- Other, please specify _____

How many school age children (Kindergarten-6th grade) do you have?

- 0
- 1
- 2
- 3
- 4 or more

Are any of your school age children (kindergarten-6th grade) cared for in a before or after school program?

- Yes
- No

Which of the following best describes your school age children's before or after school care situation?

- No Care required
- Daycare Center in the Local Community
- Child Development Center on Fort Lee
- Home Care Provider on Fort Lee
- Home Care Provider in the Local Community
- Family Member
- Other, please specify _____

How many school age children (7th-9th grade) do you have?

- 0
- 1
- 2
- 3
- 4 or more

How many school age children (10th-12th grade) do you have?

- 0
- 1
- 2
- 3
- 4 or more

How many children do you have in college? Include those who will start school in the Fall of 2009.

- 0
- 1
- 2
- 3
- 4 or more

Starting in the fall of 2009, how many of your children will attend college in Virginia?

- 0
- 1
- 2
- 3
- 4 or more

Starting in the fall of 2009, how many will live at the college location during the school year?

- 0
- 1
- 2
- 3
- 4 or more

Starting in the fall of 2009, how many will live with you while attending college?

- 0
- 1
- 2
- 3
- 4 or more