COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Nominating Committee Meeting
DRAFT AGENDA
Tuesday, July 12, 2022, 4:45 p.m.
DHBDS, Room 844, 8th Floor, Jefferson Building,
1220 Bank Street, Richmond, VA 23219

This meeting will be in person with all members physically present.

I.	4:45 p.m.	**Call to Order**	Kendall Lee *Committee Chair*
II.		**Approval of July 12, 2020, Agenda** ➢ *Action Required*	
III.		**Consideration of Nominees for Slate** ➢ *Action Required*	
IV.		**Adjournment**	

The Nominating Committee is an ad hoc committee formed by the current chair in accordance with Article 4 b. of the Bylaws.

Committee Members
Kendall Lee; Moira Mazzi; Christopher Olivo

STATE BOARD REGULAR MEETING SCHEDULE
2022

DATE	Location
September 28 *(Wed)*	*TBD*
December 7 *(Wed)*	*Central Office, DBHDS,* ***Richmond***

COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

DRAFT MEETING AGENDA

Wednesday, July 13, 2022
DBHDS Central Office, Jefferson Building*
1220 Bank Street, Richmond, VA

~~CONCURRENT~~ COMMITTEE MEETINGS

Wednesday, July 13, 2022, 8:30 a.m. – 9:25 a.m.
DBHDS Central Office, 13th Floor Large Conference Room, Jefferson Building
1220 Bank Street, Richmond, VA
***These meetings will be in person with a physical quorum present, but electronic or phone connection is available.**

8:30	• ~~**Policy and Evaluation Committee**~~ ~~***Room 844, 8th Floor (left of elevators)***~~ ~~*OR **ZoomGov Meeting:***~~ ~~https://virginia-gov.zoomgov.com/j/1605573084~~ ~~*Meeting ID: 160 557 3084*~~ ~~*Passcode: 691045*~~ ~~*OR*~~ ~~*Phone: 1 646 828 7666 US (New York)*~~ ~~*Meeting ID: 160 557 3084*~~ ~~*Passcode: 691045*~~ • **Planning and Budget Committee** ***13th Floor Large Conference Room*** OR see main meeting info below (same login)↓	~~Josie Mace~~ ~~*Legislative Manager*~~ UPDATE: The Policy and Evaluation Committee Meeting is canceled and will be rescheduled for a date prior to the September quarterly board meeting. Ruth Anne Walker *Board Liaison*
9:25	**Adjourn**	

CONTINUED -

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

REGULAR MEETING

Wednesday, July 13, 2022
9:30 a.m. – 2:00 p.m.
DBHDS Central State Office, 13th Floor Large Conference Room, Jefferson Building
1220 Bank Street, Richmond, VA 23219

***This meeting will be in person with a physical quorum present, but electronic or phone connection is available:**
Join ZoomGov Meeting: https://virginia-gov.zoomgov.com/j/1605195003 (this login is used for the Planning Committee)
Meeting ID: 160 519 5003
Passcode: 294916

OR
By Phone: +1 646 828 7666 US
Meeting ID: 160 519 5003
Passcode: 294916

1.	9:30	**Call to Order and Introductions** **Approval of July 13, 2022 Agenda** ➢ *Action Required* **Approval of Draft Minutes** **Regular Meeting, March 30, 2022** ➢ *Action Required*	Elizabeth Hilscher *Chair*	**6**
2.	9:35	**Officer Elections** **A. Presentation of the Slate of Candidates** **B. Nominations from the Floor** **C. Election** ➢ *Action Required* **D. Passing of the Gavel**	Kendall Lee *Nominating Committee Chair*	
3.	9:45	**Public Comment** (*3 minute limit per speaker*) *Public comment will not be accepted on petitions for rulemaking or regulatory actions in which the comment period has closed. It is preferred that persons wishing to give comment submit an email to ruthanne.walker@dbhds.virginia.gov no later than 5:00 p.m. on July 12, 2022, indicating that they wish to provide a brief verbal comment. As the names of these individuals are announced at the beginning of the public comment period, three minutes of comment may be offered, within the overall time allowed for comments. Written public comment may be sent by email to ruthanne.walker@dbhds.virginia.gov no later than 5:00 p.m. on July 12, 2022. Instructions for calling into the meeting are included above on this page.*		
4.	10:00	**Commissioner's Report**	Nelson Smith *Commissioner*	

5.	10:45	**Regulatory Actions** **A. Regulatory Updates.** **B. Final Stage** **1. Childrens Residential Regulations, 12VAC35-46: ASAM Criteria.** **2. Licensing Regulations, 12VAC35-105: ASAM Criteria.** **3. Licensing Regulations, 12VAC35-105: Behavioral Health Expansion.** ➢ *Action requested for Items 1-3: -Initiate final stage, and -Authorize request for extension of emergency regulations.* **C. Petition for Rulemaking #366: Amendments to Incorporate Requirements for Certified Preadmission Screening Clinicians.** ➢ *Action requested.* **D. Emergency/NOIRA Action with Periodic Review Operation of the Individual and Family Support Program, 12VAC35-230.** **1. Emergency Mandate to facility Compliance (Item 313.NN.).** **2. Periodic Review.** ➢ *Action requested for Items 1-2: -Authorize promulgation of an emergency/NOIRA action, and -Authorize initiation of a periodic review as part of that action.*	Ruth Anne Walker *Director of Regulatory Affairs* Susan Puglisi *Regulatory Research Specialist* *Office of Regulatory Affairs* Emily Bowles *Office of Licensing Associate Director of Licensing, Regulatory Compliance, Quality, and Training* Ruth Anne Walker Heather Norton *Assistant Commissioner* *Developmental Services*	**23** **26** **49** **117** **150** **158**
6.	11:15	**Update: Settlement Agreement** -including Priority 5: Waiver Rates	Heather Norton	
7.	11:35	**Human Rights Annual Report**	Taneika Goldman *State Human Rights Director*	
8.	12:00	**Lunch: Break and Collect Lunch**		
9.	12:30	**A&E Update: General State of Agency Facilities and Capital Projects.**	Margaret ("Mickie") Jones *Director* *Office of Architectural & Engineering Services*	
10.	12:50	**Board Member Spotlight**	Rebecca Graser	

11.	1:00	**Update: Virginia Association of Community Services Boards**	Jennifer Faison *VACSB Executive Director*	
12.	1:30	**2022 Post-Session Updates** **A. Budget** **B. Legislative**	Nathan Miles *Budget Director* Josie Mace *Legislative Affairs Manager*	
13.	1:45	**Committee Reports:** **A. Policy and Evaluation** **B. Planning and Budget**	Josie Mace Ruth Anne Walker	**21** **19**
14.	1:55	**Miscellaneous** **A. Liaison Updates** **B. Other Business**		
15.	2:15	**Adjournment**		

(Note: Times may run slightly ahead of or behind schedule.
If you are on the agenda, please plan to be at least 10 minutes early.)

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Regular Meeting
DRAFT MEETING MINUTES
9:30 a.m., Wednesday, March 30, 2022
This meeting was held in person with a physical quorum present, with electronic or phone connection available. A recording of the meeting is available.

Members Present	Elizabeth Hilscher, Chair; Rebecca Graser, Vice Chair; Paige Cash (electronic) ; Varun Choudhary; Kendall Lee; Moira Mazzi; Christopher Olivo; Sandra Price-Stroble.
Members Absent	(none)
Staff Present	• Amy Addington, Financial and Policy Analyst. • Alisha Anthony Jarvis, Mental Health First Aid Coordinator, Office of Behavioral Health Wellness. • Emily Bowles, Office of Licensing Associate Director for Licensing, Regulatory Compliance, Quality and Training. • Lauren Cunningham, Communications Director. • Taneika Goldman, Director, Office of Human Rights. • Alexandra Harris, Policy and Legislative Affairs Director. • Angela Harvell, Deputy Commissioner, Facility Services. • Meghan McGuire, Chief Public Relations Officer. • Walton F. Mitchell, III, Assistant Commissioner for Facility Services. • Suzanne Mayo, Community Integration Director. • Stacy Pendleton, Chief Human Resources Officer. • Susan Puglisi, Regulatory Research Specialist, Office of Regulatory Affairs. • Nelson Smith, Commissioner. • Ruth Anne Walker, Director of Regulatory Affairs and State Board Liaison.
Guests Present	Invited guests: • Jennifer Faison, Executive Director, Virginia Association of Community Services Boards. • Madelyn Lent, Governor's Fellow. Other Guests Physically Present: • Mary Ottinot. • Dalkinah Thomas, Intensive Community Outreach Services. Other Guests Attending Electronically:

	• Joint Legislative Audit and Review Commission: Kate Agnelli, Levar Bowers, Drew Dickinson, Tess Hintereger, Dillon Wild. • Virginia Department of Aging and Rehabilitative Services (DARS): Patti Meire, Coordinator Public Guardian and Conservator Program; George Worthington, Dementia Services Coordinator. • Heidi Dix, Virginia Association of Health Plans. • Lisa Sedjat, Executive Director, Eastern Shore Community Services Board. • Chris Whyte, Vectre Corporation. • LandGI (?phone)
Call to Order and Introductions	At 9:31 a.m., Elizabeth Hilscher, Chair, called the meeting to order and welcomed those present. A quorum of seven members was physically present, and an eighth member participated electronically.
Approval of Agenda	*At 9:32 a.m. the State Board voted to adopt the March 30, 2022, agenda. On a motion by Varun Choudhary and a second by Moira Mazzi, the agenda was approved.*
Approval of Draft Minutes	**Regular Meeting, September 29, 2021** *At 9:33 a.m., on a motion by Sandra Price-Stroble and a second by Varun Choudhary, the September minutes were approved as final.* **Regular Meeting, December 8, 2021** *On a motion by Varun Choudhary and a second by Kendall Lee, the December minutes were adopted.*
Public Comment	At 9:35 a.m., Ms. Hilscher stated a period for public comment was included on the draft agenda, and that one citizen was in attendance to give comment. Mary Ottinot thanked the board for the opportunity to share comments. Ms. Ottinot stated she brought approximately 90 pages of information to give to the board and would explain her concerns regarding the Fairfax CSB 'manifesto.' She said she is the mother of three children, a nurse from Chicago, and has worked extensively on issues that informed policy initiatives related to services for people with disabilities, domestic violence, and early learning programing at the federal, state, and local levels. Ms. Ottinot stated that despite being a registered nurse in Virginia; Washington, D.C.; Maryland; and Illinois, who is well respected by patients, families, and community members, when she called out the

	Fairfax CSB for behavior she considers unethical - illegally committing her to a state hospital, she felt who she is as a public servant no longer mattered. Ms. Ottinot stated that her purpose to comment was to report that she believes the CSB is a danger to the public and she requested an investigation be launched by the US Department of Justice. She believes that she was illegally committed to a state facility and that the CSB has attempted to cover this up. She asked that the documents she brought (including her temporary detention order) be shared with the board [staff copied and gave the packet to the board and the commissioner] and be made public, in addition to a recording of her speaking at the local human rights hearing that she made under the local human rights committee's (LHRC) strong objections. She noted that she finds it egregious that a TDO hearing in Virginia is public, which she firmly believes is a violation of federal law including the Americans with Disabilities Act; but an LHRC hearing may be made closed, with no written law that she knows of that says that it should at least be recorded. She feels the system allows for utter lack of humanity and disregard for the rule of law. Ms. Ottinot requested a meeting with the commissioner, and board members, to have a consultative meeting to help fix the system. Ms. Hilscher thanked Ms. Ottinot for her comments and stated the board would review the submitted documents.
Regulatory Actions	**Regulatory Actions** At 9:45 a.m., Ms. Hilscher directed members to page 29 in the packet. **E. Regulations for Children's Residential Facilities, 12VAC35-46.** **1. Initiate Proposed Stage for Action 5849: Amendments to align with the Family First Prevention Service Act (FFPSA).** The proposed stage action for the board's consideration was unchanged from the current emergency regulation. *At 9:50 a.m., on a motion by Dr. Choudhary, and a second by Dr. Lee, the initiation of the proposed stage was authorized.* **2. Initiate Periodic Review.**

	On a motion by Dr. Lee and a second by Ms. Price-Stroble, the initiation of the periodic review was authorized. **F. Status: Operation of the Individual and Family Support Program, 12VAC35-230: *Pending emergency authority; periodic review with action.*** Ruth Anne Walker alerted members that due to the urgency with the need to change the regulations for this program, it would likely be the case that an additional meeting of the board would need to be called before the July, *pending enactment of a budget by the General Assembly*. She stated that though a periodic review is due on this chapter, the request is held to be done in conjunction with the emergency action, since that would have significant changes. **G. General Update – Regulatory Matrix** Ms. Walker reviewed the information in the matrix on page 41.
Commissioner's Report	*NOTE: A fire emergency caused an interruption for approximately 25 minutes to evacuate the building, from 10:20-10:44 a.m.* At 9:55 a.m., Ms. Hilscher welcomed Commissioner Nelson Smith and asked board members to introduce themselves and state why they served on the board. Mr. Smith expressed appreciation for the depth of experience and regional statewide representation. The commissioner updated board members on a number of initiatives and reported that the leadership team is entering a strategic planning process, which he will present to the board when completed. In fact, the DBHDS senior leadership team would be gathering the next day to take the first step in the department's strategic planning process. Mr. Smith stressed how important it is that system challenges are overcome together with community partners. DBHDS needs a strategic plan to guide it, a North Star. This North Star plan will concentrate in three main areas of tremendous need that will help advance the Governor's vision to make Virginia the best place to live, work, and play: 1. **Workforce:** Staffing is a major concern throughout healthcare as the pandemic is driving many workers to jobs that are safer and less stressful. DBHDS needs to build and retain the workforce and create a pipeline for the future, which would have a positive impact on the entire system.

	‘A mission of hope’ is a theme of this initiative to change the narrative, with so much negative commentary about the department and the system. He sees staff across the system are doing amazing things every day. Mr. Smith will focus on building a pipeline, empowering staff, and retaining them. 2. **Comprehensive Continuum of Care:** The system must be rebalanced from a reliance on intensive interventions like inpatient care and focus intently on prevention and wellness. 3. **Data:** Virginia is spending millions of dollars to improve and expand developmental disability and behavioral health programs in the community but lacks the data needed to know if people are getting better. This needs to change. This priority is critical to monitor trends and drive outcomes. The agency will be working towards streamlined and innovative systems. Although our landscape has shifted because of COVID and other factors, much of the previous planning input from throughout Central Office, the facilities, community providers, and stakeholders can be incorporated into this planning process. Mr. Smith is motived by the needs of the people in the system to finish this process quickly and get to work. He will update the State Board as plans progress. Mr. Smith continued in detail about state hospital staffing shortages, working with law enforcement on the transportation legislation, the US Department of Justice’s Settlement Agreement with Virginia, and the Medicaid Waiver waitlist for developmental disabilities. In closing, Mr. Smith reiterated the department is working to finalize the Settlement Agreement, transform the entire system involving everyone at the state and local level to come to the table to help find solutions, build up the workforce and community services, and shore up state hospitals. Mr. Smith thanked the board for their time and passion to serve as volunteers. Ms. Hilscher responded that the commissioner touched on a couple of things that spoke to her. She has served on the board for six years and while it is true the system is broken, there are really good things happening every day. She

	believes public awareness efforts are needed to make those positive activities better known, so that when more resources and support are requested, it is understood the system is not totally broken. She agrees that mental illness needs to be destigmatized, and progress has been made especially in schools. Like the commissioner, when she visited facilities she also came away amazed and inspired by the hard work of staff. Also, she agrees that so much effort is spent on crisis management instead of prevention and early intervention. She realizes to get to that point it will take significantly more resources for a while. Dr. Lee was encouraged to hear about the efforts regarding local workforce. He works at Longwood, which now has a nursing program and it has been helpful in the area to look at ways to capitalize on the training and education of health care workers to help support the region. Dr. Choudhary stated he is happy to help the commissioner to assist him in any way that he can regarding transforming the behavioral health system. Rebecca Graser stated that, regarding the mental health state hospital crisis, there needs to be a focus on the cumbersome discharge process. Also, the culture in the state hospitals is more on the medical model versus the recovery model. The recovery model offers hope and that everyone can recover, and Virginia is a bit behind on that. (Ex. Pennsylvania in 2002, A Call for Change). Regarding workforce, where she lives in the Northern Neck, there are not big universities, but there are a number of community colleges that can bridge to the bigger universities. Paige Cash agreed with the commissioner's comments and thanked him. Ms. Hilscher thanked Mr. Smith for his time and stated the board looked forward to hearing from him again.
Priority 4: Update on Efforts to Streamline the Discharge Process	At 11:00 a.m., Angela Harvell, Deputy Commissioner of Facility Services, gave background and updates on the discharge process. Namely, that the urgency around and efficiency of the discharge planning process has been a frequent topic of discussion in the years since the bed of last resort law was implemented. In 2021, DBHDS (in collaboration with CSBs) updated the discharge protocols to more accurately reflect current needs, and included four new CSB discharge planning

	performance measures. SB1304 (2021, McPike) attempted to address discharge inefficiencies through a number of recommendations, including a study group to review and make recommendations regarding the process. The workgroup recommended an outside system review, which was done with the three largest state hospitals. Those recommendations are still being considered, and work is continuing. Ms. Graser asked clarifying questions about SB1304. She stated that 80% need to be seen within seven days of discharge, and this is impacted by CSB workforce issues.
Follow Up: Staffing Initiatives	At 11:20 a.m., Stacy Pendleton, Chief Human Resources Officer, reviewed turnover rates, vacancy rates, employee age, budget requests for staff compensation increases, direct care salaries, the work required under HB191 (Hodges, 2022) regarding the health workforce across the Commonwealth if it passes, and the development of a human resources data dashboard. Dr. Choudhary asked about psychiatrist vacancies. Ms. Pendleton indicated they are a smaller total number. He also asked if the Psychiatric Society of Virginia could be added to the list of stakeholders in HB191. Staff answered that it is not limiting; PSV should be able to be actively involved. DBHDS addresses workforce planning in a three-pronged approach: recruitment, retention, and engagement. Ms. Graser wondered if bringing some of the recent retirees back part-time would be possible. Ms. Pendleton agreed. Ms. Price-Stroble saw that work well in schools. Ms. Hilscher referenced the commissioner's initiatives, specifically community, and wondered how the department could encourage high school students to consider all the things available through the department that do not require a four year degree and might be available at a community college. Ms. Pendleton mentioned a pilot program with Petersburg High School with Central State Hospital. She referenced the work with Dr. Tanyika Mobley, DBHDS, Equity, and Inclusion Officer, to partner beyond the Office of Human Resources.
Appointments to the State Human Rights Committee	At 11:40 a.m., Taneika Goldman, Director, Office of Human Rights, gave brief remarks regarding the State Human Rights Committee (SHRC) structure. She asked for approval of the three recommended appointments: Betty Crance, family member; David Crews, healthcare provider; and reappointment

	of Julie Allen, healthcare provider and family member, and current SHRC Chair. *On a motion by Dr. Choudhary and a second by Dr. Lee, the three appointments were made.*
Lunch Break	At 12:00 p.m., Ms. Hilscher suspended the meeting for a 30 minute lunch break, reconvening at 12:30 p.m.
2022 Post-Session Updates	*At 12:32 p.m., Ms. Hilscher reconvened the meeting.* **A. Legislative** Alex Harris, Policy and Legislative Affairs Director, provided information about the status of legislation in the 2022 Regular Session of the General Assembly. DBHDS tracked over 100 bills, and provided analysis and technical assistance on over 50 bills. A special session was planned for April 4th, and all legislation must be acted on by April 27th at the Reconvened Session. Bills that passed include: Increased compensation for NGRI evaluators (SB191), video visitation in state facilities (HB388), and changes to the half mile rule (SB300). New legislative workgroups involving the system include: SB202, Alternative Custody (assigned to the Secretary of Health and Human Resources); HB1191, Marcus Alert (DBHDS); HB659, Death Investigations (DBHDS); HB1193, First Episode Psychosis (DMAS). Dr. Choudhary asked for clarification on why there is not an exemption for behavioral health beds within rules for certificate of public need (COPN), given the need for more beds. Ms. Harris indicated DBHDS has continued working with the Virginia Department of Health on this, as they manage the COPN process. She does not believe applications for behavioral health beds are being denied as there is a large demand, but rather are allowed with provision that a certain percentage of approved beds be set aside as TDO beds, holding hospitals more accountable to take more individuals under temporary detention orders. The counter argument to that is there might be fewer applications because of the strings attached. There is a balancing act, but certainly an interest in having private hospitals take on more individuals under TDOs. Dr. Choudhary also asked if there was discussion of a waiver for behavioral health professionals around telehealth because of the shortage in Virginia. Ms. Harris reported there was a bill about telehealth but not specific to behavioral health.

	Ms. Graser asked about the budget proposal for raising the reimbursement rate for peer support. Ms. Harris reported that she did not think that passed the House. **B. Budget** Nathan Miles, Budget Director, and Amy Addington, Financial and Policy Analyst, reviewed a summary of General Assembly Crossover actions regarding the House and Senate versions of the budget. The House and Senate adopted most of the introduced budget, with some notable exceptions. Areas of variance between the two chambers include: state employee compensation, compensation for facility direct care staff, funding for DD waiver slots, the DD waiver rebase, alternative custody legislation, funding to set up crisis receiving centers in three localities, DBHDS initiatives (licensing positions, marijuana campaign, recovery residencies, and Virginia Mental Health Assistance Program or "VMAP"), permanent supportive housing, agency management of capital projects, DBHDS maintenance reserve projects, DBHDS restructuring, CSB bonuses, a school MH integration pilot, Early Intervention (Part C) services, Central Office positions, and budget language around BH and DOJ program activities. Dr. Choudhary noted the number of slots allotted versus the number on the waiting list. Meghan McGuire responded that the Priority 1 list has a smaller number, which is the first target for budgeting. Ms. Graser observed that increases in permanent supportive housing would probably help the state hospital bed crisis. Mr. Olivo asked about the 50th percentile funding versus 75th percentile, and whether the department asked for 75th percentile because by the time the funding begins to be distributed, costs would increase. Mr. Miles concurred with that observation. The Reconvened Session is April 27th.
Update: Virginia Association of Community Services Boards (VACSB)	At 1:00 p.m., Jennifer Faison, VACSB Executive Director, reported on the association's activities during the 2022 General Assembly Session. She had previously reported on the biennium budget priorities, framed around the theme of 'all of us first,' referring to the need to prioritize the entire public system for behavioral health and developmental disability services, as well as the individuals served in the system.

	VACSB advocates for accountability and oversight, but also flexibility in spending. There is excitement about the upcoming retreat with DBHDS for strategic planning, along with other community partners. This will include discussion about funding structure and formulas. Also, discussion will be around a shared vision of the role of CSBs and DBHDS. The first in-person statewide conference since January of 2020. Ms. Hilscher was glad to hear of the upcoming retreat and looks forward to hearing the outcomes. Ms. Graser stated that she looks at the CSBs as the safety net, but not enough people know of their existence. She also noted the differences between rural and city CSBs; they are all so different. Ms. Faison stated she uses the phrase 'united in our mission and different in our resources.' Ms. Hilscher thanked Ms. Faison for her presentation.
Board Member Spotlight	At 1:20 p.m., Sandra Price-Stroble grew up in the Shenandoah community of Page County, and moved to Harrisonburg 26 years ago. With a bachelor's degree in Elementary Education and a master's in Counseling, Ms. Price-Stroble enjoyed working for 39 years in the Page County school system as a teacher of children of a variety of ages, and as a counselor; CSBs were a resource for her in those roles. She's served on other boards including: the Department for the Blind and Vision Impaired (some of her students were visually impaired), the Department of Human Resources Management, and most recently the Department of Health Professions through 2011. The Deeds family tragedy in 2013 motivated her to seek appointment on the State Board of BHDS. She enjoys the liaison role, in particular the support that it shows for the staff across the services system. Ms. Price-Stroble is serving in her 14th year on the local electoral board. Music has always been a very important part of her life, including serving as an organist at her church since she was 13. She joined the fundraising arm of the Shenandoah Valley Music Festival, and enjoys participating in the community in a variety of ways.
Priority 3: Public Awareness	At 1:35 p.m. Lauren Cunningham, Communications Director, reported that DBHDS public awareness efforts include social media activities; the Curb the Crisis website targeting the opioid crisis, the My Life, My Community website for developmental disability community resources, the Individual and Family Support Program (IFSP) for individuals who are on

	the wait list for developmental disability waiver services, and crisis efforts that include Virginia's Marcus Alert and the federal requirement for the 988 hotline for persons n crisis to connect with suicide prevention and mental health crisis counselors. Finally, Ms. Cunningham reported on the Virginia Mental Health Access Program (VMAP) that helps ensure more children have access to providers who are better able to screen, diagnose, manage, and treat mental health through three main program components of education, consultation, and care management. (www.vmap.org) Ms. McGuire noted all programs that touch people, yet Ms. Cunningham is the only communications staff person for this large agency. Therefore, social media is very useful to reach more people quickly. She also invited board members for suggestions for good topics or to send pictures from out in the field. Dr. Lee noted that the social media helped him when he started as a board member. Alisha Anthony Jarvis, Mental Health First Aid Coordinator in the Office of Behavioral Health Wellness, reported on Mental Health First Aid. It covers risk factors, warning signs, information on specific diagnoses and addiction disorders, points to available resources, and utilizes a five-step action plan to help someone developing a mental health problem or in crisis. There are 82,579 consumers trained as Mental Health First Aiders; 761 certified MHFA instructors. (Note: Some trainers are dual trained; total only reflects one count.) Ms. Price-Stroble commented that she had the training and would like to see it more in the school systems as mandatory to facilitate prevention. Ms. Anthony Jarvis is working with DHRM to offer it to other state agencies. Reaching out to the local CSB is the appropriate way to find out about area trainings.
Committee Reports	At 1:56 p.m. Ms. Hilscher called for the reports of the committees. **A. Policy Development and Evaluation** Rebecca Graser, Board Vice Chair and Committee Chair, reported that the committee reviewed the activity in 2021 and made plans for 2022. Next steps were planned for 1030(SYS)90-3: Consistent Collection and Utilization of Data in State Facilities and Community Services Boards to receive a

	presentation from lead staff. The draft revisions to 1034(SYS)05-1: Partnership Agreement were approved. All board policies are posted on the agency web site: https://dbhds.virginia.gov/about-dbhds/Boards-Councils/state-board-of-BHDS/bhds-policies. **B. Planning and Budget** Ms. Walker reported, a presentation was given by the Division of Finance on the agency budget and budget development process. Mr. Olivo stated he found it very interesting and included things of which he was not aware. Discussion will continue regarding fulfillment of the planning duties covered by the committee with the elimination of the Comprehensive State Plan (SB479, McClellan), which had become obsolete with more modern avenues for the information. Since 1998, the committee had been involved in development of the six-year, biennially updated plan.
Miscellaneous	**A. Liaison Updates** At 2:05 p.m., the board reviewed the collaboration letter sent on August 31, 2021, to facility and CSB directors; the explanation of the role; and the liaison assignments, which may change with new appointments. Ms. Cash reported that she met last fall electronically or in person with all CSB directors in her catchment area. Dr. Lee reported there is a new director at Crossroads CSB. **B. Other Business** • Ms. Walker informed the board of the gubernatorial Executive Directive 1 requiring all agencies to reduce regulations by 25 percent. • Member attendance of VACSB conference expenses (registration and travel) may be covered by the board's budget. • Ms. Hilscher appointed the 2022 Nominating Committee of Dr. Lee, Ms. Mazzi, and Mr. Olivo to provide a slate of officers for the election in July.
Adjournment	There being no other business, Ms. Hilscher adjourned the meeting at 2:16 p.m.

2022 MEETING SCHEDULE

DATE	Location
July 13 ***(Wed)***	*Central Office, DBHDS* ***Richmond***
Sept 28 ***(Wed)***	*TBD*
December 7 ***(Wed)***	*Central Office, DBHDS* ***Richmond***

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Planning and Budget Committee

DRAFT MINUTES
March 30, 2022
8:30 a.m. – 9:25 a.m.
DHBDS, 13TH FLOOR CONFERENCE ROOM,
JEFFERSON BUILDING, 1220 BANK STREET, RICHMOND, VA 23219

This meeting was held in person with a physical quorum present, with electronic or phone connection available. A recording of the meeting is available.

Members Present: Elizabeth Hilscher, Board and Committee Chair; E. Paige Cash (electronically); Christopher Olivo.
Members Absent: None.
Staff Present: Ken Gunn, Comptroller; Nathan Miles, Budget Director; Susan Puglisi; Ruth Anne Walker.

I. Call to Order

A quorum being present, at 8:34 a.m., Elizabeth Hilscher, Chair, called the meeting to order.

II. Welcome and Introductions

Ms. Hilscher welcomed all present, and acknowledged the staff present.

III. Adoption of Minutes, September 29, 2021

On a motion from Christopher Olivo and a second from Paige Cash the meeting minutes from September 29, 2021, were adopted unanimously.

IV. Standing Item: *Ensure that the agency's budget priorities and submission packages reflect State Board policies and shall, through the Board's biennial planning retreat, review and comment on major funding issues affecting the behavioral health and developmental services system, in accordance with procedures established in POLICY 2010 (ADM ST BD) 10-1.*

The meeting time was devoted to a presentation by Ken Gunn and Nathan Miles who gave a detailed overview of the department's state finance and budgeting processes. Topics covered included:

- An overview of the agency budget with the main categories of Central Office, community service boards, state facilities, state General Fund support, federal funds/Medicaid, local dollars, capital debt service;
- Operating, facilities, fund type, capital funding, budget language;
- Spending authority and appropriations;
- Virginia budget forecasting;
- Competing demands (needs, priorities, resources), agency constraints on spending, the agencies involved in the budget process, things that influence the budget, budget timeline;

- Analysis of prior year activity and history along with assessment of the effects of reorganization for the coming year, annual agency budget development, and agency budget execution and management.

Mr. Gunn explained the difference between his role and Mr. Miles' as defense versus offense. Mr. Miles plans how the agency can pursue appropriations. Mr. Gunn's role is to ensure compliance, proper management, system controls, and reporting.

Ms. Hilscher commented that when she has attended budget hearings before session, most attendees are present to request funding for the behavioral health and developmental services. Also, her impression is that this agency is scrutinized closely.

Ms. Cash commented on her experience on the school board and unfunded mandates at the local level, and asked how much it impacts the agency. Mr. Miles responded that an example that comes to mind is the bed of last resort legislation in 2013, that the impacts weren't fully understood at the time. Ms. Cash stated that they are often from very well-meaning legislation, like more computers, etc.

V. Other Business

There was no further business.

VI. Next Steps:

Next Meeting: July 13, 2022.

VII. Adjournment

At 9:25 a.m., Ms. Hilscher adjourned the meeting.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Policy and Evaluation Committee

DRAFT MINUTES

MARCH 30, 2022
8:30-9:25 AM
DHBDS, 8TH FLOOR NORTH SUITE CONFERENCE ROOM,
JEFFERSON BUILDING, 1220 BANK STREET, RICHMOND, VA 23219

This meeting was held in person with a physical quorum present, with electronic or phone connection available.

Members Present: Rebecca Graser, Committee Chair; Varun Choudhary; Kendall Lee; Moira Mazzi; Sandra Price-Stroble.
Members Absent: None.
Staff: Alex Harris.
Guests: JLARC staff - Kate Agnelli, Levar Bowers, Drew Dickinson, Tess Hintereger, Dillon Wild.

I. Call to Order

Rebecca Graser called the meeting to order at 8:34 am.

II. Welcome and Introductions

Ms. Graser welcomed all to the meeting.

III. Review of 2021 Policy Review Plan and Presentation of Policies for Discussion

A. 1030(SYS)90-3: Consistent Collection and Utilization of Data in State Facilities and Community Services Boards

Ms. Graser noted a subject matter expert is needed for the next meeting to provide background on this policy.

B. 1034(SYS)05-1: Partnership Agreement Revisions

Ms. Graser noted that these revisions were discussed with DBHDS staff at the December meeting. Varun Choudhary made a motion to approve the revisions, and Kendall Lee seconded. The motion passed.

IV. Discussion and Review Plan for 2022 Policy Review

Alex Harris briefly reviewed the policy review plan for 2022, and the committee members agreed to the plan and had no questions.

V. Adjournment

Ms. Graser adjourned the meeting at 8:45 a.m.

All current policies of the State Board are on the agency website at:
https://www.dbhds.virginia.gov/about-dbhds/Boards-Councils/state-board-of-BHDS/bhds-policies

COMMONWEALTH of VIRGINIA

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MEMORANDUM

To: Members, State Board of Behavioral Health and Developmental Services

Fr: Ruth Anne Walker, Director of Regulatory Affairs

Date: June 30, 2022

Regulatory Activity Status Report and Action Items:

I. Regulatory Activity Status Report, p.23.

II. Three Actions for Final Stage and Emergency Extension: ASAM (Ch. 46, Ch. 105), Behavioral Health Expansion (Ch. 105), p. 26, 49, 117.

Final Stage:

- No changes were made to the regulatory text of the Behavioral Health Expansion action since the previous stage was published.
- Both ASAM actions have changes. At the final stage of regulatory actions, changes are kept to a minimum and are for clarification or correction. **In the drafts, all amendments in the final stage are set out by brackets [ ]**. Note in the end of the Town Hall forms, **the primary focus for the board's review for final stage are in a table of changes for '*Detail of Changes Made Since the Previous Stage*.'** All other amendments unchanged from the proposed stage are in the last table in the forms.

Extension of Emergency:

- Sometimes the overall regulatory process takes longer than the 18 months of an emergency regulation and a six month extension is needed to allow the final stage to reach completion. This is the case with these three actions.

III. Petition for Rulemaking #336 with Staff Recommendation, p. 150.

IV. Emergency/NOIRA for the Individual and Family Support Program and Periodic Review, p.158.

I. REGULATORY ACTIVITY STATUS REPORT: JULY 2022 (REVISED 07/01/22)

Board	STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES			
VAC CITATION	**CHAPTER TITLE** (FULL TITLE)	**REGULATIONS IN PROCESS**		
		PURPOSE	**STAGE**	**STATUS**
12 VAC 35-46 Certain sections **and NEW** Sections 1150-1250.	**Regulations for Children's Residential Facilities**	In accordance with Item 318.B. of the 2020 Appropriation Act to align with the American Society of Addiction Medicine (ASAM) Levels of Care Criteria or an equivalent set of criteria.	• **Emergency: *To Standard.***	• Effective 2/20/2021. Expires 8/19/2022. Proposed stage public comment period ended 04/15/2022. ➢ *Action requested: Initiate final stage and request extension of the emergency regulation.*
12 VAC 35-46 Certain sections **and NEW** Sections.	*same*	In accordance with Item 318.D. of the 2021 Appropriation Act to align with the requirements of the federal Family First Prevention Service Act to meet the standards as qualified residential treatment programs (QRTPs).	• **Emergency: *To Standard.***	• Effective 01/10/22. Expires 07/09/23. Currently in proposed stage with DPB.
12 VAC 35-46	*same*	To provide the process and standards for licensing children's residential facilities.	• **Completed review.**	• Public comment closed 5/16/2022. *Amend (overhaul); draft in progress.*
12 VAC 35-105 Certain sections.	**Rules and Regulations for Licensing Facilities and Providers of Mental Health, Mental Retardation and Substance Abuse Services**	In accordance with Item 318.B. of the 2020 Appropriation Act, amendments to align with ASAM criteria.	• **Emergency: *To Standard.***	• Effective 2/20/2021. Expires 8/19/2022. ➢ *Action requested: Initiate final stage and request extension of the emergency regulation.*
12 VAC 35-105 Certain sections.	*same*	In accordance with Item 318.B. of the 2020 Appropriation Act, amendments to align with enhanced behavioral health services.	• **Emergency: *To Standard.***	• Effective 2/20/2021. Expires 8/19/2022. ➢ *Action requested: Initiate final stage and request extension of the emergency regulation.*
12 VAC 35-115	**Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services**	To protect the legal and human rights of all individuals who receive services in programs and facilities operated, funded, or licensed by DBHDS.	• **Completed review.**	• A public comment forum closed on 01/25/2021. *Amend; draft in progress.*
12 VAC 35-190	**Regulations for Voluntary Admissions to State Training Centers**	To detail criteria and procedures for voluntarily admitting persons to a state training center>	• **Completed review.**	• Public comment forum ended on 9/20/2021. *Amend minimally; draft in progress.*

12 VAC 35-200	**Regulations for Emergency and Respite Care Admission to State Training Centers**	To establish the conditions and procedures through which an individual can access emergency services and respite care in a state training center.	• **Completed review.**	• Public comment forum closed on 9/20/2021. *Amend minimally; draft in progress.*
12 VAC 35-210	**Regulations to Govern Temporary Leave from State Facilities**	To establish the general process and requirements related to temporary leave from state facilities	• **Completed review.**	➢ Public comment forum closed on 9/20/2021. *Amend minimally; draft in progress.*
12 VAC 35-230	**Operation of the Individual and Family Support Program**	In accordance with the mandate in Item 313.NN. of the 2022 Special Session 1 Appropriation to facilitate compliance with the U. S. Department of Justice's Settlement Agreement with Virginia by establishing criteria, annual funding priorities, and to ensure annual public input.	• ***Emergency/NOIRA and periodic review.***	➢ *Action requested: Initiate emergency/NOIRA and periodic review.*
12 VAC 34-250	**Certified Recovery Residences**	To implement the changes in the Code of Virginia per HB 277/SB 622 (2022) regarding DBHDS certification, minimum square footage, and disclosure of credentialing entity.	• ***Draft in progress.***	• *Expect in September.*

II. Three Actions for Final Stage and Emergency Extension: ASAM (Ch. 46 and Ch. 105), Behavioral Health Expansion (Ch. 105)

Final Stage:

- No changes were made to the regulatory text of the Behavioral Health Expansion action since the previous stage was published.
- Both ASAM actions have changes. At the final stage of regulatory actions, changes are kept to a minimum and are for clarification or correction. In the drafts, all amendments in the final stage are set out by brackets [ ]. Note in the end of the Town Hall forms, there is a table of changes for '*Detail of Changes Made Since the Previous Stage*.' This would be the primary focus for the board's review for final stage. All other amendments unchanged from the proposed stage are in the last table in the forms.

Extension of Emergency:

- Sometimes the overall regulatory process takes longer than the 18 months of an emergency regulation and a six month extension is needed to allow the final stage to reach completion. This is the case with these three actions.

☐ ASAM Final Stage Amendments to Regulations for Children's Residential Facilities [12 VAC 35 - 46], Action 5564.

townhall.virginia.gov

Final Regulation
Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services (DBHDS)
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC35-46
VAC Chapter title(s)	Regulations for Children's Residential Facilities
Action title	Amendments to align with ASAM criteria in the children's residential licensing regulations
Date this document prepared	June 24, 2022

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

The Department of Behavioral Health and Developmental Services (DBDHS) was directed by the 2020 General Assembly within Item 318.B. of the 2020 *Appropriation Act* to utilize emergency authority to promulgate licensing regulations that align with the American Society of Addiction Medicine (ASAM) Levels of Care Criteria or an equivalent set of criteria to ensure the provision of outcome-oriented and strengths-based care in the treatment of addiction. The goal of this regulatory action is to amend the licensing regulations, Regulations for Children's Residential Facilities [12VAC35-46], to align with the ASAM Levels of Care Criteria, which ensure individualized, clinically driven, participant-directed and outcome-informed treatment.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

ASAM – American Society of Addiction Medicine

DBHDS – Department of Behavioral Health and Developmental Services

State Board – State Board of Behavioral Health and Developmental Services

Statement of Final Agency Action

Provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) the name of the agency taking the action; and 3) the title of the regulation.

The State Board voted on July 13, 2022, to initiate the final stage of the action titled "Amendments to align with ASAM Criteria in the children's residential licensing regulations" to amend the Regulations for Children's Residential Facilities (12VAC35-46), with some clarifying edits to the language from the proposed stage to the final stage.

Mandate and Impetus

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding the mandate for this regulatory change, and any other impetus that specifically prompted its initiation. If there are no changes to previously reported information, include a specific statement to that effect.

The 2020 General Assembly directed DBDHS to promulgate emergency regulations to become effective within 280 days or less from the enactment of the *Appropriation Act*. This regulatory action is being utilized to enact permanent regulations following the emergency regulations.

In addition to being mandated by the General Assembly, the regulatory change is necessary as substance use disorders affect individuals, their families, the workplace, and the general community; therefore, DBHDS must incorporate best practices within its licensing regulations in order to promote recovery from the disease of addiction. This is especially a concern with the increase of substance use in general. According to the Monitoring the Futures Survey of 2019, there has been an increase in adolescent marijuana vaping from 2018 to 2019. This increase ranked among the largest single-year increases ever observed by this survey in the past 45 years among all outcomes ever measured. In 2019 the percentage of adolescents who had vaped marijuana in the last 12 months was 21% in 12th grade, 19% in 10th grade, and 7% in 8th grade.

According to the Middle School Virginia Youth Survey conducted by the Virginia Department of Health (VDH), in 2017 approximately 3% of respondents indicated that they used marijuana before age 11 and almost 10% drank alcohol before age 11. That same VDH survey of high school students illustrated that over 30% of this population in 2017 reported using alcohol in the past 30 days. The survey also indicated that 25% of respondents binge drank, 20% reported using marijuana, and approximately 3% used heroin in a 30 day period.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

DBDHS was directed by the 2020 General Assembly within Item 318.B. of the 2020 *Appropriation Act* to utilize emergency authority to promulgate regulations which align with a set of criteria to ensure the provision of outcome oriented and strengths-based care in the treatment of addiction. This regulatory action is being utilized to enact permanent regulations following the emergency regulations. Section 37.2-203 of the Code of Virginia gives the Board of Behavioral Health and Developmental Services the authority to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code and other laws of the Commonwealth administered by the DBHDS commissioner. The State Board of Behavioral Health and Developmental Services voted to adopt this regulatory action on July 13, 2022.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's intended to solve.

Substance related disorders affect the individual, their families, the workplace, and the general community; therefore, the department must incorporate best practices in licensing regulations in order to promote remission and recovery from the disease of addiction. Regulations that promote remission and recovery from the disease of addiction are essential to protect the health and welfare of citizens.

Substance use disorders (SUDs) among children, adolescents, and their families pose particular challenges for the community. Given the differences in developmental and emotional growth between youth and adults, the complex needs of this population are remarkably different from those of the traditional adult treatment population, requiring different expertise and guidance. In addition, many adolescents who abuse drugs have a history of physical, emotional, or sexual abuse, or other trauma.

Behavioral therapies, delivered by trained clinicians, can help an adolescent stay off drugs by strengthening his motivation to change. The ASAM criteria is designed to provide specific substance use disorder treatment guidance to counselors, clinicians, and case managers. Level 3.5 programming is specifically designed for youth and adults that require 24 hour care and treatment to begin and sustain a recovery process. This type of guidance can significantly improve the treatment outcomes of youth in need of residential services.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

This regulatory action amends the Regulations for Children's Residential Facilities [12VAC35- 46] to align with the ASAM Levels of Care Criteria, which ensures individualized, clinically driven, participant-directed and outcome-informed treatment. The regulatory action provides the necessary definitions for the newly aligned services to be provided and creates staff, program admission, discharge, and co-occurring enhanced program criteria for ASAM levels of care 3.5 and 3.1

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

The primary advantage of the regulatory change to the Regulations for Children's Residential Facilities is that citizens of the Commonwealth will receive more effective treatment of substance use disorders. This is an advantage to the public, the agency, and the Commonwealth. The primary disadvantage is that some providers may experience a financial burden in order to comply with the new regulations. There are no known disadvantages to the agency or the Commonwealth.

Requirements More Restrictive than Federal

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any requirement of the regulatory change which is more restrictive than applicable federal requirements. If there are no changes to previously reported information, include a specific statement to that effect.

No requirements within the regulation exceed applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any other state agencies, localities, or other entities that are particularly affected by the regulatory change. If there are no changes to previously reported information, include a specific statement to that effect.

Other State Agencies Particularly Affected:

The Department of Medical Assistance Services (DMAS) may be particularly affected by the regulatory action as DMAS is a payor to many of the DBHDS providers affected by the regulatory action. DBHDS collaborated with DMAS on the development of this regulatory action.

Localities Particularly Affected:

No locality is particularly affected to the knowledge of DBHDS.

Other Entities Particularly Affected:

Providers of substance abuse services may be particularly affected by the regulation in order to come into compliance with the regulations.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

No public comment was received during the public comment period.

Detail of Changes Made Since the Previous Stage

*List all changes made to the text since the previous stage was published in the Virginia Register of Regulations and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

Current chapter-section number	New chapter-section number, if applicable	New requirement from previous stage	Updated new requirement since previous stage	Change, intent, rationale, and likely impact of updated requirements
12VAC35-46-10			Addition of ASAM levels of care to the definitions of "Clinically managed, low-intensity residential care" and "Clinically managed, medium-intensity residential care."	Change: Adding the ASAM levels of care to the definitions of "Clinically managed, low-intensity residential care" and "Clinically managed, medium-intensity residential care." Intent: Clearer and more transparent regulations.
12VAC35-46-1160			Addition of ASAM level of care to the title, and clarifying edit to note that the staff required to be present 24 hours a day are allied professional staff.	Change: The addition of the ASAM level of care will make the regulations more transparent. The clarifying edit that allied health professional staff must be available 24 hours a day is more in line with the ASAM criteria. This notes what type of staff must be present. Intent: Clearer and more transparent regulations.
12VAC35-46-1170			Addition of ASAM level of care to the title. Clarify that MAT shall be made available for individuals with	Change: The addition of the ASAM level of care will make the regulations more transparent. Intent: Clearer and more transparent regulations.

			opioid use disorder or alcohol use disorder.	
12VAC35-46-1180			Addition of ASAM level of care to the title.	Change: The addition of the ASAM level of care will make the regulations more transparent. Intent: clearer and more transparent regulations.
12VAC35-46-1190			Addition of ASAM level of care to the title.	Change: The addition of the ASAM level of care will make the regulations more transparent. Intent: Clearer and more transparent regulations.
12VAC35-46-1200			Addition of ASAM level of care to the title.	Change: The addition of the ASAM level of care will make the regulations more transparent. Intent: Clearer and more transparent regulations.
12VAC35-46-1210			Addition of ASAM level of care to the title.	Change: The addition of the ASAM level of care will make the regulations more transparent. Intent: Clearer and more transparent regulations.
12VAC35-46-1220			Insertion of clarifying edit noting that the five hours a week must be planned clinical program activities. Removal of language that is not in line with ASAM criteria. Clarify that MAT shall be made available for individuals with opioid use disorder or alcohol use disorder.	Change: Insertion of clarifying edit noting that the five hours a week required must be planned clinical program activities. Removal of language that is not in line with ASAM criteria. Intent: Clearer and more transparent regulations.
12VAC35-46-1230			Addition of ASAM level of care to the title.	Change: The addition of the ASAM level of care will make the regulations more transparent. Intent: Clearer and more transparent regulations.

12VAC35-46-1240			Addition of ASAM level of care to the title.	Change: The addition of the ASAM level of care will make the regulations more transparent. Intent: Clearer and more transparent regulations.
12VAC35-46-1250			Addition of ASAM level of care to the title.	Change: The addition of the ASAM level of care will make the regulations more transparent. Intent: Clearer and more transparent regulations.

Detail of All Changes Proposed in this Regulatory Action

*List all changes proposed in this action and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of updated requirements
12VAC35-46-10. Definitions.		Provides current definitions for the Children's Residential Licensing Regulations.	Change: Adding the following definitions for terms utilized within the ASAM criteria: • Allied health professional; • ASAM; • Clinically managed, low-intensity residential care; • Clinically managed, medium intensity residential care; • DSM; • Medicated assisted treatment; and • Motivational enhancement Impact: Clear and transparent regulations.
	12VAC35-46-1150 (Reserved).		Intent: Space saver section.
	12VAC35-46-1160. Clinically managed, medium intensity		Intent: Provide clear staff requirements within clinically managed, medium intensity residential care programs, which provide 24 hour supportive treatment. The individuals served by clinically

	residential services staff criteria.		managed medium-intensity residential care are individuals who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-46-1170. Clinically managed medium-intensity residential services program criteria.		Intent: Provide clear program requirements within clinically managed, medium intensity residential care programs, which provide 24 hour supportive treatment. The individuals served by clinically managed, medium intensity residential care are individuals who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-46-1180. Clinically managed, medium intensity residential services admission criteria.		Intent: Provide clear admission requirements within clinically managed, medium intensity residential service programs Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-46-1190. Clinically managed medium intensity residential services discharge criteria.		Intent: Provide clear discharge requirements within clinically-managed medium-intensity residential service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-46-1200. Clinically managed medium intensity residential services co-occurring enhanced programs.		Intent: Provide additional licensing requirements for medium-intensity residential services programs, which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.

	12VAC35-46-1210. Clinically managed low-intensity residential services staff criteria.		Intent: Provide clear staff requirements within clinically managed low-intensity residential service program, which provide ongoing therapeutic environment for individuals requiring some structured support. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-46-1220. Clinically managed low-intensity residential services program criteria.		Intent: Provide clear program requirements within clinically managed low-intensity residential service programs, which provide ongoing therapeutic environment for individuals requiring some structured support. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-46-1230. Clinically managed low-intensity residential services admission criteria.		Intent: Provide clear admission requirements within clinically managed low-intensity residential service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-46-1240. Clinically-managed low-intensity residential services discharge criteria.		Intent: Provide clear discharge requirements within clinically managed low-intensity residential service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-46-1250. Clinically-managed low-intensity residential services co-occurring enhanced programs.		Intent: Provide additional licensing requirements for clinically managed low-intensity residential service programs, which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.

Amendments to Align with ASAM Criteria in Children's Residential Facilities

12VAC35-46-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise.

"Allegation" means an accusation that a facility is operating without a license or receiving public funds for services it is not certified to provide.

"Allied health professional" means a professional who is involved with the delivery of health or related services pertaining to the identification, evaluation, and prevention of diseases and disorders, such as a certified substance abuse counselor, certified substance abuse counseling assistant, peer recovery support specialist, certified nurse aide, or occupational therapist.

"Annual" means within 13 months of the previous event or occurrence.

"Applicable state regulation" means any regulation that the department determines applies to the facility. The term includes, but is not necessarily limited to, regulations promulgated by the Departments of Education, Health, Housing and Community Development, or other state agencies.

"Applicant" means the person, corporation, partnership, association, or public agency that has applied for a license.

"ASAM" means the American Society of Addiction Medicine.

"Aversive stimuli" means the physical forces (e.g., sound, electricity, heat, cold, light, water, or noise) or substances (e.g., hot pepper sauce or pepper spray) measurable in duration and intensity that when applied to a resident are noxious or painful to the resident but in no case shall the term "aversive stimuli" include striking or hitting the individual with any part of the body or with an implement or pinching, pulling, or shaking the resident.

"Behavior support" means those principles and methods employed by a provider to help a child achieve positive behavior and to address and correct a child's inappropriate behavior in a constructive and safe manner in accordance with written policies and procedures governing program expectations, treatment goals, child and staff safety and security, and the child's individualized service plan.

"Behavior support assessment" means identification of a resident's behavior triggers, successful intervention strategies, anger and anxiety management options for calming, techniques for self-management, and specific goals that address the targeted behaviors that lead to emergency safety interventions.

"Body cavity search" means any examination of a resident's rectal or vaginal cavities, except the performance of medical procedures by medical personnel.

"Brain injury" means any injury to the brain that occurs after birth, but before age 65, that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include~~, but are not limited to,~~ anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. Brain injury does not include hereditary, congenital, or degenerative brain disorders, or injuries induced by birth trauma.

"Brain Injury Waiver" means a Virginia Medicaid home and community-based waiver for persons with brain injury approved by the Centers for Medicare and Medicaid Services.

"Care" or "treatment" means a set of individually planned interventions, training, habilitation, or supports that help a resident obtain or maintain an optimal level of functioning, reduce the effects of disability or discomfort, or ameliorate symptoms, undesirable changes, or conditions specific to physical, mental, behavioral, or social functioning.

"Child" means any person legally defined as a child under state law. The term includes residents and other children coming into contact with the resident or facility (e.g., visitors). When the term is used, the requirement applies to every child at the facility regardless of whether the child has been admitted to the facility for care (e.g., ~~staff/child~~ staff to child ratios apply to all children present even though some may not be residents).

"Child-placing agency" means any person licensed to place children in foster homes or adoptive homes or a local board of social services authorized to place children in foster homes or adoptive homes.

"Children's residential facility" or "facility" means a publicly or privately operated facility, other than a private family home, where 24-hour per day care is provided to children separated from their legal guardians and is required to be licensed or certified by the Code of Virginia except:

1. Any facility licensed by the Department of Social Services as a child-caring institution as of January 1, 1987, and that receives public funds; and

2. Acute-care private psychiatric hospitals serving children that are licensed by the Department of Behavioral Health and Developmental Services under the Rules and Regulations for ~~the~~ Licensing ~~of~~ Providers ~~of Mental Health, Mental Retardation and Substance Abuse, the Individual and Family Developmental Disabilities Support Waiver, and Residential Brain Injury~~ by the Department of Behavioral Health and Developmental Services, 12VAC35-105.

"Clinically managed, low-intensity residential care" [or "Level of care 3.1"] means providing an ongoing therapeutic environment for children requiring some structured support in which treatment is directed toward applying recovery skills; preventing relapse; improving emotional functioning; promoting personal responsibility; reintegrating the child into work, education, and family environments; and strengthening adaptive skills that may not have been achieved or have been diminished during the child's active addiction. A clinically managed, low-intensity residential care is also designed for the child suffering from chronic, long-term alcoholism or drug addiction and affords an extended period of time to establish sound recovery and a solid support system.

"Clinically managed, medium-intensity residential care" [or "Level of care 3.5"]means a substance use treatment program that offers 24-hour supportive treatment of children with significant psychological and social problems by credentialed addiction treatment professionals in an interdisciplinary treatment approach. The children served by

clinically managed, medium-intensity residential care are children who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service.

"Commissioner" means the Commissioner of the Department of Behavioral Health and Developmental Services or his authorized agent.

"Complaint" means an accusation against a licensed facility regarding an alleged violation of regulations or law.

"Contraband" means any item prohibited by law or by the rules and regulations of the department, or any item that conflicts with the program or safety and security of the facility or individual residents.

"Corporal punishment" means punishment administered through the intentional inflicting of pain and discomfort to the body through actions such as, but not limited to (i) striking or hitting with any part of the body or with an implement; or (ii) any similar action that normally inflicts pain or discomfort.

"Counseling" means certain formal treatment interventions such as individual, family, and group modalities that provide for support and problem solving. Such interventions take place between provider staff and resident families or groups and are aimed at enhancing appropriate psychosocial functioning or personal sense of well-being.

"Corrective action plan" means the provider's pledged corrective action in response to cited areas of noncompliance documented by the department. A corrective action plan must be completed within a specified time.

"Crisis" means any acute emotional disturbance in which a resident presents an immediate danger to self or others or is at risk of serious mental or physical health deterioration caused by acute mental distress, behavioral or situational factors, or acute substance abuse related problems.

"Crisis intervention" means those activities aimed at the rapid management of a crisis.

"Day" means calendar day unless the context clearly indicates otherwise.

"Department" or "DBHDS" means the Department of Behavioral Health and Developmental Services ~~(DBHDS)~~.

"Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or a combination of mental and physical impairments other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to nine years of age, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability

without meeting three or more of the criteria described in clauses (i) through (v) if the individual without services and supports has a high probability of meeting those criteria later in life.

"Diagnostic and Statistical Manual of Mental Disorders" or "DSM" means the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, DSM-5, of the American Psychiatric Association.

"DOE" means the Department of Education.

"Emergency" means a sudden, generally unexpected occurrence or set of circumstances demanding immediate action. Emergency does not include regularly scheduled time off for permanent staff or other situations that should reasonably be anticipated.

"Emergency admission" means the sudden, unplanned, unexpected admittance of a child who needs immediate care or a court-ordered placement.

"Goal" means expected results or conditions that usually involve a long period of time and that are written in behavioral terms in a statement of relatively broad scope. Goals provide guidance in establishing specific short-term objectives directed toward the attainment of the goal.

"Good character and reputation" means findings have been established and knowledgeable and objective people agree that the individual maintains business or professional, family, and community relationships that are characterized by honesty, fairness, truthfulness, and dependability, and has a history or pattern of behavior that demonstrates that the individual is suitable and able to care for, supervise, and protect children. Relatives by blood or marriage, and persons who are not knowledgeable of the individual, such as recent acquaintances, shall not be considered objective references.

"Group home" means a children's residential facility that is a community-based, homelike single dwelling, or its acceptable equivalent, other than the private home of the operator, and serves up to 12.

"Health record" means the file maintained by the provider that contains personal health information.

"Human research" means any systematic investigation including research development, testing, and evaluation, utilizing human subjects, that is designed to develop or contribute to generalized knowledge. Human research shall not include research exempt from federal research regulations pursuant to 45 CFR 46.101(b).

"Immediately" means directly without delay.

"Independent living program" means a competency-based program that is specifically approved by the department to provide the opportunity for the residents to develop the skills necessary to live successfully on their own following completion of the program.

"Individualized service plan" means a written plan of action developed and modified at intervals to meet the needs of a specific resident. It specifies measurable short and

long-term goals, objectives, strategies, and time frames for reaching the goals and the individuals responsible for carrying out the plan.

"Intellectual disability" means ~~mental retardation~~ a disability originating before 18 years of age, characterized concurrently by (i) significant subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with accepted professional practice that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

"Legal guardian" means the natural or adoptive parents or other person, agency, or institution that has legal custody of a child.

"License" means a document verifying approval to operate a children's residential facility and that indicates the status of the facility regarding compliance with applicable state regulations.

"Live-in staff" means staff who are required to be on duty for a period of 24 consecutive hours or more during each work week.

"Living unit" means the space in which a particular group of children in care of a residential facility reside. A living unit contains sleeping areas, bath and toilet facilities, and a living room or its equivalent for use by the residents of the unit. Depending upon its design, a building may contain one living unit or several separate living units.

"Mechanical restraint" means the use of a mechanical device that cannot be removed by the individual to restrict the freedom of movement or functioning of a limb or a portion of an individual's body when that behavior places him or others at imminent risk.

"Medication" means prescribed and over-the-counter drugs.

"Medication administration" means the direct application of medications by injection, inhalation, or ingestion or any other means to a resident by (i) persons legally permitted to administer medications; or (ii) the resident at the direction and in the presence of persons legally permitted to administer medications.

"Medication assisted treatment" or "MAT" means the use of U.S. Food and Drug Administration-approved medications in combination with counseling and behavioral therapies to provide treatment of substance use disorders.

"Medication error" means an error made in administering a medication to a resident including the following: (i) the wrong medication is given to the resident; (ii) the wrong resident is given the medication; (iii) the wrong dosage is given to a resident; (iv) medication is given to a resident at the wrong time or not at all; and (v) the proper method is not used to give the medication to the resident. A medication error does not include a resident's refusal of offered medication.

~~"Mental retardation" ("intellectual disability") means a disability originating before the age of 18 years characterized concurrently by (i) significantly subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at~~

~~least two standard deviations below the mean; and (ii) significant limitations in adaptive behavior as expressed as conceptual, social, and practical adaptive skills (§ 37.2-100 of the Code of Virginia). According to the American Association of Intellectual Disabilities (AAID) definition, these impairments should be assessed in the context of the individual's environment, considering cultural and linguistic diversity as well as differences in communication, and sensory motor and behavioral factors. Within an individual limitations often coexist with strengths. The purpose of describing limitations is to develop a profile of needed supports. With personalized supports over a sustained period, the functioning of an individual will improve. In some organizations the term "intellectual disability" is used instead of "mental retardation."~~

"Motivational enhancement" means a person-centered approach that is collaborative, employs strategies to strengthen motivation for change, increases engagement in substance use services, resolves ambivalence about changing substance use behaviors, and supports individuals to set goals to change their substance use.

"Neurobehavioral services" means the assessment, evaluation, and treatment of cognitive, perceptual, behavioral, and other impairments caused by brain injury, that affect an individual's ability to function successfully in the community.

"Objective" means expected short-term results or conditions that must be met in order to attain a goal. Objectives are stated in measurable, behavioral terms and have a specified time for achievement.

"On-duty" means that period of time during which a staff person is responsible for the supervision of one or more children.

~~"On-site"~~ "On-site" means services that are delivered by the provider and are an integrated part of the overall service delivery system.

"Parent" means a natural or adoptive parent or surrogate parent appointed pursuant to DOE's regulations governing special education programs for students with disabilities.~~"~~ "Parent" means either parent unless the facility has been provided documentation that there is a legally binding instrument, a state law, or court order governing such matters as divorce, separation, or custody, that provides to the contrary.

"Pat down" means a thorough external body search of a clothed resident.

"Personal health information" means oral, written, or otherwise recorded information that is created or received by an entity relating to either an individual's physical or mental health or the provision of or payment for health care to an individual.

"Placement" means an activity by any person that provides assistance to a parent or legal guardian in locating and effecting the movement of a child to a foster home, adoptive home, or children's residential facility.

"Premises" means the tracts of land on which any part of a residential facility for children is located and any buildings on such tracts of land.

"Provider" means any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) residential services to

children with mental illness, ~~mental retardation (intellectual disability)~~ developmental disability, or substance abuse; or (ii) residential services for persons with brain injury.

"Record" means up-to-date written or automated information relating to one resident. This information includes social data, agreements, all correspondence relating to the care of the resident, service plans with periodic revisions, aftercare plans and discharge summary, and any other data related to the resident.

"Resident" means a person admitted to a children's residential facility for supervision, care, training, or treatment on a 24-hour per day basis.

"Residential treatment program" means 24-hour, supervised, medically necessary, out-of-home programs designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, or training needs of a child or adolescent in order to prevent or minimize the need for more intensive inpatient treatment. Services include, but shall not be limited to, assessment and evaluation, medical treatment (including medication), individual and group counseling, neurobehavioral services, and family therapy necessary to treat the child. The service provides active treatment or training beginning at admission related to the resident's principle diagnosis and admitting symptoms. These services do not include interventions and activities designed only to meet the supportive nonmental health special needs including~~, but not limited to,~~ personal care, habilitation, or academic educational needs of the resident.

"Respite care facility" means a facility that is specifically approved to provide short-term, periodic residential care to children accepted into its program in order to give the parents or legal guardians temporary relief from responsibility for their direct care.

"Rest day" means a period of not less than 24 consecutive hours during which a staff person has no responsibility to perform duties related to the facility.

"Restraint" means the use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an individual from moving his body to engage in a behavior that places him or others at imminent risk. There are three kinds of restraints:

1. Mechanical restraint means the use of a mechanical device that cannot be removed by the individual to restrict the freedom of movement or functioning of a limb or a portion of an individual's body when that behavior places him or others at imminent risk.

2. Pharmacological restraint means the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that individual's behavior places him or others at imminent risk and the administered medication is not a standard treatment for the individual's medical or psychiatric condition.

3. Physical restraint, also referred to as manual hold, means the use of a physical intervention or hands-on hold to prevent an individual from moving his body when that individual's behavior places him or others at imminent risk.

"Routine admission" means the admittance of a child following evaluation of an application for admission and execution of a written placement agreement.

"Rules of conduct" means a listing of a facility's rules or regulations that is maintained to inform residents and others about behaviors that are not permitted and the consequences applied when the behaviors occur.

"Sanitizing agent" means any substance approved by the Environmental Protection Agency to destroy bacteria.

"Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person by physically blocking the door, or by any other physical or verbal means so that the individual cannot leave it.

"Self-admission" means the admittance of a child who seeks admission to a temporary care facility as permitted by Virginia statutory law without completing the requirements for "routine admission."

"Serious incident" means:

1. Any accident or injury requiring medical attention by a physician;

2. Any illness that requires hospitalization;

3. Any overnight absence from the facility without permission;

4. Any runaway; or

5. Any event that affects, or potentially may affect, the health, safety, or welfare of any resident being served by the provider.

"Serious injury" means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician.

"Service" ~~or "services"~~ means planned individualized interventions intended to reduce or ameliorate mental illness, ~~mental retardation (intellectual disability)~~ developmental disability, or substance abuse through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, ~~mental retardation (intellectual disability)~~ developmental disability, or substance abuse. Services include residential services, including those for persons with brain injury.

"Severe weather" means extreme environment or climate conditions that pose a threat to the health, safety, or welfare of residents.

"Social skills training" means activities aimed at developing and maintaining interpersonal skills.

"Strategies" means a series of steps and methods used to meet goals and objectives.

"Strip search" means a visual inspection of the body of a resident when that resident's outer clothing or total clothing is removed and an inspection of the removed clothing. Strip searches are conducted for the detection of contraband.

"Structured program of care" means a comprehensive planned daily routine including appropriate supervision that meets the needs of each resident both individually and as a group.

"Student/intern" means an individual who simultaneously is affiliated with an educational institution and a residential facility. Every student/intern who is not an employee is either a volunteer or contractual service provider depending upon the relationship among the student/intern, educational institution, and facility.

"Substantial compliance" means that while there may be noncompliance with one or more regulations that represents minimal risk, compliance clearly and obviously exists with most of the regulations as a whole.

"Systemic deficiency" means violations documented by the department that demonstrate defects in the overall operation of the facility or one or more of its components.

"Target population" means individuals with a similar, specified characteristic or disability.

"Temporary contract worker" means an individual who is not a direct salaried employee of the provider but is employed by a third party and is not a consistently scheduled staff member.

"Therapy" means provision of direct diagnostic, preventive, and treatment services where functioning is threatened or affected by social and psychological stress or health impairment.

"Time out" means the involuntary removal of a resident by a staff person from a source of reinforcement to a different open location for a specified period of time or until the problem behavior has subsided to discontinue or reduce the frequency of problematic behavior.

"Treatment" means individually planned, sound, and therapeutic interventions that are intended to improve or maintain functioning of an individual receiving services in those areas that show impairment as the result of mental disability, substance addiction, or physical impairment. In order to be considered sound and therapeutic, the treatment must conform to current acceptable professional practice.

"Variance" means temporary or permanent waiver of compliance with a regulation or portion of a regulation, or permission to meet the intent of the regulation by a method other than that specified in the regulation, when the department, in its sole discretion, determines (i) enforcement will create an undue hardship and (ii) resident care will not be adversely affected.

"Volunteers" means any individual or group who of their own free will, and without any financial gain, provides goods and services to the program without compensation.

12VAC35-46-1150. (Reserved).

12VAC35-46-1160. Clinically managed, medium-intensity residential services [Level of care 3.5] staff criteria.

A clinically managed, medium-intensity residential care program shall meet the following staff requirements. The program shall:

1. Ensure the availability of emergency consultation with a licensed physician by telephone or in person in case of emergency related to an individual's substance use disorder, available 24 hours a day, seven days a week. The program shall also provide [allied health professional] staff 24 hours a day;

2. Provide licensed clinicians who are able to obtain and interpret information regarding the signs and symptoms of intoxication and withdrawal, as well as the appropriate monitoring and treatment of those conditions and how to facilitate entry into ongoing care;

3. Provide appropriately trained staff who are competent to implement physician-approved protocols for the child's or adolescent's observation, supervision, and treatment, including over the counter medications for symptomatic relief, determination for the appropriate level of care, and facilitation of the child's or adolescent's transition to continuing care;

4. Provide staff training that shall include at a minimum the requirements within 12VAC35-46-310, and all staff administering over the counter medications shall complete the training program approved by the Board of Nursing and required by subsection L of § 54.1-3408 of the Code of Virginia;

5. Provide access, as needed, to medical evaluation and consultation, which shall be available 24 hours a day to monitor the safety and outcome of withdrawal management in this setting, in accordance with the provider's written criteria for admission and discharge as required by 12VAC35-46-640 and 12VAC35-46-765; and

6. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-46-1170. Clinically managed, medium-intensity residential services [Level of care 3.5] program criteria.

A clinically managed, medium-intensity residential care program shall meet the following programmatic requirements. The program shall:

1. Provide daily clinical services, including a range of cognitive, behavioral, and other therapies in individual or group therapy, programming, and psychoeducation as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

2. Provide counseling and clinical interventions to teach a child or adolescent the skills needed for daily productive activity, prosocial behavior, and reintegration into family and community;

3. Provide motivational enhancement and engagement strategies appropriate to the child's or adolescent's stage of readiness to change and level of comprehension;

4. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;

5. Provide family and caregiver treatment services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

6. Provide educational, vocational, and informational programming adaptive to individual needs;

7. Utilize random drug screening to monitor progress and reinforce treatment gains as appropriate to an individual treatment plan;

8. Ensure and document that the length of stay is determined by the child's or adolescent's condition and functioning;

9. Make medication assisted treatment (MAT) available for all individuals [with opioid use disorder or alcohol use disorder]. MAT may be provided by facility staff or coordinated through alternative resources;

10. Provide educational services in accordance with state law to maintain the educational and intellectual development of the child or adolescent while they are admitted to the service. When indicated, additional educational opportunities shall be provided to remedy deficits in the educational level of children or adolescents who have fallen behind because of their involvement with alcohol and other drugs;

11. Ensure that all children and adolescents served by the residential service have access to the substance use treatment program; and

12. Provide daily clinical services to assess and address the child's or adolescent's withdrawal status and service needs. This may include nursing or medical monitoring, use of medications to alleviate symptoms, or individual or group therapy or programming specific to withdrawal and withdrawal support.

12VAC35-46-1180. Clinically managed, medium-intensity residential services [Level of care 3.5] admission criteria.

A. A clinically managed, medium-intensity residential care program provides treatment for children who have impaired functioning across a broad range of psychosocial domains, including disruptive behaviors, delinquency and juvenile justice involvement, educational difficulties, family conflicts and chaotic home situations, developmental immaturity, and psychological problems.

B. Before a clinically managed, medium-intensity residential service program may admit a child or adolescent, the child or adolescent shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the child or adolescent to:

1. Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate to high severity as defined by the DSM; and

2. Meet the admission criteria of Level 3.5 of ASAM, including the specific criteria for adolescent populations.

12VAC35-46-1190. Clinically managed, medium-intensity residential services [Level of care 3.5] discharge criteria.

Before a clinically managed, medium-intensity residential service program may discharge or transfer a child or adolescent, the child or adolescent shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of children or adolescents who have:

1. Achieved the goals of the treatment services and no longer require ASAM 3.5 level of care;

2. Been unable to achieve the goals of the child's or adolescent's treatment but could achieve the child's or adolescent's goals with a different type of treatment; or

3. Achieved the child's or adolescent's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

12VAC35-46-1200. Clinically managed, medium-intensity residential services [Level of care 3.5] co-occurring enhanced programs.

A. Clinically managed, medium-intensity residential services co-occurring enhanced programs shall offer psychiatric services, medication evaluation, and laboratory services. Such services shall be available by telephone within eight hours and onsite or closely coordinated offsite within 24 hours.

B. Clinically managed, medium-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals, including addiction psychiatrists, who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Clinically managed, medium-intensity residential services co-occurring enhanced programs shall offer planned clinical activities designed to stabilize the child's or adolescent's mental health problems and psychiatric symptoms and to maintain such stabilization, including medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental disorder.

12VAC35-46-1210. Clinically managed, low-intensity residential services [Level of care 3.1] staff criteria.

A clinically managed, low-intensity residential services program shall meet the following staff requirements. The program shall:

1. Offer telephone or in-person consultation with a physician and emergency services, available 24 hours a day, seven days a week by the clinically managed, low-intensity residential services provider. The program shall also provide allied health professional staff present onsite 24 hours a day;

2. Have clinical staff, with the credentials described in subdivision 3 of this section, who are knowledgeable about the biological and psychosocial dimensions of substance use

disorder and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions;

3. Have a team comprised of appropriately trained and credentialed medical, addiction, and mental health professionals; and

4. Have staff that shall be knowledgeable about child or adolescent development and experienced in engaging and working with children or adolescents.

5. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-46-1220. Clinically managed, low-intensity residential services [Level of care 3.1] program criteria.

A clinically managed, low-intensity residential services program shall meet the following programmatic requirements. The program shall:

1. Offer a minimum of five hours a week of [planned clinical program activities which are] professionally directed [~~treatment~~,] in addition to other treatment services offered to children or adolescents [~~, such as partial hospitalization or intensive outpatient treatment~~]. Services shall be designed to stabilize the child's or adolescent's substance use disorder, improve the child's or adolescent's ability to structure, and organize the tasks of daily living and recovery;

2. Collaborate with care providers to develop an individual treatment plan for each child or adolescent with time-specific goals and objectives;

3. Provide counseling and clinical monitoring to support successful initial involvement in regular, productive daily activity;

4. Provide case management services;

5. Provide motivational interventions appropriate to the child's or adolescent's stage of readiness to change and level of comprehension;

6. Maintain direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services. Include the ability to arrange for needed procedures as appropriate to the severity and urgency of the child's or adolescent's condition;

7. Provide family and caregiver treatment and peer recovery support services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

8. Provide addiction pharmacotherapy and the ability to arrange for pharmacotherapy for psychiatric medications;

9. Utilize random drug screening to monitor progress and reinforce treatment gains;

10. Ensure that all children and adolescents served by the residential service have access to the substance use treatment program; and

11. Make MAT available for all children [with opioid use disorder or alcohol use disorder]. MAT may be provided by facility staff or coordinated through alternative resources.

12VAC35-46-1230. Clinically managed, low-intensity residential services [Level of care 3.1] admission criteria.

Before a clinically managed, low-intensity residential service program may admit a child or adolescent, the child or adolescent shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the child or adolescent to:

1. Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate to high severity as defined by the DSM; and

2. Meet the admission criteria of Level 3.1 of ASAM, including the specific criteria of adolescent populations.

12VAC35-46-1240. Clinically managed, low-intensity residential services [Level of care 3.1] discharge criteria.

Before a clinically managed, low-intensity residential service program may discharge or transfer a child or adolescent, the child or adolescent shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of children or adolescents who have:

1. Achieved the goals of the treatment services and no longer require ASAM 3.1 level of care;

2. Been unable to achieve the goals of the child's or adolescent's treatment but could achieve the child's or adolescent's goals with a different type of treatment; or

3. Achieved the child's or adolescent's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

12VAC35-46-1250. Clinically managed, low-intensity residential services [Level of care 3.1] co-occurring enhanced programs.

A. Clinically managed, low-intensity residential services co-occurring enhanced programs shall offer appropriate psychiatric services, including medication evaluation and laboratory services. Such services shall be provided onsite or closely coordinated offsite, as appropriate to the severity and urgency of the child's or adolescent's mental condition.

B. Clinically managed, low-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals who are able to assess and treat co-occurring disorders with the capacity to involve addiction-trained psychiatrists.

C. Clinically managed, low-intensity residential services co-occurring enhanced programs shall offer planned clinical activities that are designed to stabilize the child's or

adolescent's mental health problems and psychiatric symptoms and to maintain such stabilization, including medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental disorder.

Documents Incorporated by Reference (12VAC35-46)

Report of Tuberculosis Screening, Virginia Department of Health, http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/Tuberculosis/Forms/documents/Form2.pdf.

U.S. Department of Health and Human Services and U.S. Department of Agriculture Dietary Guidelines for Americans, 6th Edition, January 2005, U.S. Government Printing Office, Washington, D.C.

The ASAM: Treatment for Addictive, Substance-Related and Co-Occurring Conditions, Third Edition, American Society of Addiction Medicine, 11400 Rockville Pike, Suite 200, Rockville, MD 20852, asam.org.

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. DSM-5, American Psychiatric Association, 800 Maine Avenue, SW, Suite 900 Washington, DC 20024, psychiatry.org

☐ **ASAM Final Stage Amendments to Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services [12 VAC 35 - 105], Action 5563.**

townhall.virginia.gov

Final Regulation
Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services (DBHDS)

Virginia Administrative Code (VAC) Chapter citation(s)	12VAC35-105
VAC Chapter title(s)	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services
Action title	Amendments to align with the ASAM Criteria
Date this document prepared	June 24, 2022

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

The Department of Behavioral Health and Developmental Services (DBHDS) was directed by the 2020 General Assembly within Item 318. B. of the 2020 *Appropriation Act* to utilize emergency authority to promulgate licensing regulations that align with the American Society of Addiction Medicine Levels of Care Criteria (ASAM) or an equivalent set of criteria to ensure the provision of outcome-oriented and strengths-based care in the treatment of addiction. The goal of this regulatory action is to amend the licensing regulation, Rules and Regulations for Licensing Providers by the DBHDS ("Licensing Regulations"), 12VAC35-105, to align with the ASAM Levels of Care Criteria which ensures individualized, clinically driven, participant-directed and outcome-informed treatment.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

ASAM – American Society of Addiction Medicine

DBHDS – Department of Behavioral Health and Developmental Services

DMAS – The Department of Medical Assistance Services

State Board – State Board of Behavioral Health and Developmental Services

Statement of Final Agency Action

Provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) the name of the agency taking the action; and 3) the title of the regulation.

The State Board voted on July 13, 2022, to initiate the final stage of the action titled "Amendments to align with the ASAM Criteria" to amend the Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (12VAC35-105), with some clarifying edits to the language from the proposed stage to the final stage.

Mandate and Impetus

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding the mandate for this regulatory change, and any other impetus that specifically prompted its initiation. If there are no changes to previously reported information, include a specific statement to that effect.

The 2020 General Assembly directed DBHDS to promulgate emergency regulations to become effective within 280 days or less from the enactment of Item 318. B. of the 2020 *Appropriation Act*. This regulatory action is being utilized to establish permanent regulations following the emergency regulations.

In addition to the mandate from the General Assembly, this regulatory action is needed to incorporate best practices into the Licensing Regulations in order to promote recovery from the disease of addiction because substance-related disorders affect individuals, their families, the workplace, and the general community. Executive Order 9 (2016) declared the opioid addiction crisis a public health emergency in Virginia. Since that time, DBHDS and a number of sister agencies have worked to make policy changes to address the crisis.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

DBHDS was directed by the 2020 General Assembly within the *Appropriation Act* to utilize emergency authority to promulgate regulations which align with a set of criteria to ensure the provision of outcome-oriented and strengths-based care in the treatment of addiction. Item 318 of the 2020 Acts of Assembly Chapter 1289 charges the Department to make the changes within this regulatory action. Section 37.2-203 of the Code of Virginia gives the State Board of Behavioral Health and Developmental Services the authority to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the DBHDS Commissioner. The State Board of Behavioral Health and Developmental Services voted to adopt this regulatory action on July 13, 2022.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's intended to solve.

The purpose of this regulatory action is to align Virginia's licensing regulations with the ASAM levels of care criteria. This alignment is necessary to incorporate best practices into the Licensing Regulations in order to promote remission and recovery from the disease of addiction. Regulations that promote remission and recovery from the disease of addiction are essential to protecting the health and welfare of the citizens of Virginia.

Substance related disorders affective individuals needing or receiving DBHDS provider services, their families, the workplace, and the general community. An essential component of Virginia's efforts to address the opioid epidemic is ensuring that a range of quality, evidence-based, substance use related

services that span the spectrum of levels of care are available throughout the Commonwealth. The alignment of Virginia's DBHDS's licensing regulations with the ASAM criteria will help advance that effort.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

This regulatory action amends the Licensing Regulations to align with the ASAM Levels of Care Criteria which ensures individualized, clinically driven, individual-directed, and outcome-informed treatment. The regulatory action provides the necessary definitions for the newly aligned services to be provided and creates, staff, program, admission, discharge, and co-occurring enhanced program for ASAM levels of care:

- 4.0 (Medically managed intensive inpatient services),
- 3.7 (Medically monitored intensive inpatients services),
- 3.5 (Clinically managed high-intensity residential services),
- 3.3 (Clinically managed population-specific high-intensity residential services),
- 3.1 (Clinically managed low-intensity residential services),
- 2.5 (Substance abuse partial hospitalization services),
- 2.1 (Substance abuse intensive outpatient services)
- 1.0 (Substance abuse outpatient services), and
- Medication assisted opioid treatment services.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

The primary advantage of the regulatory change is licensing regulations that incorporate best practices related to treatment of substance related conditions, which in turn will result in citizens receiving more effective treatment of substance related conditions. This is an advantage to the public, the agency, and the Commonwealth. The primary disadvantage is that some providers may experience a financial burden in order to comply with the new regulations. There are no known disadvantages to the agency or the Commonwealth.

Requirements More Restrictive than Federal

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any requirement of the regulatory change which is more restrictive than applicable federal requirements. If there are no changes to previously reported information, include a specific statement to that effect.

No requirements within the regulation exceed applicable federal requirements. The requirements regarding opioid treatment programs bring the Licensing Regulations into alignment with the federal regulations regarding Certification and Treatment Standards for Opioid Treatment Programs (42 CFR Part 8 Subpart C).

Agencies, Localities, and Other Entities Particularly Affected

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any other state agencies, localities, or other entities that are particularly affected by the regulatory change. If there are no changes to previously reported information, include a specific statement to that effect.

Other State Agencies Particularly Affected

The Department of Medical Assistance Services (DMAS) may be particularly affected by the regulatory action as DMAS is a payor to many of the DBHDS providers affected by this regulatory action. DBHDS collaborated with DMAS on the development of every stage of this regulatory action. A majority of the proposed edits from the proposed stage to the final stage are changes requested by DMAS.

Localities Particularly Affected

No locality is particularly affected to the knowledge of DBHDS.

Other Entities Particularly Affected

Providers of substance abuse services may be particularly affected by the regulation in order to come into compliance with the regulations.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

The Department received only one comment, related to an individual receiving services no longer being able to receive private duty nursing services. As this comment is outside the scope of this action, it is not addressed here; however, the Department reached out to the commenter to assist them privately with receiving services.

Detail of Changes Made Since the Previous Stage

*List all changes made to the text since the previous stage was published in the Virginia Register of Regulations and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

Current chapter-section number	New chapter-section number, if applicable	New requirement from previous stage	Updated new requirement since previous stage	Change, intent, rationale, and likely impact of updated requirements

12VAC35-105-20			Addition of the term: [“Addition" means a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Addiction is defined as the inability to consistently abstain, impairment in behavioral control, persistence of cravings, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.]	The addition of the term “Addiction” is a clarifying edit requested by DMAS to ensure transparency of the regulations. This definition of addiction comes from ASAM.
			Within the definition of each ASAM service the numerical level of care was added.	This is a clarifying edit requested by providers, internal DBHDS subject matter experts, and other agencies as providers and specialists often refer to the level of care number rather than the name of the ASAM service.
			An edit was made to the definition of credentialed addiction treatment professional was made changing and combining the terms “a licensed clinical nurse specialist” and “a licensed psychiatric nurse practitioner” to (vii) a licensed [~~psychiatric clinical~~] nurse [~~specialist~~ practitioner with experience or training in psychiatry or	This edit more accurately reflects the title of these specialists within the Commonwealth of Virginia, given recent regulatory changes by the Department of Health Professions.

			mental health] ; (viii) [~~a licensed psychiatric nurse practitioner; (ix)~~]	
			Edits were made to the definition of “medication assisted opioid treatment” and “medication assisted treatment” as follows: "Medication assisted opioid treatment ~~(Opioid treatment service)~~" means an intervention [~~strategy that combines outpatient treatment with the~~of] administering or dispensing of [~~synthetic narcotics~~medications], such as methadone, ~~or~~ buprenorphine [~~(suboxone)~~], or naltrexone approved by the federal Food and Drug Administration for the purpose of [~~replacing the use of and reducing the craving for~~ treating] opioid [~~substances, such as heroin or other narcotic drugs~~use disorder]. "Medication assisted treatment" or "MAT" means the use of U.S. Food and Drug Administration approved medications in combination with counseling and behavioral therapies to provide treatment of substance use disorders. Medication assisted treatment includes [~~medications assisted~~ medications for] opioid [use disorder as well as medications for] treatment [of alcohol use disorder].	These are clarifying edits requested by subject matter experts to simplify the definitions.
			The term “Substance abuse residential	This is no longer a licensed service as the

			treatment for women and children" was removed.	service was subsumed by an ASAM level of care service. Impact of updated requirements: Clearer more transparent and more accurate regulations.
12VAC35-105-30			The ASAM level of care numbers were added to each of the ASAM services within the list of licensed services.	This is a clarifying edit requested by providers, internal DBHDS subject matter experts as well as several sister agencies. Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-925			Correction of the reference to the peer recovery specialist regulations (12VAC35-250).	Impact of updated requirements: More accurate regulations.
12VAC35-105-950			Updating the term "state methadone authority" to the correct term "SOTA."	Impact of updated requirements: More accurate regulations.
12VAC35-105-1430			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1440			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1450			Incorporating the numerical level of care to the section title and correcting the diagnostic criteria.	Impact of updated requirements: Clearer, more transparent, and more accurate regulations.
12VAC35-105-1460			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1470			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1480			Incorporating the numerical level of care to the section title.	

			Noting that the assessment may be conducted by a licensed nurse practitioner or a licensed physician assistant. Clarify that MAT shall be available for individuals with opioid use disorder or alcohol use disorder.	This edit brings the provision in alignment with the ASAM Criteria. Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1490			Incorporating the numerical level of care to the section title. Utilizing the defined term “credentialed addiction treatment professional.”	Impact of updated requirements: Clearer, more accurate, and more transparent regulations.
12VAC35-105-1500			Incorporating the numerical level of care to the section title. Updating the diagnostic criteria to more accurately reflect the ASAM Criteria.	Impact of updated requirements: Clearer, more accurate, and more transparent regulations.
12VAC35-105-1510			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1520			Incorporating the numerical level of care to the section title. Utilizing the defined term credentialed addiction treatment professional.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1530			Incorporating the level of care numerical to the section title. Clarifying edit regarding staffing, which shall be by credentialed addiction treatment professionals in addition to other allied health professionals.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1540			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.

			Use of the defined term “credentialed addiction treatment professional.” Clarify that MAT shall be available for individuals with opioid use disorder or alcohol use disorder.	
12VAC35-1550			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-1560			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-1570			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-1580			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-1590			Incorporating the numerical level of care to the section title. Use of the defined term “credentialed addiction treatment professional.” Clarify that MAT shall be available for individuals with opioid use disorder or alcohol use disorder.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-1600			Incorporating the numerical level of care to the section title. Updating the diagnostic criteria to more accurately reflect the ASAM Criteria.	Impact of updated requirements: Clearer more accurate and more transparent regulations.
12VAC35-105-1610			Incorporating the level of care numerical to the section title.	Impact of updated requirements: Clearer, and more transparent regulations.
12VAC35-105-1620			Incorporating the numerical level of care to the section title	Impact of updated requirements: Clearer and more transparent regulations.

12VAC35-105-1630			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1640			Incorporating the numerical level of care to the section title. Clarify that MAT shall be available for individuals with opioid use disorder or alcohol use disorder.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1650			Incorporating the numerical level of care to the section title Updating the diagnostic criteria to more accurately reflect the ASAM Criteria.	Impact of updated requirements: Clearer, more accurate and more transparent regulations.
12VAC35-105-1660			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1670			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1680			Incorporating the level of care numerical to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1690			Incorporating the numerical level of care to the section title. Update the term “programming” with “skilled treatment services” to more accurately reflect ASAM requirements. Clarify that MAT shall be available for individuals with opioid use disorder or alcohol use disorder.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1700			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer

				and more transparent regulations.
12VAC35-105-1710			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1720			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1730			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1740			Incorporating the numerical level of care to the section title. Clarify that MAT shall be available for individuals with opioid use disorder or alcohol use disorder.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1750			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1760			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1770			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1780			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1790			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1800			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1810			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.
12VAC35-105-1820			Incorporating the numerical level of care to the section title.	Impact of updated requirements: Clearer and more transparent regulations.

Detail of All Changes Proposed in this Regulatory Action

*List all changes proposed in this action and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of updated requirements
12VAC35-105-20. Definitions		Provides current definitions for the Licensing Regulations.	Change: Adding the following definitions for terms utilized within the ASAM criteria: • Addiction; • Allied health professionals; • ASAM; • Clinically managed high-intensity residential care; • Clinically managed low-intensity residential care; • Clinically managed population specific high-intensity residential services; • Credentialed addiction treatment professional; • Diagnostic and Statistical Manual of Mental Disorders • Intensity of Service; • Medically managed intensive inpatient service; •Medically monitored intensive inpatient treatment; • Medication assisted treatment; • Mental health intensive outpatient services; • Mental health outpatient service; • Mental health partial hospitalization service; • Motivational enhancement; • Substance abuse intensive outpatient service; • Substance abuse outpatient service; and • Substance abuse partial hospitalization services.

			Removing the following terms which will no longer be used due to alignment with ASAM: • Medically managed withdrawal services; • Outpatient service; • Partial hospitalization service; • Social detoxification service; • Substance abuse intensive outpatient service; and • Substance abuse residential treatment for women and children. Amending the following terms: • Medical detoxification; and • Medication assisted opioid treatment.
12VAC35-105-30. Licenses.		Provides the current list of specific services which require a license.	Change: Adding the new ASAM license titles within the list of services which require a license including: • Clinically managed high-intensity residential care; • Clinically-managed low-intensity residential care; • Medically managed intensive inpatient service; • Medically monitored intensive inpatient treatment; • Medication assisted opioid treatment; • Mental health intensive outpatient; • Mental health outpatient; • Mental health partial hospitalization; • Specific high-intensity residential; substance abuse outpatient; and • Substance abuse partial hospitalization. Removal of terms which will not be utilized due to ASAM alignment including: • Managed withdrawal, including medical detoxification and social detoxification; • Opioid treatment/medication assisted treatment; • Outpatient; • Partial hospitalization; and • Substance abuse residential treatment for women and children. Impact: Clearer regulations, and some providers may have their

			license type changed due to the new terminology.
12VAC35-105-925. Standards for the evaluation of new licenses for providers of services to individuals with opioid addiction.		Provides the standards for providers of services to individuals with opioid addictions.	Change: Update the requirements of providers of services to individuals with opioid addictions, specifically requirements related to personnel, and minimum services provided. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
12VAC35-105-930. Registration certification or accreditation		Provides requirements for opioid treatment services with regard to registration, certification, or accreditation.	Change: Updating the terminology within the section to reflect the ASAM terminology. Specifically, replacing the term “opioid treatment service” with “medication assisted opioid treatment service.” Impact: Clarity of the regulations.
	12VAC35-105-935. Criteria for patient admission.		Change: Adding the required patient admission criteria for providers of services to individuals with opioid addictions. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
12VAC35-105-940. Criteria for involuntary termination from treatment.		Provides requirements for opioid treatment services with regard to involuntary termination from treatment	Change: Minor corrections. Impact: Clarity of the regulations.
	12VAC35-105-945. Criteria for patient discharge.		Change: Adding the required patient discharge criteria for providers of services to individuals with opioid addictions. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
12VAC35-105-950. Service operation schedule.		Provides service operation schedule requirements for providers of opioid treatment services.	Change: Adding a requirement that each provider must have a policy that addresses medication for new and at risk patients within opioid treatment programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth. Alignment with federal regulations.
12VAC35-105-960.		Provides requirements for the physical examination of	Change: Clarifying that the report of the individual’s physical examination

Initial and periodic assessment services.		individuals receiving opioid treatment services.	shall be documented within the individual's service record. Adding the requirement for a consent to treatment form. Adding the requirement for additional coordination by providers to prevent medication duplication. Impact: Robust, effective substance use disorder treatment within the Commonwealth. Alignment with federal regulations.
	12VAC35-105-965. Special services for pregnant individuals.		Change: Adding the required services for patients who are pregnant and being treated for opioid addictions. Impact: Robust, effective substance use disorder treatment within the Commonwealth. Alignment with federal regulations.
12VAC35-105-980. Drug screens.		Provides requirements for opioid treatment services regarding drug screens.	Change: Increasing the requirements to one drug screen per month. Impact: Robust, effective substance use disorder treatment within the Commonwealth. Alignment with federal regulations.
12VAC35-105-990. Take-home medication.		Provides requirements for opioid treatment services regarding take-home medication.	Change: Adding requirements regarding the determination for approval of take home medication. Adding the requirements regarding the amount of take home medication. Additionally, adding that individuals within short-term detoxification are not qualified for unsupervised take home use. Finally, requiring that providers maintain policies and procedures to identify the theft or diversion of take home medication. Impact: Robust, effective substance use disorder treatment within the Commonwealth. Alignment with federal regulations.
12VAC35-105-1000. Preventing duplication of medication services.		Requires opioid treatment service providers to take steps to prevent the duplication of opioid treatment services.	Change: Updating the terminology within the section to reflect the ASAM terminology. Specifically, replacing the terms "opioid medication services" and "opioid treatment service" to "medication assisted opioid treatment services." Impact: Clarity of the regulations.

12VAC35-1110. Admission assessments.		Provides the requirements for physical assessments during admission.	Change: Replaces “managed withdrawal services” with “medically monitored intensive inpatient services.”
12VAC35-105-1010		Provides the requirements for opioid treatment service providers with regards to guest medication.	Change: Updating the terminology within the section to reflect the ASAM terminology. Adding a definition of guest. Impact: Clarity of the regulations.
	12VAC35-105-1420 (Reserved).		Intent: Space saver section.
	12VAC35-105-1430. Medically managed intensive inpatient Level of care 4.0 staff criteria		Intent: Provide clear staff requirements within medically managed intensive inpatient programs, which are programs provided within an acute care inpatient setting such as an acute care hospital. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1440. Medically managed intensive inpatient Level of care 4.0 program criteria.		Intent: Provide clear program requirements within medically managed intensive inpatient programs which are programs provided within an acute care inpatient setting such as an acute care hospital. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1450 Medically managed intensive inpatient Level of care 4.0 admission criteria		Intent: Provide clear admission requirements within medically managed intensive inpatient programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1460. Medically managed intensive inpatient Level of care 4.0 discharge criteria		Intent: Provide clear discharge requirements within medically managed intensive inpatient programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1470. Medically		Intent: Provide additional licensing requirements for medically managed intensive inpatient

	managed intensive inpatient Level of care 4.0 co-occurring enhanced programs.		programs that treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-105-1480. Medically monitored intensive inpatient services Level of care 3.7 staff criteria		Intent: Provide clear staff requirements within medically monitored intensive inpatient treatment programs, which provide 24 hour care in a facility under the supervision of medical personnel providing directed evaluation, observation, and medical monitoring. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1490. Medically monitored intensive inpatient services Level of care 3.7 program criteria.		Intent: Provide clear program requirements within medically monitored intensive inpatient treatment programs, which provide 24 hour care in a facility under the supervision of medical personnel providing directed evaluation, observation, and medical monitoring. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1500 Medically monitored intensive inpatient Level of care 3.7 admission criteria		Intent: Provide clear admission requirements within medically monitored intensive inpatient programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1510. Medically monitored intensive inpatient Level of care 3.7 discharge criteria		Intent: Provide clear discharge requirements within medically monitored intensive inpatient programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1520. Medically monitored		Intent: Provide additional licensing requirements for medically monitored intensive inpatient

	intensive inpatient Level of care 3.7 co-occurring enhanced programs.		programs, which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-105-1530. Clinically managed high-intensity residential services Level of care 3.5 staff criteria		Intent: Provide clear staff requirements within clinically managed high intensity residential care programs, which provide 24 hour supportive treatment. The individuals served by clinically managed high-intensity residential care are individuals who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1540. Clinically managed high-intensity residential services Level of care 3.5 program criteria		Intent: Provide clear program requirements within clinically managed high intensity residential care programs, which provide 24 hour supportive treatment. The individuals served by clinically managed high intensity residential care are individuals who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1550. Clinically managed high-intensity residential services Level of care 3.5 admission criteria		Intent: Provide clear admission requirements within clinically managed high-intensity residential service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered.
	12VAC35-105-1560. Clinically managed high-intensity residential services Level of care 3.5		Intent: Provide clear discharge requirements within clinically managed high-intensity residential service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered.

	discharge criteria		
	12VAC35-105-1570. Clinically managed high-intensity residential services Level of care 3.5 co-occurring enhanced programs.		Intent: Provide additional licensing requirements for clinically managed high-intensity residential service programs, which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-105-1580 Clinically managed population-specific high-intensity residential services Level of care 3.3 staff criteria		Intent: Provide clear staff requirements within high intensity residential services programs, which provide a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of the individuals served. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1590. Clinically managed population-specific high-intensity residential services Level of care 3.3 program criteria		Intent: Provide clear program requirements within high intensity residential services programs, which provide a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of the individuals served. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1600. Clinically managed population-specific high-intensity residential services Level of care 3.3 admission criteria		Intent: Provide clear admission requirements within high intensity residential services programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered
	12VAC35-105-1610. Clinically managed population		Intent: Provide clear discharge requirements within high intensity residential services programs.

	specific high intensity residential services Level of care 3.3 discharge criteria.		Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered
	12VAC35-105-1620. Clinically managed population-specific high-intensity residential services Level of care 3.3 co-occurring enhanced programs.		Intent: Provide additional licensing requirements for high intensity residential services programs, which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-105-1630. Clinically managed low-intensity residential service Level of care 3.1 staff criteria		Intent: Provide clear staff requirements within clinically managed low-intensity residential service program, which provide ongoing therapeutic environment for individuals requiring some structured support. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1640. Clinically managed low-intensity residential services Level of care 3.1 program criteria		Intent: Provide clear program requirements within clinically managed low-intensity residential service programs, which provide ongoing therapeutic environment for individuals requiring some structured support. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1650. Clinically managed low-intensity residential services Level of care 3.1 admission criteria		Intent: Provide clear admission requirements within clinically managed low-intensity residential service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1660. Clinically managed low-		Intent: Provide clear discharge requirements within clinically managed low-intensity residential service programs.

	intensity residential services Level of care 3.1 discharge criteria.		Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1670. Clinically managed low-intensity residential services Level of care 3.1 co-occurring enhanced programs.		Intent: Provide additional licensing requirements for clinically managed low-intensity residential service programs, which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-105-1680. Substance abuse partial hospital services Level of care 2.5 staff criteria		Intent: Provide clear staff requirements within partial hospitalization programs, which provide services for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1690. Substance abuse partial hospital services Level of care 2.5 program criteria.		Intent: Provide clear program requirements within partial hospitalization programs, which provide services for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1700. Substance abuse partial hospitalization Level of care 2.5 admission criteria		Intent: Provide clear admission requirements within partial hospitalization programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1710. Substance abuse partial hospitalization Level of care		Intent: Provide clear discharge requirements within partial hospitalization programs. Impact: Robust, effective substance use disorder treatment within the

	2.5 discharge criteria		Commonwealth that is appropriately administered.
	12VAC35-105-1720. Substance abuse partial hospitalization Level of care 2.5 co-occurring enhanced programs.		Intent: Provide additional licensing requirements for partial hospitalization programs, which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-105-1730. Substance abuse intensive outpatient Level of care 2.1 staff criteria		Intent: Provide clear staff requirements within intensive outpatient service programs, which provide between 9 and 19 hours of structured treatment consisting primarily of counseling and education. Within this level of care an individual's needs for psychiatric and medical services are generally addressed through referrals. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1740. Substance abuse intensive outpatient services Level of care 2.1 program criteria		Intent: Provide clear program requirements within intensive outpatient programs, which provide between 9 and 19 hours of structured treatment consisting primarily of counseling and education. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1750. Substance abuse intensive outpatient service Level of care 2.1 admission criteria		Intent: Provide clear admission requirements within intensive outpatient service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1760. Substance abuse intensive outpatient services Level of care 2.1		Intent: Provide clear discharge requirements within intensive outpatient service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.

	discharge criteria.		
	12VAC35-105-1770. Substance abuse intensive outpatient service Level of care 2.1 co-occurring enhanced programs.		Intent: Provide additional licensing requirements for intensive outpatient service programs, which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-105-1780. Substance abuse outpatient services Level of care 1.0 staff criteria		Intent: Provide clear staff requirements within outpatient service programs, which provide an organized nonresidential service for fewer than 9 contact hours a week. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1790. Substance abuse outpatient services Level of care 1.0 program criteria		Intent: Provide clear program requirements within outpatient programs, which provide an organized nonresidential service for fewer than 9 contact hours a week. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1800. Substance abuse outpatient services Level of care 1.0 admission criteria		Intent: Provide clear admission requirements within outpatient service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1810. Substance abuse outpatient services Level of care 1.0 discharge criteria		Intent: Provide clear discharge requirements within outpatient service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1820. Substance abuse outpatient services Level of care 1.0		Intent: Provide additional licensing requirements for outpatient service programs, which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers

	co-occurring enhanced programs.		treating individuals with co-occurring disorders.

Amendments to Align with ASAM Criteria in the Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services

12VAC35-105-20. Definitions ~~and units of measurement~~.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Virginia Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse. Examples of abuse include acts such as:

1. Rape, sexual assault, or other criminal sexual behavior;

2. Assault or battery;

3. Use of language that demeans, threatens, intimidates, or humiliates the individual;

4. Misuse or misappropriation of the individual's assets, goods, or property;

5. Use of excessive force when placing an individual in physical or mechanical restraint;

6. Use of physical or mechanical restraints on an individual that is not in compliance with federal and state laws, regulations, and policies, professional accepted standards of practice, or his individualized services plan; or

7. Use of more restrictive or intensive services or denial of services to punish an individual or that is not consistent with his individualized services plan.

"Activities of daily living" or "ADLs" means personal care activities and includes bathing, dressing, transferring, toileting, grooming, hygiene, feeding, and eating. An individual's degree of independence in performing these activities is part of determining the appropriate level of care and services.

["Addiction" means a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Addiction is defined as the inability to consistently abstain, impairment in behavioral control, persistence of cravings, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.]

"Admission" means the process of acceptance into a service as defined by the provider's policies.

"Allied health professional" means a professional who is involved with the delivery of health or related services pertaining to the identification, evaluation, and prevention of diseases and disorders, such as a certified substance abuse counselor, certified substance abuse counseling assistant, peer recovery support specialist, certified nurse aide, or occupational therapist.

"ASAM" means the American Society of Addiction Medicine.

"Authorized representative" means a person permitted by law or 12VAC35-115 to authorize the disclosure of information or consent to treatment and services or participation in human research.

"Behavior intervention" means those principles and methods employed by a provider to help an individual receiving services to achieve a positive outcome and to address challenging behavior in a constructive and safe manner. Behavior intervention principles and methods shall be employed in accordance with the individualized services plan and written policies and procedures governing service expectations, treatment goals, safety, and security.

"Behavioral treatment plan," "functional plan," or "behavioral support plan" means any set of documented procedures that are an integral part of the individualized services plan and are developed on the basis of a systematic data collection, such as a functional assessment, for the purpose of assisting individuals to achieve the following:

1. Improved behavioral functioning and effectiveness;
2. Alleviation of symptoms of psychopathology; or
3. Reduction of challenging behaviors.

"Brain injury" means any injury to the brain that occurs after birth, but before age 65, that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. Brain injury does not include hereditary, congenital, or degenerative brain disorders or injuries induced by birth trauma.

"Care," "treatment," or "support" means the individually planned therapeutic interventions that conform to current acceptable professional practice and that are intended to improve or maintain functioning of an individual receiving services delivered by a provider.

"Case management service" or "support coordination service" means services that can include assistance to individuals and their family members in accessing needed services that are responsive to the individual's needs. Case management services include identifying potential users of the service; assessing needs and planning services; linking the individual to services and supports; assisting the individual directly to locate, develop, or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; discharge planning; and advocating for individuals in response to their changing needs. "Case management service" does not include assistance in which the only function is maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs.

"Clinical experience" means providing direct services to individuals with mental illness or the provision of direct geriatric services or special education services. Experience may include supervised internships, practicums, and field experience.

"Clinically managed high-intensity residential care" [or "Level of care 3.5"] means a substance use treatment program that offers 24-hour supportive treatment of individuals with significant psychological and social problems by credentialed addiction treatment professionals in an interdisciplinary treatment approach. A clinically managed high-intensity residential care program provides treatment to individuals who present with significant challenges, such as physical, sexual, or emotional trauma; past criminal or antisocial behaviors, with a risk of continued criminal behavior; an extensive history of treatment; inadequate anger management skills; extreme impulsivity; and antisocial value system.

"Clinically managed low-intensity residential care" [or "Level of care 3.1"] means providing an ongoing therapeutic environment for individuals requiring some structured support in which treatment is directed toward applying recovery skills; preventing relapse; improving emotional functioning; promoting personal responsibility; reintegrating the individual into work, education, and family environments; and strengthening and developing adaptive skills that may not have been achieved or have been diminished during the individual's active addiction. A clinically managed low-intensity residential care program also provides treatment for individuals suffering from chronic, long-term alcoholism or drug addiction and affords an extended period of time to establish sound recovery and a solid support system.

"Clinically managed population specific high-intensity residential services" [or "Level of care 3.3"] means a substance use treatment program that provides a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of individuals. The functional limitations of individuals who are placed within this level of care are primarily cognitive and can be either temporary or permanent.

"Commissioner" means the Commissioner of the Department of Behavioral Health and Developmental Services.

"Community gero-psychiatric residential services" means 24-hour care provided to individuals with mental illness, behavioral problems, and concomitant health problems who are usually age 65 or older in a geriatric setting that is less intensive than a psychiatric hospital but more intensive than a nursing home or group home. Services include assessment and individualized services planning by an interdisciplinary services team, intense supervision, psychiatric care, behavioral treatment planning and behavior interventions, nursing, and other health related services.

"Complaint" means an allegation of a violation of this chapter or a provider's policies and procedures related to this chapter.

"Co-occurring disorders" means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, a developmental disability, substance abuse (substance use disorders), or brain injury.

"Co-occurring services" means individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders.

"Corrective action plan" means the provider's pledged corrective action in response to cited areas of noncompliance documented by the regulatory authority.

"Correctional facility" means a facility operated under the management and control of the Virginia Department of Corrections.

"Credentialed addiction treatment professional" means a person who possesses one of the following credentials issued by the appropriate health regulatory board: (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) a licensed nurse practitioner or a licensed physician assistant with experience or training in addiction medicine; (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical social worker; (vi) a licensed professional counselor; (vii) a licensed [~~psychiatric clinical~~] nurse [~~specialist~~ practitioner with experience or training in psychiatry or mental health] ; (viii) [~~a licensed psychiatric nurse practitioner; (ix)~~] a licensed marriage and family therapist; (x) a licensed substance abuse treatment practitioner; (xi) a resident who is under the supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and is registered with the Virginia Board of Counseling; (xii) a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology (18VAC125-20-10); or (xiii) a supervisee in social work who is under the supervision of a licensed clinical social worker and is registered with the Virginia Board of Social Work (18VAC140-20-10).

"Crisis" means a deteriorating or unstable situation often developing suddenly or rapidly that produces acute, heightened, emotional, mental, physical, medical, or behavioral distress.

"Crisis stabilization" means direct, intensive nonresidential or residential direct care and treatment to nonhospitalized individuals experiencing an acute crisis that may jeopardize their current community living situation. Crisis stabilization is intended to avert hospitalization or rehospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis; and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Day support service" means structured programs of training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills for adults with a developmental disability provided to groups or individuals in nonresidential community-based settings. Day support services may provide opportunities for peer interaction and community integration and are designed to enhance the following: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, social skills, medication management, prevocational skills, and transportation skills. The term "day support service" does not include services in which the primary function is to provide employment-related services, general educational services, or general recreational services.

"Department" means the Virginia Department of Behavioral Health and Developmental Services.

"Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or a combination of mental and physical impairments other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in

substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to nine years of age, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual without services and supports has a high probability of meeting those criteria later in life.

"Developmental services" means planned, individualized, and person-centered services and supports provided to individuals with developmental disabilities for the purpose of enabling these individuals to increase their self-determination and independence, obtain employment, participate fully in all aspects of community life, advocate for themselves, and achieve their fullest potential to the greatest extent possible.

"Diagnostic and Statistical Manual of Mental Disorders" or "DSM" means the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, DSM-5, of the American Psychiatric Association.

"Direct care position" means any position that includes responsibility for (i) treatment, case management, health, safety, development, or well-being of an individual receiving services or (ii) immediately supervising a person in a position with this responsibility.

"Discharge" means the process by which the individual's active involvement with a service is terminated by the provider, individual, or authorized representative.

"Discharge plan" means the written plan that establishes the criteria for an individual's discharge from a service and identifies and coordinates delivery of any services needed after discharge.

"Dispense" means to deliver a drug to an ultimate user by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery (§ 54.1-3400 et seq. of the Code of Virginia).

"Emergency service" means unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, available 24 hours a day and seven days per week. Emergency services also may include walk-ins, home visits, jail interventions, and preadmission screening activities associated with the judicial process.

"Group home or community residential service" means a congregate service providing 24-hour supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.

"HCBS Waiver" means a Medicaid Home and Community Based Services Waiver.

"Home and noncenter based" means that a service is provided in the individual's home or other noncenter-based setting. This includes noncenter-based day support, supportive in-home, and intensive in-home services.

"Individual" or "individual receiving services" means a current direct recipient of public or private mental health, developmental, or substance abuse treatment, rehabilitation, or habilitation services and includes the terms "consumer," "patient," "resident," "recipient," or "client". When the term is used in this chapter, the requirement applies to every individual receiving licensed services from the provider.

"Individualized services plan" or "ISP" means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.

"Informed choice" means a decision made after considering options based on adequate and accurate information and knowledge. These options are developed through collaboration with the individual and his authorized representative, as applicable, and the provider with the intent of empowering the individual and his authorized representative to make decisions that will lead to positive service outcomes.

"Informed consent" means the voluntary written agreement of an individual, or that individual's authorized representative, to surgery, electroconvulsive treatment, use of psychotropic medications, or any other treatment or service that poses a risk of harm greater than that ordinarily encountered in daily life or for participation in human research. To be voluntary, informed consent must be given freely and without undue inducement; any element of force, fraud, deceit, or duress; or any form of constraint or coercion.

"Initial assessment" means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.

"Inpatient psychiatric service" means intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in § 32.1-123 of the Code of Virginia or in a special unit of such a hospital.

"Instrumental activities of daily living" or "IADLs" means meal preparation, housekeeping, laundry, and managing money. A person's degree of independence in performing these activities is part of determining appropriate level of care and services.

"Intellectual disability" means a disability originating before 18 years of age, characterized concurrently by (i) significant subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with accepted professional practice that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

"Intensity of service" means the number, type, and frequency of staff interventions and other services provided during treatment at a particular level of care.

"Intensive community treatment service" or "ICT" means a self-contained interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a full-time psychiatrist that:

1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illness, especially those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services;

2. Minimally refers individuals to outside service providers;

3. Provides services on a long-term care basis with continuity of caregivers over time;

4. Delivers 75% or more of the services outside program offices; and

5. Emphasizes outreach, relationship building, and individualization of services.

"Intensive in-home service" means family preservation interventions for children and adolescents who have or are at-risk of serious emotional disturbance, including individuals who also have a diagnosis of developmental disability. Intensive in-home service is usually time-limited and is provided typically in the residence of an individual who is at risk of being moved to out-of-home placement or who is being transitioned back home from an out-of-home placement. The service includes 24-hour per day emergency response; crisis treatment; individual and family counseling; life, parenting, and communication skills; and case management and coordination with other services.

"Intermediate care facility/individuals with intellectual disability" or "ICF/IID" means a facility or distinct part of a facility certified by the Virginia Department of Health as meeting the federal certification regulations for an intermediate care facility for individuals with intellectual disability and persons with related conditions and that addresses the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, providing active treatment as defined in 42 CFR 435.1010 and 42 CFR 483.440.

"Investigation" means a detailed inquiry or systematic examination of the operations of a provider or its services regarding an alleged violation of regulations or law. An investigation may be undertaken as a result of a complaint, an incident report, or other information that comes to the attention of the department.

"Licensed mental health professional" or "LMHP" means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavior analyst, or licensed psychiatric/mental health nurse practitioner.

"Location" means a place where services are or could be provided.

~~"Medically managed withdrawal services" means detoxification services to eliminate or reduce the effects of alcohol or other drugs in the individual's body.~~

"Mandatory outpatient treatment order" means an order issued by a court pursuant to § 37.2-817 of the Code of Virginia.

"Medical detoxification" means a service provided in a hospital or other 24-hour care facility under the supervision of medical personnel using medication to systematically eliminate or reduce ~~effects~~ the presence of alcohol or other drugs in the individual's body.

"Medical evaluation" means the process of assessing an individual's health status that includes a medical history and a physical examination of an individual conducted by a licensed medical practitioner operating within the scope of his license.

"Medically managed intensive inpatient service" [or "Level of care 4.0"] means an organized service delivered in an inpatient setting, including an acute care general hospital, psychiatric unit in a general hospital, or a freestanding psychiatric hospital. This service is appropriate for individuals whose acute biomedical and emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care. Services at this level of care are managed by a physician who is responsible for diagnosis, treatment, and treatment plan decisions in collaboration with the individual.

"Medically monitored intensive inpatient treatment" [or "Level of care 3.7"] means a substance use treatment program that provides 24-hour care in a facility under the supervision of medical personnel. The care provided includes directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. The care provided may include the use of medication to address the effects of substance use. This service is appropriate for an individual whose subacute biomedical, emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment but who does not need the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program.

"Medication" means prescribed or over-the-counter drugs or both.

"Medication administration" means the direct application of medications by injection, inhalation, ingestion, or any other means to an individual receiving services by (i) persons legally permitted to administer medications or (ii) the individual at the direction and in the presence of persons legally permitted to administer medications.

"Medication assisted opioid treatment ~~(Opioid treatment service)~~" means an intervention [~~strategy that combines outpatient treatment with the~~of] administering or dispensing of [~~synthetic narcotics~~medications], such as methadone~~,~~ ~~or~~ buprenorphine [~~(suboxone)~~], or naltrexone approved by the federal Food and Drug Administration for the purpose of [~~replacing the use of and reducing the craving for~~treating] opioid [~~substances, such as heroin or other narcotic drugs~~use disorder].

"Medication assisted treatment" or "MAT" means the use of U.S. Food and Drug Administration approved medications in combination with counseling and behavioral therapies to provide treatment of substance use disorders. Medication assisted treatment includes [~~medication assisted~~medications for] opioid [use disorder as well as medications for] treatment [of alcohol use disorder].

"Medication error" means an error in administering a medication to an individual and includes when any of the following occur: (i) the wrong medication is given to an individual, (ii) the wrong individual is given the medication, (iii) the wrong dosage is given to an individual, (iv) medication is given to an individual at the wrong time or not at all, or (v) the wrong method is used to give the medication to the individual.

"Medication storage" means any area where medications are maintained by the provider, including a locked cabinet, locked room, or locked box.

"Mental Health Community Support Service" or "MCHSS" means the provision of recovery-oriented services to individuals with long-term, severe mental illness. MHCSS includes skills training and assistance in accessing and effectively utilizing services and supports that are essential to meeting the needs identified in the individualized services plan and development of environmental supports necessary to sustain active community living as independently as possible. MHCSS may be provided in any setting in which the individual's needs can be addressed, skills training applied, and recovery experienced.

"Mental health intensive outpatient service" means a structured program of skilled treatment services focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to treatment. This service is provided over a period of time for individuals requiring more intensive services than an outpatient service can provide and may include individual, family, or group counseling or psychotherapy; skill development and psychoeducational activities; certified peer support services; medication management; and psychological assessment or testing.

"Mental health outpatient service" means treatment provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Mental health outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory, and other ancillary services, medical services, and medication services. Mental health outpatient service specifically includes:

1. Mental health services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;

2. Mental health services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or

3. Mental health services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Mental health partial hospitalization service" means time-limited active treatment interventions that are more intensive than outpatient services, designed to stabilize and ameliorate acute symptoms and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization is provided through a minimum of 20 hours per week of skilled treatment services focused on individuals who require intensive, highly coordinated, structured, and interdisciplinary ambulatory treatment within a stable environment that is of greater intensity than intensive outpatient, but of lesser intensity than inpatient.

"Mental illness" means a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others.

"Missing" means a circumstance in which an individual is not physically present when and where he should be and his absence cannot be accounted for or explained by his supervision needs or pattern of behavior.

"Motivational enhancement" means a person-centered approach that is collaborative, employs strategies to strengthen motivation for change, increases engagement in substance use services, resolves ambivalence about changing substance use behaviors, and supports individuals to set goals to change their substance use.

"Neglect" means the failure by a person, or a program or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse.

"Neurobehavioral services" means the assessment, evaluation, and treatment of cognitive, perceptual, behavioral, and other impairments caused by brain injury that affect an individual's ability to function successfully in the community.

~~"Outpatient service" means treatment provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. "Outpatient service" specifically includes:~~

~~1. Services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;~~

~~2. Services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or~~

~~3. Services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.~~

~~"Partial hospitalization service" means time-limited active treatment interventions that are more intensive than outpatient services, designed to stabilize and ameliorate acute symptoms, and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization is focused on individuals with serious mental illness, substance abuse (substance use disorders), or co-occurring disorders at risk of hospitalization or who have been recently discharged from an inpatient setting.~~

"Person-centered" means focusing on the needs and preferences of the individual; empowering and supporting the individual in defining the direction for his life; and promoting self-determination, community involvement, and recovery.

"Program of assertive community treatment service" or "PACT" means a self-contained interdisciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a full-time or part-time psychiatrist that:

1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses, including those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services;

2. Minimally refers individuals to outside service providers;

3. Provides services on a long-term care basis with continuity of caregivers over time;

4. Delivers 75% or more of the services outside program offices; and

5. Emphasizes outreach, relationship building, and individualization of services.

"Provider" means any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders) or (ii) residential services for individuals with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601, and 54.1-3701 of the Code of Virginia.

"Psychosocial rehabilitation service" means a program of two or more consecutive hours per day provided to groups of adults in a nonresidential setting. Individuals must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the individual about mental illness, substance abuse, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment. Psychosocial rehabilitation includes skills training, peer support, vocational rehabilitation, and community resource development oriented toward empowerment, recovery, and competency.

"Qualified developmental disability professional" or "QDDP" means a person who possesses at least one year of documented experience working directly with individuals who have a developmental disability and who possesses one of the following credentials: (i) a doctor of medicine or osteopathy licensed in Virginia, (ii) a registered nurse licensed in Virginia, (iii) a licensed occupational therapist, or (iv) completion of at least a bachelor's degree in a human services field, including sociology, social work, special education, rehabilitation counseling, or psychology.

"Qualified mental health professional" or "QMHP" means a person who by education and experience is professionally qualified and registered by the Board of Counseling in accordance with 18VAC115-80 to provide collaborative mental health services for adults or children. A QMHP shall not engage in independent or autonomous practice. A QMHP shall provide such services as an employee or independent contractor of the department or a provider licensed by the department.

"Qualified mental health professional-adult" or "QMHP-A" means a person who by education and experience is professionally qualified and registered with the Board of Counseling in accordance with 18VAC115-80 to provide collaborative mental health services for adults. A QMHP-A shall provide such services as an employee or independent contractor of the department or a provider licensed by the department. A QMHP-A may be an occupational therapist who by education and experience is professionally qualified and registered with the Board of Counseling in accordance with 18VAC115-80.

"Qualified mental health professional-child" or "QMHP-C" means a person who by education and experience is professionally qualified and registered with the Board of Counseling in accordance with 18VAC115-80 to provide collaborative mental health services for children. A QMHP-C shall provide such services as an employee or independent contractor of the department or a provider licensed by the department. A QMHP-C may be an occupational therapist who by education and experience is professionally qualified and registered with the Board of Counseling in accordance with 18VAC115-80.

"Qualified mental health professional-eligible" or "QMHP-E" means a person receiving supervised training in order to qualify as a QMHP in accordance with 18VAC115-80 and who is registered with the Board of Counseling.

"Qualified paraprofessional in mental health" or "QPPMH" means a person who must meet at least one of the following criteria: (i) registered with the United States Psychiatric Association (USPRA) as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) has an associate's degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least one year of experience providing direct services to individuals with a diagnosis of mental illness; (iii) licensed as an occupational therapy assistant, and supervised by a licensed occupational therapist, with at least one year of experience providing direct services to individuals with a diagnosis of mental illness; or (iv) has a minimum of 90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP-A providing services to individuals with mental illness and at least one year of experience (including the 12 weeks of supervised experience).

"Quality improvement plan" means a detailed work plan developed by a provider that defines steps the provider will take to review the quality of services it provides and to manage initiatives to improve quality. A quality improvement plan consists of systematic and continuous actions that lead to measurable improvement in the services, supports, and health status of the individuals receiving services.

"Recovery" means a journey of healing and transformation enabling an individual with a mental illness to live a meaningful life in a community of his choice while striving to achieve his full potential. For individuals with substance abuse (substance use disorders), recovery is an incremental process leading to positive social change and a full return to biological, psychological, and social functioning. For individuals with a developmental disability, the concept of recovery does not apply in the sense that individuals with a developmental disability will need supports throughout their entire lives although these may change over time. With supports, individuals with a developmental disability are capable of living lives that are fulfilling and satisfying and that bring meaning to themselves and others whom they know.

"Referral" means the process of directing an applicant or an individual to a provider or service that is designed to provide the assistance needed.

"Residential crisis stabilization service" means (i) providing short-term, intensive treatment to nonhospitalized individuals who require multidisciplinary treatment in order to stabilize acute psychiatric symptoms and prevent admission to a psychiatric inpatient unit; (ii) providing normative environments with a high assurance of safety and security for crisis intervention; and (iii) mobilizing the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Residential service" means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services provide a range of living arrangements from highly structured and intensively supervised to relatively independent requiring a modest amount of staff support and monitoring. Residential services include residential treatment, group homes, supervised living, residential crisis stabilization, community gero-psychiatric residential, ICF/IID, sponsored residential homes, medical and social detoxification, [and] neurobehavioral services [~~, and substance abuse residential treatment for women and children~~].

"Residential treatment service" means providing an intensive and highly structured mental health, substance abuse, or neurobehavioral service, or services for co-occurring disorders in a residential setting, other than an inpatient service.

"Respite care service" means providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular care giver. Persons providing respite care are recruited, trained, and supervised by a licensed provider. These services may be provided in a variety of settings including residential, day support, in-home, or a sponsored residential home.

"Restraint" means the use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an individual receiving services from moving his body to engage in a behavior that places him or others at imminent risk. There are three kinds of restraints:

1. Mechanical restraint means the use of a mechanical device that cannot be removed by the individual to restrict the individual's freedom of movement or functioning of a limb or portion of an individual's body when that behavior places him or others at imminent risk.

2. Pharmacological restraint means the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that individual's behavior places him or others at imminent risk and the administered medication is not a standard treatment for the individual's medical or psychiatric condition.

3. Physical restraint, also referred to as manual hold, means the use of a physical intervention or hands-on hold to prevent an individual from moving his body when that individual's behavior places him or others at imminent risk.

"Restraints for behavioral purposes" means using a physical hold, medication, or a mechanical device to control behavior or involuntary restrict the freedom of movement of an individual in an instance when all of the following conditions are met: (i) there is an emergency; (ii) nonphysical interventions are not viable; and (iii) safety issues require an immediate response.

"Restraints for medical purposes" means using a physical hold, medication, or mechanical device to limit the mobility of an individual for medical, diagnostic, or surgical purposes, such as routine dental care or radiological procedures and related post-procedure care processes, when use of the restraint is not the accepted clinical practice for treating the individual's condition.

"Restraints for protective purposes" means using a mechanical device to compensate for a physical or cognitive deficit when the individual does not have the option to remove

the device. The device may limit an individual's movement, for example, bed rails or a gerichair, and prevent possible harm to the individual or it may create a passive barrier, such as a helmet to protect the individual.

"Restriction" means anything that limits or prevents an individual from freely exercising his rights and privileges.

"Risk management" means an integrated system-wide program to ensure the safety of individuals, employees, visitors, and others through identification, mitigation, early detection, monitoring, evaluation, and control of risks.

"Root cause analysis" means a method of problem solving designed to identify the underlying causes of a problem. The focus of a root cause analysis is on systems, processes, and outcomes that require change to reduce the risk of harm.

"Screening" means the process or procedure for determining whether the individual meets the minimum criteria for admission.

"Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical means so that the individual cannot leave it.

"Serious incident" means any event or circumstance that causes or could cause harm to the health, safety, or well-being of an individual. The term "serious incident" includes death and serious injury.

"Level I serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III serious incident. Level I serious incidents do not result in significant harm to individuals, but may include events that result in minor injuries that do not require medical attention or events that have the potential to cause serious injury, even when no injury occurs. "Level II serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider that results in a significant harm or threat to the health and safety of an individual that does not meet the definition of a Level III serious incident.

"Level II serious incident" includes a significant harm or threat to the health or safety of others caused by an individual. Level II serious incidents include:

1. A serious injury;

2. An individual who is or was missing;

3. An emergency room visit;

4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services, except that a psychiatric admission in accordance with the individual's Wellness Recovery Action Plan shall not constitute an unplanned admission for the purposes of this chapter;

5. Choking incidents that require direct physical intervention by another person;

6. Ingestion of any hazardous material; or

7. A diagnosis of:

a. A decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer;

b. A bowel obstruction; or

c. Aspiration pneumonia.

"Level III serious incident" means a serious incident whether or not the incident occurs while in the provision of a service or on the provider's premises and results in:

1. Any death of an individual;

2. A sexual assault of an individual; or

3. A suicide attempt by an individual admitted for services, other than licensed emergency services, that results in a hospital admission.

"Serious injury" means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner.

"Service" means (i) planned individualized interventions intended to reduce or ameliorate mental illness, developmental disabilities, or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders). Services include outpatient services, intensive in-home services, medication assisted opioid treatment services, inpatient psychiatric hospitalization, community gero-psychiatric residential services, assertive community treatment and other clinical services; day support, day treatment, partial hospitalization, psychosocial rehabilitation, and habilitation services; case management services; and supportive residential, special school, halfway house, in-home services, crisis stabilization, and other residential services; and (ii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports provided in residential services for persons with brain injury.

"Shall" means an obligation to act is imposed.

"Shall not" means an obligation not to act is imposed.

"Skills training" means systematic skill building through curriculum-based psychoeducational and cognitive-behavioral interventions. These interventions break down complex objectives for role performance into simpler components, including basic cognitive skills such as attention, to facilitate learning and competency.

~~"Social detoxification service" means providing nonmedical supervised care for the individual's natural process of withdrawal from use of alcohol or other drugs.~~

"Sponsored residential home" means a service where providers arrange for, supervise, and provide programmatic, financial, and service support to families or persons (sponsors) providing care or treatment in their own homes for individuals receiving services.

"State board" means the State Board of Behavioral Health and Developmental Services. The board has statutory responsibility for adopting regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the commissioner or the department.

"State methadone authority" means the Virginia Department of Behavioral Health and Developmental Services that is authorized by the federal Center for Substance Abuse Treatment to exercise the responsibility and authority for governing the treatment of opiate addiction with an opioid drug.

"Substance abuse (substance use disorders)" means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

"Substance abuse intensive outpatient service" [or "Level of care 2.1"] means structured treatment provided ~~in a concentrated manner for two or more consecutive hours per day to groups of individuals in a nonresidential setting. This service is provided over a period of time for individuals requiring more intensive services than an outpatient service can provide. Substance abuse intensive outpatient services include multiple group therapy sessions during the week, individual and family therapy, individual monitoring, and case management.~~ to individuals who require more intensive services than is normally provided in an outpatient service but do not require inpatient services. Treatment consists primarily of counseling and education about addiction-related and mental health challenges delivered a minimum of nine to 19 hours of services per week for adults or six to 19 hours of services per week for children and adolescents. Within this level of care an individual's needs for psychiatric and medical services are generally addressed through consultation and referrals.

"Substance abuse outpatient service" [or "Level of care 1.0"] means a center based substance abuse treatment delivered to individuals for fewer than nine hours of service per week for adults or fewer than six hours per week for adolescents on an individual, group, or family basis. Substance abuse outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Substance abuse outpatient service includes substance abuse services or an office practice that provides professionally directed aftercare, individual, and other addiction services to individuals according to a predetermined regular schedule of fewer than nine contact hours a week. Substance abuse outpatient service also includes:

1. Substance abuse services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;

2. Substance abuse services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or

3. Substance abuse services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Substance abuse partial hospitalization services" [or "Level of care 2.5"] means a short-term, nonresidential substance use treatment program provided for a minimum of 20 hours a week that uses multidisciplinary staff and is provided for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment. This level of care is designed to offer highly

structured intensive treatment to those individuals whose condition is sufficiently stable so as not to require 24-hour-per-day monitoring and care, but whose illness has progressed so as to require consistent near-daily treatment intervention.

[~~"Substance abuse residential treatment for women with children service" means a 24-hour residential service providing an intensive and highly structured substance abuse service for women with children who live in the same facility.~~]

"Suicide attempt" means a nonfatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior regardless of whether it results in injury.

"Supervised living residential service" means the provision of significant direct supervision and community support services to individuals living in apartments or other residential settings. These services differ from supportive in-home service because the provider assumes responsibility for management of the physical environment of the residence, and staff supervision and monitoring are daily and available on a 24-hour basis. Services are provided based on the needs of the individual in areas such as food preparation, housekeeping, medication administration, personal hygiene, treatment, counseling, and budgeting.

"Supportive in-home service" (formerly supportive residential) means the provision of community support services and other structured services to assist individuals, to strengthen individual skills, and that provide environmental supports necessary to attain and sustain independent community residential living. Services include drop-in or friendly-visitor support and counseling to more intensive support, monitoring, training, in-home support, respite care, and family support services. Services are based on the needs of the individual and include training and assistance. These services normally do not involve overnight care by the provider; however, due to the flexible nature of these services, overnight care may be provided on an occasional basis.

"Systemic deficiency" means violations of regulations documented by the department that demonstrate multiple or repeat defects in the operation of one or more services.

"Therapeutic day treatment for children and adolescents" means a treatment program that serves (i) children and adolescents from birth through 17 years of age and under certain circumstances up to 21 years of age with serious emotional disturbances, substance use, or co-occurring disorders or (ii) children from birth through seven years of age who are at risk of serious emotional disturbance, in order to combine psychotherapeutic interventions with education and mental health or substance abuse treatment. Services include: evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills; and individual, group, and family counseling.

"Time out" means the involuntary removal of an individual by a staff person from a source of reinforcement to a different, open location for a specified period of time or until the problem behavior has subsided to discontinue or reduce the frequency of problematic behavior.

"Volunteer" means a person who, without financial remuneration, provides services to individuals on behalf of the provider.

12VAC35-105-30. Licenses.

A. Licenses are issued to providers who offer services to individuals who have mental illness, a developmental disability, or substance abuse (substance use disorders) or have brain injury and are receiving residential services.

B. Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. These services include:

1. Case management;

2. Clinically managed high-intensity residential care [or Level of care 3.5];

3. Clinically managed low-intensity residential care [or Level of care 3.1];

4. Clinically managed population specific high-intensity residential [or Level of care 3.3];

5. Community gero-psychiatric residential;

~~3.~~ 6. ICF/IID;

~~4.~~ 7. Residential crisis stabilization;

~~5.~~ 8. Nonresidential crisis stabilization;

~~6.~~ 9. Day support;

~~7.~~ 10. Day treatment, includes therapeutic day treatment for children and adolescents;

~~8.~~ 11. Group home and community residential;

~~9.~~ 12. Inpatient psychiatric;

~~10.~~ 13. Intensive community treatment (ICT);

~~11.~~ 14. Intensive in-home;

~~12. Managed withdrawal, including medical detoxification and social detoxification;~~

~~13.~~ 15. Medically managed intensive inpatient service [or Level of care 4.0];

16. Medically monitored intensive inpatient treatment [or Level of care 3.7];

17. Medication assisted opioid treatment;

18. Mental health community support;

~~14. Opioid treatment/medication assisted treatment;~~

~~15.~~ 19. Mental health intensive outpatient;

20. Mental health outpatient;

21. Mental health partial hospitalization;

22. Emergency;

~~16. Outpatient;~~

~~17. Partial hospitalization;~~

~~18.~~ 23. Program of assertive community treatment (PACT);

~~19.~~ 24. Psychosocial rehabilitation;

~~20.~~ 25. Residential treatment;

~~21.~~ 26. Respite care;

~~22.~~ 27. Sponsored residential home;

~~23.~~ [~~28. Substance abuse residential treatment for women with children;~~

~~24. 29.~~ 28.] Substance abuse intensive outpatient;

~~25.~~ [~~30.~~29.] Substance abuse outpatient;

[~~31.~~30.] Substance abuse partial hospitalization;

[~~32.~~31.] Supervised living residential; and

~~26.~~ [~~33.~~32.] Supportive in-home.

C. A license addendum shall describe the services licensed, the disabilities of individuals who may be served, the specific locations where services are to be provided or administered, and the terms and conditions for each service offered by a licensed provider. For residential and inpatient services, the license identifies the number of individuals each residential location may serve at a given time.

Article 1

Medication Assisted Opioid Treatment ~~(Opioid Treatment Services)~~

12VAC35-105-925. Standards for the evaluation of new licenses for providers of services to individuals with opioid addiction.

A. Applicants requesting an initial license to provide a service for the treatment of opioid addiction through the use of methadone or any other opioid treatment medication or controlled substance shall supply information to the department that demonstrates the appropriateness of the proposed service in accordance with this section.

B. The proposed site of the service shall comply with § 37.2-406 of the Code of Virginia.

C. In jurisdictions without zoning ordinances, the department shall request that the local governing body advise it as to whether the proposed site is suitable for and compatible with use as an office and the delivery of health care services. The department shall make this request when it notifies the local governing body of a pending application.

D. Applicants shall demonstrate that the building or space to be used to provide the proposed service is suitable for the treatment of opioid addiction by submitting documentation of the following:

1. The proposed site complies with the requirements of the local building regulatory entity;

2. The proposed site complies with local zoning laws or ordinances, including any required business licenses;

3. In the absence of local zoning ordinances, the proposed site is suitable for and compatible with use as offices and the delivery of health care services;

4. In jurisdictions where there are no parking ordinances, the proposed site has sufficient off-street parking to accommodate the needs of the individuals being served and prevent the disruption of traffic flow;

5. The proposed site can accommodate individuals during periods of inclement weather;

6. The proposed site complies with the Virginia Statewide Fire Prevention Code; and

7. The applicant has a written plan to ensure security for storage of methadone at the site, which complies with regulations of the Drug Enforcement Agency (DEA), and the Virginia Board of Pharmacy.

E. Applicants shall submit information to demonstrate that there are sufficient personnel available to meet the following staffing requirements and qualifications:

1. The program sponsor means the person responsible for the operation of the opioid treatment program and who assumes responsibility for all its employees, including any practitioners, agents, or other persons providing medical, rehabilitative, or counseling at the program at any of its medication units. The program sponsor is responsible for ensuring the program is in continuous compliance with all federal, state, and local laws and regulations.

2. The program director shall be licensed or certified by the applicable Virginia health regulatory board ~~or by a nationally recognized certification board~~ or registered as eligible for this license or certification with relevant training, experience, or both, in the treatment of individuals with opioid addiction~~;~~. The program director is responsible for the day-to-day management of the program.

~~2.~~ 3. The medical director shall be a board-certified addictionologist or have successfully completed or will complete within one year a course of study in opiate addiction that is approved by the department; and:

a. Is responsible for ensuring all medical, psychiatric, nursing, pharmacy, toxicology, and other services offered by the medication assisted opioid treatment provider are conducted in compliance with federal regulations at all times; and

b. Shall be physically present at the program for a sufficient number of hours to ensure regulatory compliance and carry out those duties specifically assigned to the medical director by regulation.

~~3.~~ 4. A minimum of one pharmacist~~;~~.

~~4.~~ 5. Nurses~~;~~.

~~5.~~ 6. Counselors shall be licensed or certified by the applicable Virginia health regulatory board ~~or by a nationally recognized certification board~~ or eligible for this license or certification~~; and~~.

~~6.~~ 7. Personnel to provide support services.

8. Have linkage with or access to psychological, medical, and psychiatric consultation.

9. Have access to emergency medical and psychiatric care through affiliations with more intensive levels of care.

10. Have the ability to conduct or arrange for appropriate laboratory and toxicology tests.

11. Ensure all clinical staff, whether employed by the provider or available through consultation, contract, or other means, are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

F. The applicant may provide peer recovery specialists (PRS). Peer recovery specialists shall be professionally qualified by education and experience in accordance

with [~~12VAC35-105-250~~12VAC35-250]. A registered peer recovery specialist shall be a PRS registered with the Board of Counseling in accordance with 18VAC115-70 and provide such services as an employee or independent contractor of DBHDS, a provider licensed by the DBHDS, a practitioner licensed by or holding a permit issued from the Department of Health Professions, or a facility licensed by the Virginia Department of Health.

G. If there is a change in or loss of any staff in the positions listed, or any change in the provider's ability to comply with the requirements, in subsection E of this section, the provider shall formally notify the Substance Abuse and Mental Health Services Administration (SAMHSA) and DBHDS. The provider shall also submit a plan to SAMHSA and DBHDS for immediate coverage within three weeks.

H. Applicants shall submit a description for the proposed service that includes:

1. Proposed mission, philosophy, and goals of the provider;

2. Care, treatment, and services to be provided, including a comprehensive discussion of levels of care provided and alternative treatment strategies offered;

3. Proposed hours and days of operation;

4. Plans for ~~on-site~~ onsite security and services adequate to ensure the safety of patients, staff, and property; and

5. A diversion control plan for dispensed medications, including policies for use of drug screens.

~~G.~~ I. Applicants shall, in addition to the requirements of 12VAC35-105-580 C 2, provide documentation of their capability to provide the following services and support directly or by arrangement with other specified providers when such services and supports are (i) requested by an individual being served or (ii) identified as an individual need, based on the assessment conducted in accordance with 12VAC35-105-60 B and included in the individualized services plan:

1. General.

~~2.~~ a. Psychological services;

b. Social services;

~~3.~~ c. Vocational services;

~~4.~~ d. Educational services, including HIV/AIDS education and other health education services; and

~~5.~~ e. Employment services.

2. Initial medical examination services.

3. Special services for pregnant patients.

4. Initial and periodic, individualized, patient-centered assessment and treatment services.

5. Counseling services.

6. Drug abuse testing services.

7. Case management services, including medical monitoring and coordination, with onsite and offsite treatment services provided as needed.

~~H.~~ J. Applicants shall submit documentation of contact with community services boards or behavioral health authorities in their service areas to discuss their plans for operating in the area and to develop joint agreements, as appropriate.

~~I.~~ K. Applicants shall provide policies and procedures that shall address assessment, administration, and regulation of medication and dose levels appropriate to the individual. The policies and procedures shall at a minimum require that each individual served ~~to~~ be assessed every six months by the treatment team to determine if that individual is appropriate for safe and voluntary medically supervised withdrawal from opioid analgesics, including methadone or buprenorphine, alternative therapies including other medication assisted treatments, or continued federally approved pharmacotherapy treatment for opioid addiction.

~~J.~~ L. Applicants shall submit policies and procedures describing services they will provide to individuals who wish to discontinue medication assisted opioid treatment services.

~~K.~~ M. Applicants shall provide assurances that the service will have a community liaison responsible for developing and maintaining cooperative relationships with community organizations, other service providers, local law enforcement, local government officials, and the community at large.

~~L.~~ N. The department shall conduct announced and unannounced reviews and complaint investigations in collaboration with the Virginia Board of Pharmacy and DEA to determine compliance with the regulations.

12VAC35-105-930. Registration, certification, or accreditation.

A. The medication assisted opioid treatment service shall maintain current registration or certification with:

1. The federal Drug Enforcement Administration;
2. The federal Department of Health and Human Services; and
3. The Virginia Board of Pharmacy.

B. A provider of medication assisted opioid treatment services shall maintain accreditation with an entity approved under federal regulations.

12VAC35-105-935. Criteria for patient admission.

A. Before a medication assisted opioid treatment program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to (i) meet diagnostic criteria for opioid use disorder as defined within the DSM; and (ii) meet the admission criteria of Level 1.0 of ASAM. The policies shall be consistent with subsections B through E of this section.

B. A medication assisted opioid treatment program shall maintain current procedures that are designed to ensure that individuals are admitted to short or long-term detoxification treatment by qualified personnel, such as a program physician who determines that such treatment is appropriate for the specific individual by applying established diagnostic criteria. An individual with two or more unsuccessful detoxification episodes within a 12-month period must be assessed by the medication assisted opioid treatment program physician for other forms of treatment. A program shall not admit an individual for more than two detoxification treatment episodes in one year.

C. An medication assisted opioid treatment program shall maintain current procedures designed to ensure that individuals are admitted to maintenance treatment by qualified personnel who have determined, using accepted medical criteria, that the person is currently addicted to an opioid drug, and that the individual became addicted at least one year before admission for treatment. In addition, a program physician shall ensure that each individual voluntarily chooses maintenance treatment, that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the individual, and that each individual provides informed written consent to treatment.

D. A person younger than 18 years of age is required to have had two documented unsuccessful attempts at short-term detoxification or drug-free treatment within a 12-month period to be eligible for maintenance treatment. No individual younger than 18 years of age may be admitted to maintenance treatment unless parent, legal guardian, or responsible adult designated by the relevant state authority consents in writing to such treatment.

E. If clinically appropriate, the program physician may waive the requirement of a one-year history of addiction under subsection C of this section, for individuals released from penal institutions (within six months after release), for pregnant patients (program physician must certify pregnancy), and for previously treated individuals (up to two years after discharge).

12VAC35-105-940. Criteria for involuntary termination from treatment.

A. The provider shall establish criteria for involuntary termination from treatment that describe the rights of the individual receiving services and the responsibilities and rights of the provider.

B. The provider shall establish a grievance procedure as part of the rights of the individual.

C. On admission, the individual shall be given a copy of the criteria and grievance procedure and shall sign a statement acknowledging receipt of same. The signed ~~acknowledgement~~ acknowledgment shall be maintained in the individual's service record.

D. Upon admission and annually thereafter all individuals shall sign an authorization for disclosure of information to allow ~~programs~~ the provider access to the Virginia Prescription Monitoring System. ~~Failure to comply shall be grounds for nonadmission to the program.~~ Individuals who fail to sign this authorization shall be denied admission to the program.

12VAC35-105-945. Criteria for patient discharge.

Before a medication assisted opioid treatment program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require medication assisted opioid treatment level of care;

2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or

3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

12VAC35-105-950. Service operation schedule.

A. The service's days of operation shall meet the needs of the individuals served. If the service dispenses or administers a medication requiring daily dosing, the service shall operate seven days a week, 12 months a year, except for official state holidays. Prior approval from the state methadone authority shall be required for additional closed days.

B. The service may close on Sundays if all the following criteria are met:

1. The provider develops and implements policies and procedures that address recently ~~inducted~~ admitted individuals receiving services, individuals not currently on a stable dose of medication, patients that present noncompliance treatment behaviors, and individuals who previously picked up take-home medications on Sundays, security of take-home medication doses, and health and safety of individuals receiving services.

2. The provider receives prior approval from the state ~~methadone~~ opioid treatment authority (SOTA) for Sunday closings. Each program must have a policy that addresses medication for the newly inducted patients and those who are deemed at risk, for example, are still actively using illicit substances or medical issues that may warrant closer monitoring of medication.

3. Once approved, by the [~~state opioid treatment authority~~SOTA] to close on Sundays, the provider shall notify individuals receiving services in writing at least 30 days in advance of their intent to close on Sundays. The notice shall address the risks to the individuals and the security of take-home medications. All individuals shall receive an orientation addressing take-home policies and procedures, and this orientation shall be documented in the individual's service record prior to receiving take-home medications.

4. The provider shall establish procedures for emergency access to dosing information 24 hours a day, seven days a week. This information may be provided via an answering service, pager, or other electronic measures. Information needed includes the individual's last dosing time and date, and dose.

C. Medication dispensing hours shall include at least two hours each day of operation outside normal working hours, ~~i.e.~~ that is, before 9 a.m. and after 5 p.m. The ~~state methadone authority~~ SOTA may approve an alternative schedule if the SOTA determines that schedule meets the needs of the population served by the provider.

12VAC35-105-960. ~~Physical examinations~~ Initial and periodic assessment services.

A. The individual shall have a complete physical examination prior to admission to the service unless the individual is transferring from another licensed ~~opioid agonist~~ medication assisted opioid treatment service in Virginia. The provider shall maintain the report of the individual's physical examination in the individual's service record. The results of serology and other tests shall be available within 14 days of admission.

B. ~~Physical exams of each individual shall be completed annually or more frequently if there is a change in the individual's physical or mental condition.~~ The program physician shall review a consent to treatment form with the patient and sign the form prior to the individual receiving the first dose of medication.

C. The provider shall maintain the report of the individual's physical examination in the individual's service record.

D. ~~On admission, all individuals shall be offered testing for AIDS/HIV. The individual may sign a notice of refusal without prejudice.~~ The program shall have a policy to ensure that coordination of care is in place with any prescribing physician.

E. ~~The provider shall coordinate treatment services for individuals who are prescribed benzodiapines and prescription narcotics with the treating physician. The coordination shall be the responsibility of the provider's physician and shall be documented.~~ The provider shall coordinate treatment services for individuals who are prescribed benzodiazepines and prescription narcotics with the treating physician. The coordination shall be the responsibility of the provider's physician and shall be documented.

12VAC35-105-965. Special services for pregnant individuals.

The program shall ensure that every pregnant woman has the opportunity for prenatal care, prenatal education, and postpartum follow-up, either onsite or by referral to an appropriate health care provider.

12VAC35-105-980. Drug screens.

A. The provider shall perform at least ~~eight~~ one random drug ~~screens during a 12-month period~~ screen per month unless the conditions in ~~subdivision~~ subsection B of this ~~subsection~~ section apply;

B. Whenever an individual's drug screen indicates continued illicit drug use or when clinically and environmentally indicated, random drug screens shall be performed weekly.

C. Drug screens shall be analyzed for opiates, methadone (if ordered), benzodiazepines, ~~and~~ cocaine, and buprenorphine. In addition, drug screens for other drugs that have the potential for addiction shall be performed when clinically and environmentally indicated.

D. The provider shall implement a written policy on how the results of drug screens shall be used to direct treatment.

12VAC35-105-990. Take-home medication.

A. Prior to dispensing regularly scheduled take-home medication, the provider shall ensure the individual demonstrates a level of current lifestyle stability as evidenced by the following:

1. Regular clinic attendance, including dosing and participation in counseling or group sessions;

2. Absence of recent alcohol abuse and illicit drug use;

3. Absence of significant behavior problems;

4. Absence of recent criminal activities, charges, or convictions;

5. Stability of the individual's home environment and social relationships;

6. Length of time in treatment;

7. Ability to ~~assure~~ ensure take-home medications are safely stored; and

8. Demonstrated rehabilitative benefits of take-home medications outweigh the risks of possible diversion.

B. Determinations for the take-home approval shall be based on the clinical judgement of the physician in consultation with the treatment team and shall be documented in the individual's service record.

C. If it is determined that an individual in comprehensive maintenance treatment is appropriate for handling take-home medication, the amount of take-home medication shall not exceed:

1. A single take-home dose for one day when the clinic is closed for business, including Sundays and state or federal holidays.

2. A single dose each week during the first 90 days of treatment (beyond that in subdivision 1 of this subsection). The individual shall ingest all other doses under the supervision of a medication administration trained employee.

3. Two doses per week in the second 90 days of treatment (beyond that in subdivision 1 of this subsection).

4. Three doses per week in the third 90 days of treatment (beyond that in subdivision 1 of this subsection).

5. A maximum six-day supply of take-home doses in the remaining months of the first year of treatment.

6. A maximum two-week supply of take-home medication after one year of continuous treatment.

7. One month's supply of take-home medication after two years of continuous treatment with monthly visits made by the individual served.

D. No medication shall be dispensed to individuals in short-term detoxification treatment or interim maintenance treatment for unsupervised take-home use.

E. Medication assisted opioid treatment providers shall maintain current procedures adequate to identify the theft or diversion of take-home medications. These procedures shall require the labeling of containers with the medication assisted opioid treatment providers name, address, and telephone number. Programs shall ensure that the take-home supplies are packaged in a manner that is designed to reduce the risk of accidental ingestion, including child proof containers.

F. The provider shall educate the individual on the safe transportation and storage of take-home medication.

12VAC35-105-1000. Preventing duplication of medication services.

To prevent duplication of medication assisted opioid ~~medication~~ treatment services to an individual, prior to admission of the individual, the provider shall implement ~~a~~ written policy and procedures for contacting every medication assisted opioid treatment service within a 50-mile radius before admitting an individual.

12VAC35-105-1010. Guests.

A. For the purpose of this section a guest is a patient of a medication assisted opioid treatment service in another state or another area of Virginia, who is traveling and is not yet eligible for take-home medication. Guest dosing shall be approved by the individual's home clinic.

B. The provider shall not dispense medication to any guest unless the guest has been receiving such medication services from another provider and documentation from that provider has been received prior to dispensing medication.

~~B.~~ C. Guests may receive medication for up to 28 days. To continue receiving medication after 28 days, the guest must be admitted to the service. Individuals receiving guest medications as part of a residential treatment service may exceed the 28-day maximum time limit at the medication assisted opioid treatment service.

Article 2

Medically ~~Managed Withdrawal~~ Monitored Intensive Inpatient Services [Part 1]

12VAC35-105-1110. Admission assessments.

During the admission process, providers of ~~managed withdrawal services~~ medically monitored intensive inpatient services shall:

1. Identify individuals with a high-risk for medical complications or who may pose a danger to themselves or others;
2. Assess substances used and time of last use;
3. Determine time of last meal;
4. Administer a urine screen;
5. Analyze blood alcohol content or administer a breathalyzer; and
6. Record vital signs.

12VAC35-105-1420. (Reserved.).

Part VII

Addition Medicine Service Requirements

Article 1

Medically Managed Intensive Inpatient [Level of care 4.0]

12VAC35-105-1430. Medically managed intensive inpatient [Level of care 4.0] staff criteria.

A medically managed intensive inpatient program shall meet the following staff requirements:

1. Have a team of appropriately trained and credentialed professionals who provide medical management by physicians 24 hours a day, primary nursing care and observation 24 hours a day, and professional counseling services 16 hours a day;
2. Have an interdisciplinary team of appropriately credentialed clinical staff, which may include addiction-credentialed physicians, nurse practitioners, physician assistants, nurses, counselors, psychologists, and social workers, who assess and treat individuals with severe substance use disorders or addicted individuals with concomitant acute biomedical, emotional, or behavioral disorders;
3. Have staff who are knowledgeable about the biopsychosocial dimensions of addiction as well as biomedical, emotional, behavioral, and cognitive disorders;
4. Have facility-approved addiction counselors or licensed, certified, or registered addiction clinicians who administer planned interventions according to the assessed needs of the individual; and

5. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1440. Medically managed intensive inpatient [Level of care 4.0] program criteria.

A medically managed intensive inpatient program shall meet the following programmatic requirements. The program shall:

1. Deliver services in a 24-hour medically managed, acute care setting and shall be available to all individuals within that setting;

2. Provide cognitive, behavioral, motivational, pharmacologic, and other therapies provided on an individual or group basis, depending on the individual's needs;

3. Provide, for the individual who has a severe biomedical disorder, physical health interventions to supplement addiction treatment;

4. Provide, for the individual who has stable psychiatric symptoms, individualized treatment activities designed to monitor the individual's mental health;

5. Provide planned clinical interventions that are designed to enhance the individual's understanding and acceptance of his addiction illness;

6. Provide family and caregiver treatment services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

7. Provide health education services;

8. Make medication assisted treatment (MAT) available for all individuals admitted to the service. MAT may be provided by facility staff or coordinated through alternative resources; and

9. Comply with 12VAC35-105-1055 through 12VAC35-105-1130.

12VAC35-105-1450. Medically managed intensive inpatient [Level of care 4.0] admission criteria.

Before a medically managed intensive inpatient program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:

1. Meet diagnostic criteria for a substance use disorder or [~~addictive disorder of moderate to high severity~~substance induced disorder] as defined by the DSM; and

2. Meet the admission criteria of Level 4.0 of ASAM, including the specific criteria for adult and adolescent populations.

12VAC35-105-1460. Medically managed intensive inpatient [Level of care 4.0] discharge criteria.

Before a medically managed intensive inpatient program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require ASAM 4.0 level of care;

2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or

3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

12VAC35-105-1470. Medically managed intensive inpatient [Level of care 4.0] co-occurring enhanced programs.

A. Medically managed intensive inpatient co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals who assess and treat the individual's co-occurring mental disorders. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

B. Medically managed intensive inpatient co-occurring enhanced programs shall offer individualized treatment activities designed to stabilize the individual's active psychiatric symptoms, including medication evaluation and management.

Article 2

Medically Monitored Intensive Inpatient Services [Level of care 3.7 Part 2]

12VAC35-105-1480. Medically monitored intensive inpatient services [Level of care 3.7] staff criteria.

A medically monitored intensive inpatient treatment program shall meet the following staff requirements. The program shall:

1. Have a licensed physician to oversee the treatment process and ensure quality of care. A physician, a licensed nurse practitioner, or a licensed physician assistant shall be available 24 hours a day in person or by telephone. A physician[, a licensed nurse practitioner, or a licensed physician assistant] shall assess the individual in person within 24 hours of admission;

2. Offer 24-hour nursing care and conduct a nursing assessment on admission. The level of nursing care must be appropriate to the severity of needs of individuals admitted to the service;

3. Have interdisciplinary staff, which may include physicians, nurses, addiction counselors, and behavioral health specialists, who are able to assess and treat the individual and obtain and interpret information regarding the individual's psychiatric and substance use or addictive disorders;

4. Offer daily onsite counseling and clinical services. Clinical staff shall be knowledgeable about the biological and psychosocial dimensions of addiction and other behavioral health disorders with specialized training in behavior management techniques and evidence-based practices;

5. Have staff able to provide a planned regimen of 24-hour professionally directed evaluation, care, and treatment services;

6. Make MAT available for all individuals [with opioid use disorder or alcohol use disorder]. MAT may be provided by facility staff or coordinated through alternative resources; and

7. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1490. Medically monitored intensive inpatient services [Level of care 3.7] program criteria.

A medically monitored intensive inpatient treatment program shall meet the following programmatic requirements. The program shall:

1. Be made available to all individuals within the inpatient setting;

2. Provide a combination of individual and group therapy as deemed appropriate by a [~~licensed mental health professional~~credentialed addiction treatment professional] and included in an assessment and treatment plan. Such therapy shall be adapted to the individual's level of comprehension;

3. Make available medical and nursing services onsite to provide ongoing assessment and care of addiction needs;

4. Provide direct affiliations with other easily accessible levels of care or close coordination through referral to more or less intensive levels of care and other services;

5. Provide family and caregiver treatment services as deemed appropriate by a [~~licensed mental health professional~~credentialed addiction treatment professional] and included in an assessment and treatment plan;

6. Provide educational and informational programming adapted to individual needs. The educational and informational programming shall include materials designed to enhance the individual's understanding of addiction and may include peer recovery support services as appropriate;

7. Utilize random drug screening to monitor drug use and reinforce treatment gains;

8. Regularly monitor the individual's adherence in taking any prescribed medications; and

9. Comply with 12VAC35-105-1055 through 12VAC35-105-1130.

12VAC35-105-1500. Medically monitored intensive inpatient [Level of care 3.7] admission criteria.

Before a medically monitored intensive inpatient program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:

1. Meet diagnostic criteria for a [~~substance use disorder of the DSM or addictive disorder of moderate to high severity~~moderate or severe substance use or addictive disorder]; and

2. Meet the admission criteria of Level 3.7 of ASAM, including the specific criteria for adult and adolescent populations.

12VAC35-105-1510. Medically monitored intensive inpatient [Level of care 3.7] discharge criteria.

A. Before a medically monitored intensive inpatient program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require ASAM 3.7 level of care;

2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or

3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

B. Discharge planning shall occur for individuals and include realistic plans for the continuity of MAT services as indicated.

12VAC35-105-1520. Medically monitored intensive inpatient [Level of care 3.7] co-occurring enhanced programs.

A. Medically monitored intensive inpatient co-occurring enhanced programs shall offer psychiatric services, medication evaluation, and laboratory services as indicated by the needs of individuals admitted to the service. A psychiatrist shall assess the individual by telephone within four hours of admission and in person with 24 hours following admission. [~~An LMHP~~ A credentialed addiction treatment professional] shall conduct a behavioral health-focused assessment at the time of admission. A registered nurse shall monitor the individual's progress and administer or monitor the individual's self-administration of psychotropic medications.

B. Medically monitored intensive inpatient co-occurring enhanced programs shall be staffed by addiction psychiatrists and appropriately credentialed behavioral health professionals who are able to assess and treat co-occurring psychiatric disorders and who have specialized training in behavior management techniques and evidence based practices. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Medically monitored intensive inpatient co-occurring enhanced programs shall offer planned clinical activities designed to promote stabilization of the individual's behavioral health needs and psychiatric symptoms and to promote such stabilization, including medication education and management and motivational and engagement strategies.

Article 3

Clinically Managed High-Intensity Residential Services [Level of care 3.5]

12VAC35-105-1530. Clinically managed high-intensity residential services [Level of care 3.5] staff criteria.

A clinically managed high-intensity residential care program shall meet the following staff requirements. The program shall:

1. Offer telephone or in-person consultation with a physician, a licensed nurse practitioner, or a licensed physician assistant in case of emergency related to an individual's substance use disorder 24 hours a day seven days a week;

2. Offer onsite 24-hour-a-day clinical staffing by credentialed addiction treatment professionals [~~and~~ in addition to] other allied health professionals, such as peer recovery specialists, who work in an interdisciplinary team;

3. Have clinical staff knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Staff shall be able to identify the signs and symptoms of acute psychiatric conditions. Staff shall have specialized training in behavior management techniques; and

4. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1540. Clinically managed high-intensity residential services [Level of care 3.5] program criteria.

A clinically managed high-intensity residential care program shall meet the following programmatic requirements. The program shall:

1. Provide daily clinical services, including a range of cognitive, behavioral, and other therapies in individual or group therapy; programming; and psychoeducation as deemed appropriate by a [~~licensed professional~~credentialed addiction treatment professional] and included in an assessment and treatment plan;

2. Provide counseling and clinical interventions to teach an individual the skills needed for daily productive activity, prosocial behavior, and reintegration into family and community;

3. Provide motivational enhancement and engagement strategies appropriate to an individual's stage of readiness to change and level of comprehension;

4. Have direct affiliations with other easily accessible levels of care or provide coordination through referral to more or less intensive levels of care and other services;

5. Provide family and caregiver treatment services as deemed appropriate by a [~~licensed professional~~ credentialed addiction treatment professional] and included in an assessment and treatment plan;

6. Provide educational, vocational, and informational programming adaptive to individual needs;

7. Utilize random drug screening to monitor progress and reinforce treatment gains as appropriate to an individual treatment plan;

8. Ensure and document that the length of an individual's stay shall be determined by the individual's condition and functioning;

9. Make a substance use treatment program available for all individuals; and

10. Make MAT available for all individuals [with opioid use disorder or alcohol use disorder]. Medication assisted treatment may be provided by facility staff, or coordinated through alternative resources.

12VAC35-105-1550. Clinically managed high-intensity residential services [Level of care 3.5] admission criteria.

A. The individuals served by clinically managed high-intensity residential care are individuals who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service.

B. Before a clinically managed high-intensity residential service program may admit an individual, the individual shall meet the criteria for admission as defined by the

provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:

1. Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate to high severity as defined by the DSM; and

2. Meet the admission criteria of Level 3.5 of ASAM.

12VAC35-105-1560. Clinically managed high-intensity residential services [Level of care 3.5] discharge criteria.

Before a clinically managed high-intensity residential service program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require ASAM 3.5 level of care;

2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or

3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

12VAC35-105-1570. Clinically managed high-intensity residential services [Level of care 3.5] co-occurring enhanced programs.

A. Clinically managed high-intensity residential services co-occurring enhanced programs shall offer psychiatric services, medication evaluation, and laboratory services. Such services shall be available by telephone within eight hours and onsite or closely coordinated offsite within 24 hours.

B. Clinically managed high-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals, including addiction psychiatrists who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Clinically managed high-intensity residential services co-occurring enhanced programs shall offer planned clinical activities designed to stabilize the individual's mental health problems and psychiatric symptoms and to maintain such stabilization, including medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the individual's substance use disorder and any co-occurring mental disorder.

Article 4

Clinically Managed Population-Specific High Intensity Residential Services [Level of care 3.3]

12VAC35-105-1580. Clinically managed population-specific high-intensity residential services [Level of care 3.3] staff criteria.

A high-intensity residential services program shall meet the following staff requirements. The program shall:

1. Offer telephone or in-person consultation with a physician, a licensed nurse practitioner, or a physician assistant in case of emergency related to an individual's substance use disorder 24 hours a day, seven days a week;

2. Have allied health professional staff onsite 24 hours a day. At least one clinician with competence in the treatment of substance use disorder shall be available onsite or by telephone 24 hours a day;

3. Have clinical staff knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment and able to identify the signs and symptoms of acute psychiatric conditions. Staff shall have specialized training in behavior management techniques; and

4. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1590. Clinically managed population-specific high-intensity residential services [Level of care 3.3] program criteria.

A high-intensity residential services program shall meet the following programmatic requirements. The program shall:

1. Provide daily clinical services that shall include a range of cognitive, behavioral, and other therapies administered on an individual and group basis, medication education and management, educational groups, and occupational or recreation activities as deemed appropriate by a [~~licensed professional~~credentialed addiction treatment professional] and included in an assessment and treatment plan;

2. Provide daily professional addiction and mental health treatment services that may include relapse prevention, exploring interpersonal choices, peer recovery support, and development of a social network;

3. Provide services to improve the individual's ability to structure and organize the tasks of daily living and recovery. Such services shall accommodate the cognitive limitations within this population;

4. Make available medical, psychiatric, psychological, and laboratory and toxicology services through consultation or referral as indicated by the individual's condition;

5. Provide case management, including ongoing transition and continuing care planning;

6. Provide motivational interventions appropriate to the individual's stage of readiness to change and designed to address the individual's functional limitations;

7. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;

8. Provide family and caregiver treatment services as deemed appropriate by an assessment and treatment plan;

9. Utilize random drug screening to monitor progress and reinforce treatment gains;

10. Regularly monitor the individual's adherence to taking prescribed medications;

11. Make the substance use treatment program available to all individuals served by the residential care service; and

12. Make MAT available for all individuals [with opioid use disorder or alcohol use disorder]. Medication assisted treatment may be provided by facility staff or coordinated through alternative resources.

12VAC35-105-1600. Clinically managed population-specific high-intensity residential services [Level of care 3.3] admission criteria.

Before a clinically managed, population-specific, high-intensity residential service program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:

1. Meet diagnostic criteria for [~~a substance use disorder or addictive disorder of moderate to high severity~~ a moderate or severe substance use or addictive disorder] as defined by the DSM; and

2. Meet the admission criteria of Level 3.3 of ASAM.

12VAC35-105-1610. Clinically managed population-specific high-intensity residential services [Level of care 3.3] discharge criteria.

A. Before a clinically managed, population-specific, high-intensity residential service program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require ASAM 3.3 level of care;

2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or

3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

B. Discharge planning shall occur for individuals and include realistic plans for the continuity of MAT services as indicated.

12VAC35-105-1620. Clinically managed population-specific high-intensity residential services [Level of care 3.3] co-occurring enhanced programs.

A. Clinically managed population-specific high-intensity residential services co-occurring enhanced programs shall offer psychiatric services, medication evaluation, and laboratory services. Such services shall be available by telephone within eight hours and

onsite or closely coordinated offsite within 24 hours, as appropriate to the severity and urgency of the individual's mental condition.

B. Clinically managed population-specific high-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed psychiatrists and licensed mental health professionals who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Clinically managed population-specific high-intensity residential services co-occurring enhanced programs shall offer planned clinical activities designed to stabilize the individual's mental health problems and psychiatric symptoms and to maintain such stabilization, including medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental health disorder.

Article 5

Clinically Managed Low-Intensity Residential Services [Level of care 3.1]

12VAC35-105-1630. Clinically managed low-intensity residential services [Level of care 3.1] staff criteria.

A clinically managed low-intensity residential services program shall meet the following staff requirements. The program shall:

1. Offer telephone or in-person consultation with a physician in case of emergency related to an individual's substance use disorder, available 24 hours a day, seven days a week. The program shall also provide allied health professional staff onsite 24 hours a day;

2. Have clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use disorder and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions;

3. Have a team comprised of appropriately trained and credentialed medical, addiction, and mental health professionals; and

4. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1640. Clinically managed low-intensity residential services [Level of care 3.1] program criteria.

A clinically managed low-intensity residential services program shall meet the following programmatic requirements. The program shall:

1. Offer a minimum of five hours a week of professionally directed treatment in addition to other treatment services offered to individuals, such as partial hospitalization or intensive outpatient treatment the focus of which is stabilizing the individual's substance use disorder. Services shall be designed to improve the individual's ability to structure and organize the tasks of daily living and recovery;

2. Ensure collaboration with care providers to develop an individual treatment plan for each individual with time-specific goals and objectives;

3. Provide counseling and clinical monitoring to support successful initial involvement in regular, productive daily activity;

4. Provide case management services;

5. Provide motivational interventions appropriate to the individual's stage of readiness to change and level of comprehension;

6. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;

7. Include the ability to arrange for needed procedures as appropriate to the severity and urgency of the individual's condition;

8. Provide family and caregiver treatment and peer recovery support services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

9. Provide addiction pharmacotherapy and the ability to arrange for pharmacotherapy for psychiatric medications;

10. Utilize random drug screening to monitor progress and reinforce treatment gains;

11. Make a substance abuse treatment program available to all individuals; and

12. Make MAT available for all individuals [with opioid use disorder and alcohol use disorder]. Medication assisted treatment may be provided by facility staff or coordinated through alternative resources.

12VAC35-105-1650. Clinically managed low-intensity residential services [Level of care 3.1] admission criteria.

Before a clinically managed low-intensity residential service program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:

1. Meet diagnostic criteria for a [~~substance use disorder or addictive disorder of moderate to high severity~~moderate or severe substance use or addictive disorder] as defined by the DSM; and

2. Meet the admission criteria of Level 3.1 of ASAM.

12VAC35-105-1660. Clinically managed low-intensity residential services [Level of care 3.1] discharge criteria.

Before a clinically managed low-intensity residential service program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require ASAM 3.1 level of care;

2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or

3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

12VAC35-105-1670. Clinically managed low-intensity residential services [Level of care 3.1] co-occurring enhanced programs.

A. Clinically managed low-intensity residential services co-occurring enhanced programs shall offer psychiatric services, including medication evaluation and laboratory services. Such services shall be provided onsite or closely coordinated offsite, as appropriate to the severity and urgency of the individual's mental condition.

B. Clinically managed low-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed licensed mental health professionals who are able to assess and treat co-occurring disorders with the capacity to involve addiction-trained psychiatrists. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Clinically managed low-intensity residential services co-occurring enhanced programs shall offer planned clinical activities that are designed to stabilize the individual's mental health problems and psychiatric symptoms and to maintain such stabilization, including medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental disorder.

Article 6

Partial Hospitalization [Level of care 2.5]

12VAC35-105-1680. Substance abuse partial hospitalization services [~~(ASAM 2.5 level of care)~~Level of care 2.5] staff criteria.

A substance abuse partial hospitalization program shall meet the following staff requirements. The program shall:

1. Have an interdisciplinary team of addiction treatment professionals, which may include counselors, psychologists, social workers, and addiction-credentialed physicians. Physicians treating individuals in this level shall have specialty training or experience in addiction medicine;

2. Have staff able to obtain and interpret information regarding the individual's biopsychosocial needs;

3. Have staff trained to understand the signs and symptoms of mental disorders and to understand and be able to explain the uses of psychotropic medications and their interactions with substance-related disorders; and

4. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1690. Substance abuse partial hospitalization services [Level of care 2.5] program criteria.

A substance abuse partial hospitalization program shall meet the following programmatic requirements. The program shall:

1. Offer no fewer than 20 hours of [~~programming~~skilled treatment services] per week in a structured program. Services may include individual and group counseling, medication management, family therapy, peer recovery support services, educational groups, or occupational and recreational therapy;

2. Provide a combination of individual and group therapy as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

3. Provide medical and nursing services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

4. Provide motivational enhancement and engagement strategies appropriate to an individual's stage of readiness to change and level of comprehension;

5. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;

6. Provide family and caregiver treatment services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

7. Provide educational and informational programming adaptable to individual needs;

8. Ensure and document that the length of service shall be determined by the individual's condition and functioning;

9. Make emergency services available by telephone 24 hours a day, seven days a week when the program is not in session; and

10. Make MAT available for all individuals [with opioid use disorder or alcohol use disorder]. MAT may be provided by facility staff or coordinated through alternative resources.

12VAC35-105-1700. Substance abuse partial hospitalization [Level of care 2.5] admission criteria.

Before a substance abuse partial hospitalization program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:

1. Meet diagnostic criteria for a substance use disorder or addictive disorder as defined by the DSM; and

2. Meet the admission criteria of Level 2.5 of ASAM, including the specific criteria for adult and adolescent populations.

12VAC35-105-1710. Substance abuse partial hospitalization [Level of care 2.5] discharge criteria.

Before a substance abuse partial hospitalization program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require ASAM 2.5 level of care;

2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or

3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

12VAC35-105-1720. Substance abuse partial hospitalization [Level of care 2.5] co-occurring enhanced programs.

A. Substance abuse partial hospitalization co-occurring enhanced programs shall offer psychiatric services appropriate to the individual's mental health condition. Such services shall be available by telephone and onsite or closely coordinated offsite, within a shorter time than in a co-occurring capable program.

B. Substance abuse partial hospitalization co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals who assess and treat co-occurring mental disorders. Intensive case management shall be delivered by cross-trained, interdisciplinary staff through mobile outreach and shall involve engagement-oriented addiction treatment and psychiatric programming. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Substance abuse partial hospitalization co-occurring enhanced programs shall offer intensive case management, assertive community treatment, medication management, and psychotherapy.

Article 7

Intensive Outpatient Services [Level of care 2.1]

12VAC35-105-1730. Substance abuse intensive outpatient services [Level of care 2.1] staff criteria.

A substance abuse intensive outpatient services program shall meet the following staff requirements. The program shall:

1. Be staffed by interdisciplinary team of appropriately credentialed addiction treatment professionals, which may include counselors, psychologists, social workers, and addiction-credentialed physicians. Physicians shall have specialty training or experience in addiction medicine or addiction psychiatry;

2. Have program staff that are able to obtain and interpret information regarding the individual's biopsychosocial needs;

3. Have program staff trained to understand the signs and symptoms of mental disorders and to understand and be able to explain the uses of psychotropic medications and their interactions with substance use and other addictive disorders; and

4. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1740. Substance abuse intensive outpatient services [Level of care 2.1] program criteria.

A substance abuse intensive outpatient program shall meet the following programmatic requirements. The program shall:

1. Offer a minimum of three service hours per service day to achieve no fewer than nine hours and no more than 19 hours of programming per week in a structured environment;

2. Ensure psychiatric and other medical consultation shall be available within 24 hours by telephone and within 72 hours in person;

3. Offer consultation in case of emergency related to an individual's substance use disorder by telephone 24 hours a day, seven days a week when the treatment program is not in session;

4. Provide a combination of individual and group therapy as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

5. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;

6. Provide family and caregiver treatment and peer recovery support services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

7. Provide education and informational programming adaptable to individual needs and developmental status;

8. Ensure and document that the length of service shall be determined by the individual's condition and functioning; and

9. Make MAT available for all individuals [with opioid use disorder and alcohol use disorder]. MAT may be provided by facility staff or coordinated through alternative resources.

12VAC35-105-1750. Substance abuse intensive outpatient services [Level of care 2.1] admission criteria.

Before a substance abuse intensive outpatient service program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:

1. Meet diagnostic criteria for a substance use disorder or addictive disorder as defined by the DSM; and

2. Meet the admission criteria of Level 2.1 of ASAM, including the specific criteria for adult and adolescent populations.

12VAC35-105-1760. Substance abuse intensive outpatient services [Level of care 2.1] discharge criteria.

Before a substance abuse intensive outpatient service program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require ASAM 2.1 level of care;

2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or

3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

12VAC35-105-1770. Substance abuse intensive outpatient services [Level of care 2.1] co-occurring enhanced programs.

A. Substance abuse intensive outpatient services co-occurring enhanced programs shall offer psychiatric services appropriate to the individual's mental health condition. Such services shall be available by telephone and onsite or closely coordinated offsite, within a shorter time than in a co-occurring capable program.

B. Substance abuse intensive outpatient services co-occurring enhanced programs shall be staffed by appropriately credential mental health professionals who assess and treat co-occurring mental disorders. Capacity to consult with an addiction psychiatrist shall be available. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Substance abuse intensive outpatient services co-occurring enhanced programs shall offer intensive case management, assertive community treatment, medication management, and psychotherapy.

Article 8

Substance Abuse Outpatient Services [Level of care 1.0]

12VAC35-105-1780. Substance abuse outpatient services [Level of care 1.0] staff criteria.

Substance abuse outpatient service programs shall meet the following staff requirements. The program shall:

1. Have appropriately credentialed or licensed treatment professionals who assess and treat substance-related mental and addictive disorders;

2. Have program staff who are capable of monitoring stabilized mental health problems and recognizing any instability of individuals with co-occurring mental health conditions;

3. Provide medication management services by a licensed independent practitioner with prescribing authority; and

4. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1790. Substance abuse outpatient service [Level of care 1.0] program criteria.

Substance abuse outpatient service programs shall meet the following programmatic requirements. The program shall:

1. Offer no more than nine hours of programming a week;

2. Ensure emergency services shall be available by telephone 24 hours a day, seven days a week;

3. Provide individual or group counseling, motivational enhancement, family therapy, educational groups, occupational and recreational therapy, psychotherapy, addiction, and pharmacotherapy as indicated by each individual's needs;

4. For individuals with mental illness, ensure the use of psychotropic medication, mental health treatment and that the individual's relationship to substance abuse disorders shall be addressed as the need arises;

5. Provide medical, psychiatric, psychological, laboratory, and toxicology services onsite or through consultation or referral. Medical and psychiatric consultation shall be available within 24 hours by telephone, or if in person, within a timeframe appropriate to the severity and urgency of the consultation requested;

6. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services; and

7. Ensure through documentation that the duration of treatment varies with the severity of the individual's illness and response to treatment.

12VAC35-105-1800. Substance abuse outpatient service [Level of care 1.0] admission criteria.

Before a substance abuse outpatient service program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:

1. Meet diagnostic criteria for a substance use disorder or addictive disorder as defined by the DSM; and

2. Meet the admission criteria of Level 1.0 of ASAM, including the specific criteria for adult and adolescent populations.

12VAC35-105-1810. Substance abuse outpatient services [Level of care 1.0] discharge criteria.

Before a substance abuse outpatient service program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require ASAM 1.0 level of care;

2. Been unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment; or

3. Achieved the individual's original treatment goals but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

12VAC35-105-1820. Substance abuse outpatient services [Level of care 1.0] co-occurring enhanced programs.

A. Substance abuse outpatient services co-occurring enhanced programs shall offer ongoing intensive case management for highly crisis-prone individuals with co-occurring disorders.

B. Substance abuse outpatient services co-occurring enhanced programs shall include credentialed mental health trained personnel who are able to assess, monitor,

and manage the types of severe and chronic mental disorders seen in a level 1 setting as well as other psychiatric disorders that are mildly unstable. Staff shall be knowledgeable about management of co-occurring mental and substance-related disorders, including assessment of the individual's stage of readiness to change and engagement of individuals who have co-occurring mental disorders. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Substance abuse outpatient services co-occurring enhanced programs shall offer therapies to actively address, monitor, and manage psychotropic medication, mental health treatment, and interaction with substance-related and addictive disorders.

Documents Incorporated by Reference (12VAC35-105)

The ASAM: Treatment for Addictive, Substance-Related and Co-Occurring Conditions, Third Edition, American Society of Addiction Medicine, Address, asam.org.

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. DSM-5, American Psychiatric Association, 800 Maine Avenue, S.W., Suite 900 Washington, DC 20024, psychiatry.org

☐ **Behavioral Health Expansion Final Stage Amendments to Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services [12 VAC 35 - 105], Action 5565.**

No changes were made to the regulatory text since the previous stage was published.

townhall.virginia.gov

Final Regulation
Agency Background Document

Agency name	Virginia Department of Behavioral Health and Developmental Services
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC35-105
VAC Chapter title(s)	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services
Action title	Amendments to align with enhanced behavioral health services
Date this document prepared	May 27, 2022

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

The General Assembly included the following requirements for the Department of Medical Assistance Services (DMAS) within Item 313 of the 2020 Appropriation Act (HB 2005, Chapter 56):

YYY. 3. Effective on or after January 1, 2021, DMAS shall implement programmatic changes and reimbursement rates for the following services: assertive community treatment, multi-systemic therapy and family functional therapy.

4. Effective on or after July 1, 2021, DMAS shall implement programmatic changes and reimbursement rates for the following services: intensive outpatient services, partial hospitalization programs, mobile crisis intervention services, 23 hour temporary observation services, crisis stabilization services and residential crisis stabilization unit services.
In order to further the implementation of these programmatic changes, the General Assembly directed the Department of Behavioral Health and Developmental Services (DBHDS), within Item 318.B. of the 2020 *Appropriation Act*, to promulgate emergency regulations to ensure that the DBHDS licensing regulations support high quality, community-based mental health services and align with the changes being made to the Medicaid behavioral health regulations for the services funded in the budget that support evidence based, trauma-informed, prevention-focused and cost-effective services for members across the lifespan.

The amendments to the Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services ("Licensing Regulations") [12VAC35-105] contained in this action consist of only those changes that are necessary to align the DBHDS Licensing Regulations with changes to Medicaid behavioral health regulations by removing provisions that would conflict with newly funded behavioral health services and establishing new licensed services for those newly funded behavioral health services that cannot be nested under an existing DBHDS license.

As stated above, most of the anticipated newly funded behavioral health services are consistent with existing DBHDS licensed services. For these services, including functional family therapy, multisystemic family therapy, intensive outpatient services, partial hospitalization programs, mobile crisis intervention services, 23 hour temporary observation services, crisis stabilization services, and residential crisis stabilization unit services; only very minimal changes are included in this action. The existing license requirements for Program for Assertive Community Treatment (PACT) services, however, are inconsistent with the Assertive Community Treatment (ACT) services that will be funded as part of the behavioral health enhancement initiative (Project BRAVO). Substantive changes have been made to the service specific sections in the Licensing Regulations for this service to align licensing requirements with ACT service expectations. These changes are intended to ensure that providers licensed to provide ACT services adhere to a base level of fidelity to the ACT model.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

ACT: Assertive community treatment
CPRS: Certified peer recovery specialist
CSAC: Certified substance abuse counselor
DBHDS: Department of Behavioral Health and Developmental Services
DMAS: Department of Medical Assistance Services
ICT: Intensive community treatment
LMHP: Licensed mental health professional
LPN: Licensed professional nurse
PACT: Program of Assertive Community Treatment
QMHP: Qualified mental health professional
RN: Registered nurse

Statement of Final Agency Action

Provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) the name of the agency taking the action; and 3) the title of the regulation.

The State Board voted on July 13, 2022, to initiate the final stage of the action titled "Amend the Licensing Regulations to align with enhanced behavioral health services to amend the Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (12VAC35-105), with no edits to the language from the proposed stage to the final stage.

Mandate and Impetus

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding the mandate for this regulatory change, and any other impetus that specifically prompted its initiation. If there are no changes to previously reported information, include a specific statement to that effect.

The 2020 General Assembly, per Item 318.B. of the 2020 *Appropriation Act*, directed DBHDS to promulgate emergency regulations, to be effective within 280 days or less from the enactment of the *Act*, to ensure that licensing regulations support high quality community-based mental health services and align with the changes being made to the Medicaid behavioral health regulations. This regulatory action is being utilized to establish permanent regulations following the emergency regulations.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

Section 37.2-203 of the Code of Virginia authorizes the State Board of Behavioral Health and Developmental Services to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the DBHDS Commissioner or the department. On July 15, 2020, the State Board adopted the emergency amendments to regulation 12VAC35-105 and initiated a notice of intended regulatory action for the standard permanent process. The State Board of Behavioral Health and Developmental Services voted to adopt a proposed stage regulatory action on July 28, 2021. The State Board of Behavioral Health and Developmental Services voted to adopt this final stage regulatory action on July 13, 2022.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's intended to solve.

The purpose of this regulatory action is to align the DBHDS Licensing Regulations with ongoing interagency efforts to enhance Virginia's behavioral health services system. The changes in this regulatory action will ensure that DBHDS's regulations for behavioral health providers align with changes to Medicaid funded behavioral health services in the Commonwealth by eliminating licensing provisions that conflict with Medicaid service expectations and creating new licensed services for those newly funded services that cannot be nested under an existing DBHDS licensed service.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

The substantive provisions of this regulatory action include:

1) The creation of a service definition and license for Mental Health Intensive Outpatient Service;
2) Revised definition of Substance Abuse Intensive Outpatient Service;
3) The creation of ACT as a newly licensed service in place of the previously licensed PACT service. This includes modification of the licensing requirements to align with the ACT service model and ensure that providers licensed to provide ACT services meet a basic level of fidelity to the ACT model;
4) Removal of the provisions of the regulations related to intensive community treatment (ICT) as it will no longer be a licensed service.

The new services defined in this action will ensure that Virginia's licensing regulations align with and support the Commonwealth's initiatives to enhance behavioral healthcare in Virginia and support high quality community-based mental health services.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

Virginia's behavioral health system is undergoing a multi-phased, interagency process of enhancing the behavioral health services available in the Commonwealth. This process requires coordination between agencies with responsibilities for licensing, funding, and overseeing the delivery of behavioral health services in the Commonwealth. The primary advantages of this regulatory action to the public are: 1) ensuring that Virginians have access to a continuum of high quality behavioral health services, 2) ensuring that a base level of model fidelity is adhered to by providers of ACT, and 3) aligning DBHDS licensing regulations and Medicaid service expectations to ensure that the licensing and funding of behavioral health services are congruent.

The aligning of DBHDS and DMAS regulations regarding behavioral health enhancement initiatives will prove an advantage to the Commonwealth because a continuum of publicly funded, high quality, community-based behavioral health services will reduce the need for more costly inpatient hospitalization.

There are no known disadvantages to the public or the Commonwealth to these regulatory changes.

Requirements More Restrictive than Federal

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any requirement of the regulatory change which is more restrictive than applicable federal requirements. If there are no changes to previously reported information, include a specific statement to that effect.

There are no identified requirements which are more restrictive than applicable federal requirements

Agencies, Localities, and Other Entities Particularly Affected

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any other state agencies, localities, or other entities that are particularly affected by the regulatory change. If there are no changes to previously reported information, include a specific statement to that effect.

Other State Agencies Particularly Affected

The DMAS regulations and funding streams are complementary to these regulations and the licensed services they address.

Localities Particularly Affected

Many community services boards provide behavioral health services, including PACT and ICT, and will be affected similarly to private providers, but no locality will be particularly affected.

Other Entities Particularly Affected

Any person, entity or organization offering behavioral health services that is licensed by DBHDS will be affected.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

No public comment was receiving during the public comment period.

Detail of Changes Made Since the Previous Stage

*List all changes made to the text since the previous stage was published in the Virginia Register of Regulations and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

No changes were made to the regulatory text since the previous stage was published in the Virginia Register of Regulations.

Detail of All Changes Proposed in this Regulatory Action

List all changes proposed in this action and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new

*requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of updated requirements
20		Defines terms used within the Licensing Regulations including: "Intensive community treatment service" or "ICT" "Program of assertive community treatment" or "PACT" "Partial hospitalization" Substance Abuse Intensive Outpatient Service	Removes definition of Intensive community treatment service or "ICT" Removes definition of Program of assertive community treatment or "PACT" Removes definition of "Partial Hospitalization" Update definition of Substance Abuse Intensive Outpatient Service Adds new definitions for: • Assertive community treatment or "ACT." • Mental Health Intensive Outpatient Service.
30		Lists services for which providers may be licensed by DBHDS, including: Intensive community treatment (ICT) and Program of Assertive Community Treatment (PACT)	Adds "Mental health intensive outpatient service" as a DBHDS licensed service. Removes "Intensive community treatment (ICT)" and "Program of Assertive Community Treatment (PACT)" from list of licensed services, and replaces with "Assertive Community Treatment (ACT)"
1360		Defines admission and discharge criteria for Intensive Community Treatment (ICT) and Program of Assertive Community Treatment (PACT) providers	Changes Program of Assertive Community Treatment (PACT) to Assertive Community Treatment (ACT) Removes language related to ICT. Adds personality disorder and brain injury to the list of sole diagnoses that render an individual ineligible for ACT services. Updates the criteria for discharge. Makes the following non-substantive language changes: Replaces "substance addition or abuse" with "substance use disorder."

1370		Defines the minimum treatment team and staffing requirements for ICT and PACT teams • Requires ICT and PACT team leader to be a QMHP-A with at least three years' experience in the provision of mental health services to adults with serious mental illness. • Requires ICT teams to be staffed with at least one full time nurse, and PACT teams to be staffed with at least two full time nurses, at least one of whom shall be a Registered Nurse (RN). • Requires ICT and PACT teams to have one full-time vocational specialist and one full-time substance abuse specialist • Requires a peer specialist who is a QPPMH or QMHP-A who is or has been a recipient of mental health services for severe and persistent mental illness. • Requires a psychiatrist who is a physician who is board certified in psychiatry or who is board eligible in psychiatry and is licensed to practice medicine in Virginia • Requires each team to have a psychiatrist on staff, who must be a physician who is board certified in psychiatry or who is board eligible in psychiatry. • Defines minimum staffing capacity for ICT and PACT teams. PACT teams shall have at least 10 full-time equivalent clinical employees or contractors. And PACT and ICT teams must maintain a minimum staff to individual ratio of 1:10.	Removes references to PACT and ICT Creates separate treatment team and staffing requirements for ACT teams. Makes substantive changes to ACT team staffing requirements to align with ACT service requirements, including: • Requires ACT team leader to be a Licensed Mental Health Professional (LMHP), or a Registered Qualified Mental Health Professional-Adult (QMHP-A) if already employed by the employer as a team leader prior to July 1, 2020. • Differentiates nurse staffing requirements based on the size of the ACT Team. o Small ACT teams shall have at least one full-time nurse, who shall be either an RN or an LPN. o Medium ACT teams shall have at least one full time RN, and at least one additional full-time nurse, who shall be LPN's or RNs. o Large ACT teams shall have at least one full-time RN, and at least two additional full-time nurses who shall e LPNs or RNs. • Requires Vocational Specialist to be a registered QMHP with demonstrated expertise in vocational services through experience or education. • Requires ACT Co-occurring disorder specialist to be a LMHP, registered QMHP, or Certified Substance Abuse Specialist (CSAC) with training or experience working with adults with co-occurring serious mental illness and substance use disorder. • Requires a peer recovery specialist to be a Certified Peer Recovery Specialist (CPRS) or

			certify as a CPRS within the first year of employment. • Allows a Psychiatric Nurse Practitioner practicing within the scope of practice of a Psychiatric Nurse Practitioner to fill the psychiatrist position on an ACT team. • Requires generalist clinical staff as follows: o Small ACT teams shall have at least one generalist clinical staff; o Medium ACT teams shall have at least two generalist clinical staff; o Large ACT teams shall have at least three generalist clinical staff. • Defines minimum staff to individual ratios that ACT teams must maintain based on the size of the team and the team's caseload. • Requires ACT teams to have 24-hour responsibility for directly responding to psychiatric crises, including meeting the following criteria: o The team shall be available to individuals in crisis 245 hours per day, seven days per week, including in person when needed as determined by the team; o The team shall be the first-line crisis evaluator and responder for individuals serviced by the team; and o The team shall have access to the practical, individualized crisis plans developed to help them address crises for each individual receiving services.
1380		Defines minimum number of contacts that ICT and PACT teams must make with individuals receiving services, and requires face-to-face contact, or attempts to make face-to-face contact with individuals in accordance with the individual's individualized services plan	• Removes references to ICT and PACT and replaces with ACT. • Language changes for clarity • Requires documentation of attempts to make contact with individuals

1390		Requires daily organizational meetings and progress notes be maintained by ICT and PACT teams	Removes references to ICT and PACT and replaces with ACT
1410		Defines minimum service requirements for ICT and PACT teams Providers shall document that the following services are provided consistent with the individual's assessment and ISP. 1. Ongoing assessment to ascertain the needs, strengths, and preferences of the individual; 2. Case management; 3. Nursing; 4. Support for wellness self-management, including the development and implementation of individual recovery plans, symptom assessment, and recovery education; 5. Psychopharmacological treatment, administration, and monitoring; 6. Substance abuse assessment and treatment for individuals with a co-occurring diagnosis of mental illness and substance abuse; 7. Individual supportive therapy; 8. Skills training in activities of daily living, social skills, interpersonal relationships, and leisure time; 9. Supportive in-home services; 10. Work-related services to help find and maintain employment; 11. Support for resuming education; 12. Support, psychoeducation, consultation, and skill-teaching to family members, and significant others; 13. Collaboration with families and assistance to individuals with children; 14. Direct support to help individuals secure and maintain decent, affordable housing that is integrated into the broader community and to	Amends service requirements to align with ACT service expectations and philosophy. Providers shall document that the following services are provided consistent with the individual's assessment and ISP. 1. Ongoing assessment to ascertain the needs, strengths, and preferences of the individual; 2. Case management; 3. Nursing; 4. Support for wellness self-management, including the development and implementation of individual recovery plans, symptom assessment, and recovery education; 5. Psychopharmacological treatment, administration, and monitoring; 6. Co-occurring diagnosis substance use disorder services that are non-confrontational, trauma informed, person-centered, consider interactions of mental illness and substance use, and have goals determined by the individual; 7. Empirically supported interventions and psychotherapy; 8. Psychiatric rehabilitation to include skill-building, coaching, and access to necessary resources to help individuals with personal care, safety skills, money management skills, grocery shopping, cooking, food safety and storage, purchasing and caring for clothing, household maintenance and cleaning skills, social skills, and use of transportation and other community resources; 9. Work-related services to help find and maintain employment; 10. Support for resuming education; 11. Support, psychoeducation, consultation, and skill-teaching to family members, and significant others, and broader natural support systems, which shall be directed exclusively to the well-being and benefit of the individual;

		obtain legal and advocacy services, financial support, money-management services, medical and dental services, transportation, and natural supports in the community; and 15. Mobile crisis assessment, interventions to prevent or resolve potential crises, and admission to and discharge from psychiatric hospitals.	12. Collaboration with families and development of family and other natural supports; 13. Assistance in obtaining and maintaining safe, decent, and affordable housing that follows the individual's preferences in level of independence and location, consistent with an evidence based Supportive Housing Model. 14. Direct support to help individuals obtain legal and advocacy services, financial support, money-management services, medical and dental services, transportation, and natural supports in the community; and 15. Mobile Crisis assessment, interventions to prevent or resolve potential crises, and admission to and discharge from psychiatric hospitals. 16. Assistance in developing and maintaining natural supports and social relationships; 17. Medication education, assistance, and support; 18. Peer support services, such as coaching, mentoring, assistance with self-advocacy and self-direction, and modeling recovery practices.

Amendments to Align with Enhanced Behavioral Health Services in the Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services

12VAC35-105-20. Definitions and units of measurement.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Virginia Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse. Examples of abuse include acts such as:

1. Rape, sexual assault, or other criminal sexual behavior;
2. Assault or battery;

3. Use of language that demeans, threatens, intimidates, or humiliates the individual;

4. Misuse or misappropriation of the individual's assets, goods, or property;

5. Use of excessive force when placing an individual in physical or mechanical restraint;

6. Use of physical or mechanical restraints on an individual that is not in compliance with federal and state laws, regulations, and policies, professional accepted standards of practice, or his individualized services plan; or

7. Use of more restrictive or intensive services or denial of services to punish an individual or that is not consistent with his individualized services plan.

"Activities of daily living" or "ADLs" means personal care activities and includes bathing, dressing, transferring, toileting, grooming, hygiene, feeding, and eating. An individual's degree of independence in performing these activities is part of determining the appropriate level of care and services.

"Admission" means the process of acceptance into a service as defined by the provider's policies.

"Assertive community treatment service" or "ACT" means a self-contained interdisciplinary community-based team of medical, behavioral health, and rehabilitation professionals who use a team approach to meet the needs of an individual with severe and persistent mental illness. ACT teams:

1. Provide person-centered services addressing the breadth of an individual's needs, helping him achieve his personal goals;

2. Serve as the primary provider of all the services that an individual receiving ACT services needs;

3. Maintain a high frequency and intensity of community-based contacts;

4. Maintain a very low individual-to-staff ratio;

5. Offer varying levels of care for all individuals receiving ACT services, and appropriately adjust service levels according to each individual's needs over time;

6. Assist individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles, such as worker, family member, resident, spouse, tenant, or friend;

7. Carry out planned assertive engagement techniques, including rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques;

8. Monitor the individual's mental status and provide needed supports in a manner consistent with the individual's level of need and functioning;

9. Deliver all services according to a recovery-based philosophy of care; and

10. Promote self-determination, respect for the individual receiving ACT as an individual in such individual's own right, and engage peers in promoting recovery and regaining meaningful roles and relationships in the community.

"Authorized representative" means a person permitted by law or 12VAC35-115 to authorize the disclosure of information or consent to treatment and services or participation in human research.

"Behavior intervention" means those principles and methods employed by a provider to help an individual receiving services to achieve a positive outcome and to address challenging behavior in a constructive and safe manner. Behavior intervention principles and methods shall be employed in accordance with the individualized services plan and written policies and procedures governing service expectations, treatment goals, safety, and security.

"Behavioral treatment plan," "functional plan," or "behavioral support plan" means any set of documented procedures that are an integral part of the individualized services plan and are developed on the basis of a systematic data collection, such as a functional assessment, for the purpose of assisting individuals to achieve the following:

1. Improved behavioral functioning and effectiveness;
2. Alleviation of symptoms of psychopathology; or
3. Reduction of challenging behaviors.

"Brain injury" means any injury to the brain that occurs after birth~~, but before age 65,~~ that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. Brain injury does not include hereditary, congenital, or degenerative brain disorders or injuries induced by birth trauma.

"Care," "treatment," or "support" means the individually planned therapeutic interventions that conform to current acceptable professional practice and that are intended to improve or maintain functioning of an individual receiving services delivered by a provider.

"Case management service" or "support coordination service" means services that can include assistance to individuals and their family members in accessing needed services that are responsive to the individual's needs. Case management services include identifying potential users of the service; assessing needs and planning services; linking the individual to services and supports; assisting the individual directly to locate, develop, or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; discharge planning; and advocating for individuals in response to their changing needs. "Case management service" does not include assistance in which the only function is maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs.

"Clinical experience" means providing direct services to individuals with mental illness or the provision of direct geriatric services or special education services. Experience may include supervised internships, practicums, and field experience.

"Commissioner" means the Commissioner of the Department of Behavioral Health and Developmental Services.

"Community gero-psychiatric residential services" means 24-hour care provided to individuals with mental illness, behavioral problems, and concomitant health problems who are usually age 65 or older in a geriatric setting that is less intensive than a psychiatric hospital but more intensive than a nursing home or group home. Services include assessment and individualized services planning by an interdisciplinary services team, intense supervision, psychiatric care, behavioral treatment planning and behavior interventions, nursing, and other health related services.

"Complaint" means an allegation of a violation of this chapter or a provider's policies and procedures related to this chapter.

"Co-occurring disorders" means the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, a developmental disability, substance abuse (substance use disorders), or brain injury.

"Co-occurring services" means individually planned therapeutic treatment that addresses in an integrated concurrent manner the service needs of individuals who have co-occurring disorders.

"Corrective action plan" means the provider's pledged corrective action in response to cited areas of noncompliance documented by the regulatory authority.

"Correctional facility" means a facility operated under the management and control of the Virginia Department of Corrections.

"Crisis" means a deteriorating or unstable situation often developing suddenly or rapidly that produces acute, heightened, emotional, mental, physical, medical, or behavioral distress.

"Crisis stabilization" means direct, intensive nonresidential or residential direct care and treatment to nonhospitalized individuals experiencing an acute crisis that may jeopardize their current community living situation. Crisis stabilization is intended to avert hospitalization or rehospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis; and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Day support service" means structured programs of training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills for adults with a developmental disability provided to groups or individuals in nonresidential community-based settings. Day support services may provide opportunities for peer interaction and community integration and are designed to enhance the following: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, social skills, medication management, prevocational skills, and transportation skills. The term "day support service" does not include services in which the primary function is to provide employment-related services, general educational services, or general recreational services.

"Department" means the Virginia Department of Behavioral Health and Developmental Services.

"Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or a combination of mental and physical impairments other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or

extended duration and are individually planned and coordinated. An individual from birth to nine years of age, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual without services and supports has a high probability of meeting those criteria later in life.

"Developmental services" means planned, individualized, and person-centered services and supports provided to individuals with developmental disabilities for the purpose of enabling these individuals to increase their self-determination and independence, obtain employment, participate fully in all aspects of community life, advocate for themselves, and achieve their fullest potential to the greatest extent possible.

"Direct care position" means any position that includes responsibility for (i) treatment, case management, health, safety, development, or well-being of an individual receiving services or (ii) immediately supervising a person in a position with this responsibility.

"Discharge" means the process by which the individual's active involvement with a service is terminated by the provider, individual, or authorized representative.

"Discharge plan" means the written plan that establishes the criteria for an individual's discharge from a service and identifies and coordinates delivery of any services needed after discharge.

"Dispense" means to deliver a drug to an ultimate user by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery (§ 54.1-3400 et seq. of the Code of Virginia).

"Emergency service" means unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, available 24 hours a day and seven days per week. Emergency services also may include walk-ins, home visits, jail interventions, and preadmission screening activities associated with the judicial process.

"Group home or community residential service" means a congregate service providing 24-hour supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.

"HCBS Waiver" means a Medicaid Home and Community Based Services Waiver.

"Home and noncenter based" means that a service is provided in the individual's home or other noncenter-based setting. This includes noncenter-based day support, supportive in-home, and intensive in-home services.

"Individual" or "individual receiving services" means a current direct recipient of public or private mental health, developmental, or substance abuse treatment, rehabilitation, or habilitation services and includes the terms "consumer," "patient," "resident," "recipient," or "client". When the term is used in this chapter, the requirement applies to every individual receiving licensed services from the provider.

"Individualized services plan" or "ISP" means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to

address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans.

"Informed choice" means a decision made after considering options based on adequate and accurate information and knowledge. These options are developed through collaboration with the individual and his authorized representative, as applicable, and the provider with the intent of empowering the individual and his authorized representative to make decisions that will lead to positive service outcomes.

"Informed consent" means the voluntary written agreement of an individual, or that individual's authorized representative, to surgery, electroconvulsive treatment, use of psychotropic medications, or any other treatment or service that poses a risk of harm greater than that ordinarily encountered in daily life or for participation in human research. To be voluntary, informed consent must be given freely and without undue inducement; any element of force, fraud, deceit, or duress; or any form of constraint or coercion.

"Initial assessment" means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services.

"Inpatient psychiatric service" means intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use disorders) in a hospital as defined in § 32.1-123 of the Code of Virginia or in a special unit of such a hospital.

"Instrumental activities of daily living" or "IADLs" means meal preparation, housekeeping, laundry, and managing money. A person's degree of independence in performing these activities is part of determining appropriate level of care and services.

"Intellectual disability" means a disability originating before 18 years of age, characterized concurrently by (i) significant subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with accepted professional practice that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

~~"Intensive community treatment service" or "ICT" means a self-contained interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a full-time psychiatrist that:~~

~~1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illness, especially those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services;~~

~~2. Minimally refers individuals to outside service providers;~~

~~3. Provides services on a long-term care basis with continuity of caregivers over time;~~

~~4. Delivers 75% or more of the services outside program offices; and~~

~~5. Emphasizes outreach, relationship building, and individualization of services.~~

"Intensive in-home service" means family preservation interventions for children and adolescents who have or are at-risk of serious emotional disturbance, including individuals who also have a diagnosis of developmental disability. Intensive in-home service is usually time-limited and is provided typically in the residence of an individual who is at risk of being moved to out-of-home placement or who is being transitioned back home from an out-of-home placement. The service includes 24-hour per day emergency response; crisis treatment; individual and family counseling; life, parenting, and communication skills; and case management and coordination with other services.

"Intermediate care facility/individuals with intellectual disability" or "ICF/IID" means a facility or distinct part of a facility certified by the Virginia Department of Health as meeting the federal certification regulations for an intermediate care facility for individuals with intellectual disability and persons with related conditions and that addresses the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, providing active treatment as defined in 42 CFR 435.1010 and 42 CFR 483.440.

"Investigation" means a detailed inquiry or systematic examination of the operations of a provider or its services regarding an alleged violation of regulations or law. An investigation may be undertaken as a result of a complaint, an incident report, or other information that comes to the attention of the department.

"Licensed mental health professional" or "LMHP" means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavior analyst, or licensed psychiatric/mental health nurse practitioner.

"Location" means a place where services are or could be provided.

"Medically managed withdrawal services" means detoxification services to eliminate or reduce the effects of alcohol or other drugs in the individual's body.

"Mandatory outpatient treatment order" means an order issued by a court pursuant to § 37.2-817 of the Code of Virginia.

"Medical detoxification" means a service provided in a hospital or other 24-hour care facility under the supervision of medical personnel using medication to systematically eliminate or reduce effects of alcohol or other drugs in the individual's body.

"Medical evaluation" means the process of assessing an individual's health status that includes a medical history and a physical examination of an individual conducted by a licensed medical practitioner operating within the scope of his license.

"Medication" means prescribed or over-the-counter drugs or both.

"Medication administration" means the direct application of medications by injection, inhalation, ingestion, or any other means to an individual receiving services by (i) persons legally permitted to administer medications or (ii) the individual at the direction and in the presence of persons legally permitted to administer medications.

"Medication assisted treatment (Opioid treatment service)" means an intervention strategy that combines outpatient treatment with the administering or dispensing of synthetic narcotics, such as methadone or buprenorphine (suboxone), approved by the

federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.

"Medication error" means an error in administering a medication to an individual and includes when any of the following occur: (i) the wrong medication is given to an individual, (ii) the wrong individual is given the medication, (iii) the wrong dosage is given to an individual, (iv) medication is given to an individual at the wrong time or not at all, or (v) the wrong method is used to give the medication to the individual.

"Medication storage" means any area where medications are maintained by the provider, including a locked cabinet, locked room, or locked box.

"Mental Health Community Support Service " or "MCHSS" means the provision of recovery-oriented services to individuals with long-term, severe mental illness. MHCSS includes skills training and assistance in accessing and effectively utilizing services and supports that are essential to meeting the needs identified in the individualized services plan and development of environmental supports necessary to sustain active community living as independently as possible. MHCSS may be provided in any setting in which the individual's needs can be addressed, skills training applied, and recovery experienced.

"Mental health intensive outpatient service" means a structured program of skilled treatment services focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to treatment. This service is provided over a period of time for individuals requiring more intensive services than an outpatient service can provide and may include individual, family, or group counseling or psychotherapy; skill development and psychoeducational activities; certified peer support services; medication management; and psychological assessment or testing.

"Mental health outpatient service" means treatment provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Mental health outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory, and other ancillary services, medical services, and medication services. Mental health outpatient service specifically includes:

1. Mental health services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;

2. Mental health services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or

3. Mental health services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Mental health partial hospitalization service" means time-limited active treatment interventions that are more intensive than outpatient services, designed to stabilize and ameliorate acute symptoms, and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization is provided through a minimum of 20 hours per week of skilled treatment services focused on individuals who require intensive, high coordinated, structured, and interdisciplinary ambulatory treatment within

a stable environment that is of greater intensity than intensive outpatient, but of lesser intensity than inpatient.

"Mental illness" means a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others.

"Missing" means a circumstance in which an individual is not physically present when and where he should be and his absence cannot be accounted for or explained by his supervision needs or pattern of behavior.

"Neglect" means the failure by a person, or a program or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse.

"Neurobehavioral services" means the assessment, evaluation, and treatment of cognitive, perceptual, behavioral, and other impairments caused by brain injury that affect an individual's ability to function successfully in the community.

~~"Outpatient service" means treatment provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. "Outpatient service" specifically includes:~~

~~1. Services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;~~

~~2. Services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or~~

~~3. Services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.~~

~~"Partial hospitalization service" means time-limited active treatment interventions that are more intensive than outpatient services, designed to stabilize and ameliorate acute symptoms, and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization is focused on individuals with serious mental illness, substance abuse (substance use disorders), or co-occurring disorders at risk of hospitalization or who have been recently discharged from an inpatient setting.~~

"Person-centered" means focusing on the needs and preferences of the individual; empowering and supporting the individual in defining the direction for his life; and promoting self-determination, community involvement, and recovery.

~~"Program of assertive community treatment service" or "PACT" means a self-contained interdisciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a full-time or part-time psychiatrist that:~~

~~1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses, including those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services;~~

~~2. Minimally refers individuals to outside service providers;~~

~~3. Provides services on a long-term care basis with continuity of caregivers over time;~~

~~4. Delivers 75% or more of the services outside program offices; and~~

~~5. Emphasizes outreach, relationship building, and individualization of services.~~

"Provider" means any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders) or (ii) residential services for individuals with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601, and 54.1-3701 of the Code of Virginia.

"Psychosocial rehabilitation service" means a program of two or more consecutive hours per day provided to groups of adults in a nonresidential setting. Individuals must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the individual about mental illness, substance abuse, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment. Psychosocial rehabilitation includes skills training, peer support, vocational rehabilitation, and community resource development oriented toward empowerment, recovery, and competency.

"Qualified developmental disability professional" or "QDDP" means a person who possesses at least one year of documented experience working directly with individuals who have a developmental disability and who possesses one of the following credentials: (i) a doctor of medicine or osteopathy licensed in Virginia, (ii) a registered nurse licensed in Virginia, (iii) a licensed occupational therapist, or (iv) completion of at least a bachelor's degree in a human services field, including sociology, social work, special education, rehabilitation counseling, or psychology.

"Qualified mental health professional" or "QMHP" means a person who by education and experience is professionally qualified and registered by the Board of Counseling in accordance with 18VAC115-80 to provide collaborative mental health services for adults or children. A QMHP shall not engage in independent or autonomous practice. A QMHP shall provide such services as an employee or independent contractor of the department or a provider licensed by the department.

"Qualified mental health professional-adult" or "QMHP-A" means a person who by education and experience is professionally qualified and registered with the Board of

Counseling in accordance with 18VAC115-80 to provide collaborative mental health services for adults. A QMHP-A shall provide such services as an employee or independent contractor of the department or a provider licensed by the department. A QMHP-A may be an occupational therapist who by education and experience is professionally qualified and registered with the Board of Counseling in accordance with 18VAC115-80.

"Qualified mental health professional-child" or "QMHP-C" means a person who by education and experience is professionally qualified and registered with the Board of Counseling in accordance with 18VAC115-80 to provide collaborative mental health services for children. A QMHP-C shall provide such services as an employee or independent contractor of the department or a provider licensed by the department. A QMHP-C may be an occupational therapist who by education and experience is professionally qualified and registered with the Board of Counseling in accordance with 18VAC115-80.

"Qualified mental health professional-eligible" or "QMHP-E" means a person receiving supervised training in order to qualify as a QMHP in accordance with 18VAC115-80 and who is registered with the Board of Counseling.

"Qualified paraprofessional in mental health" or "QPPMH" means a person who must meet at least one of the following criteria: (i) registered with the United States Psychiatric Association (USPRA) as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) has an associate's degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least one year of experience providing direct services to individuals with a diagnosis of mental illness; (iii) licensed as an occupational therapy assistant, and supervised by a licensed occupational therapist, with at least one year of experience providing direct services to individuals with a diagnosis of mental illness; or (iv) has a minimum of 90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP-A providing services to individuals with mental illness and at least one year of experience (including the 12 weeks of supervised experience).

"Quality improvement plan" means a detailed work plan developed by a provider that defines steps the provider will take to review the quality of services it provides and to manage initiatives to improve quality. A quality improvement plan consists of systematic and continuous actions that lead to measurable improvement in the services, supports, and health status of the individuals receiving services.

"Recovery" means a journey of healing and transformation enabling an individual with a mental illness to live a meaningful life in a community of his choice while striving to achieve his full potential. For individuals with substance abuse (substance use disorders), recovery is an incremental process leading to positive social change and a full return to biological, psychological, and social functioning. For individuals with a developmental disability, the concept of recovery does not apply in the sense that individuals with a developmental disability will need supports throughout their entire lives although these may change over time. With supports, individuals with a developmental disability are capable of living lives that are fulfilling and satisfying and that bring meaning to themselves and others whom they know.

"Referral" means the process of directing an applicant or an individual to a provider or service that is designed to provide the assistance needed.

"Residential crisis stabilization service" means (i) providing short-term, intensive treatment to nonhospitalized individuals who require multidisciplinary treatment in order to stabilize acute psychiatric symptoms and prevent admission to a psychiatric inpatient unit; (ii) providing normative environments with a high assurance of safety and security for crisis intervention; and (iii) mobilizing the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Residential service" means providing 24-hour support in conjunction with care and treatment or a training program in a setting other than a hospital or training center. Residential services provide a range of living arrangements from highly structured and intensively supervised to relatively independent requiring a modest amount of staff support and monitoring. Residential services include residential treatment, group homes, supervised living, residential crisis stabilization, community gero-psychiatric residential, ICF/IID, sponsored residential homes, medical and social detoxification, neurobehavioral services, and substance abuse residential treatment for women and children.

"Residential treatment service" means providing an intensive and highly structured mental health, substance abuse, or neurobehavioral service, or services for co-occurring disorders in a residential setting, other than an inpatient service.

"Respite care service" means providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular care giver. Persons providing respite care are recruited, trained, and supervised by a licensed provider. These services may be provided in a variety of settings including residential, day support, in-home, or a sponsored residential home.

"Restraint" means the use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an individual receiving services from moving his body to engage in a behavior that places him or others at imminent risk. There are three kinds of restraints:

1. Mechanical restraint means the use of a mechanical device that cannot be removed by the individual to restrict the individual's freedom of movement or functioning of a limb or portion of an individual's body when that behavior places him or others at imminent risk.

2. Pharmacological restraint means the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that individual's behavior places him or others at imminent risk and the administered medication is not a standard treatment for the individual's medical or psychiatric condition.

3. Physical restraint, also referred to as manual hold, means the use of a physical intervention or hands-on hold to prevent an individual from moving his body when that individual's behavior places him or others at imminent risk.

"Restraints for behavioral purposes" means using a physical hold, medication, or a mechanical device to control behavior or involuntary restrict the freedom of movement of an individual in an instance when all of the following conditions are met: (i) there is an emergency; (ii) nonphysical interventions are not viable; and (iii) safety issues require an immediate response.

"Restraints for medical purposes" means using a physical hold, medication, or mechanical device to limit the mobility of an individual for medical, diagnostic, or surgical

purposes, such as routine dental care or radiological procedures and related post-procedure care processes, when use of the restraint is not the accepted clinical practice for treating the individual's condition.

"Restraints for protective purposes" means using a mechanical device to compensate for a physical or cognitive deficit when the individual does not have the option to remove the device. The device may limit an individual's movement, for example, bed rails or a gerichair, and prevent possible harm to the individual or it may create a passive barrier, such as a helmet to protect the individual.

"Restriction" means anything that limits or prevents an individual from freely exercising his rights and privileges.

"Risk management" means an integrated system-wide program to ensure the safety of individuals, employees, visitors, and others through identification, mitigation, early detection, monitoring, evaluation, and control of risks.

"Root cause analysis" means a method of problem solving designed to identify the underlying causes of a problem. The focus of a root cause analysis is on systems, processes, and outcomes that require change to reduce the risk of harm.

"Screening" means the process or procedure for determining whether the individual meets the minimum criteria for admission.

"Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical means so that the individual cannot leave it.

"Serious incident" means any event or circumstance that causes or could cause harm to the health, safety, or well-being of an individual. The term "serious incident" includes death and serious injury.

"Level I serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider and does not meet the definition of a Level II or Level III serious incident. Level I serious incidents do not result in significant harm to individuals, but may include events that result in minor injuries that do not require medical attention or events that have the potential to cause serious injury, even when no injury occurs. "Level II serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider that results in a significant harm or threat to the health and safety of an individual that does not meet the definition of a Level III serious incident.

"Level II serious incident" includes a significant harm or threat to the health or safety of others caused by an individual. Level II serious incidents include:

1. A serious injury;

2. An individual who is or was missing;

3. An emergency room visit;

4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services, except that a psychiatric admission in accordance with the individual's Wellness Recovery Action Plan shall not constitute an unplanned admission for the purposes of this chapter;

5. Choking incidents that require direct physical intervention by another person;

6. Ingestion of any hazardous material; or

7. A diagnosis of:

a. A decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer;

b. A bowel obstruction; or

c. Aspiration pneumonia.

"Level III serious incident" means a serious incident whether or not the incident occurs while in the provision of a service or on the provider's premises and results in:

1. Any death of an individual;

2. A sexual assault of an individual; or

3. A suicide attempt by an individual admitted for services, other than licensed emergency services, that results in a hospital admission.

"Serious injury" means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner.

"Service" means (i) planned individualized interventions intended to reduce or ameliorate mental illness, developmental disabilities, or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders). Services include outpatient services, intensive in-home services, opioid treatment services, inpatient psychiatric hospitalization, community gero-psychiatric residential services, assertive community treatment and other clinical services; day support, day treatment, partial hospitalization, psychosocial rehabilitation, and habilitation services; case management services; and supportive residential, special school, halfway house, in-home services, crisis stabilization, and other residential services; and (ii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports provided in residential services for persons with brain injury.

"Shall" means an obligation to act is imposed.

"Shall not" means an obligation not to act is imposed.

"Skills training" means systematic skill building through curriculum-based psychoeducational and cognitive-behavioral interventions. These interventions break down complex objectives for role performance into simpler components, including basic cognitive skills such as attention, to facilitate learning and competency.

"Social detoxification service" means providing nonmedical supervised care for the individual's natural process of withdrawal from use of alcohol or other drugs.

"Sponsored residential home" means a service where providers arrange for, supervise, and provide programmatic, financial, and service support to families or persons (sponsors) providing care or treatment in their own homes for individuals receiving services.

"State board" means the State Board of Behavioral Health and Developmental Services. The board has statutory responsibility for adopting regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the commissioner or the department.

"State methadone authority" means the Virginia Department of Behavioral Health and Developmental Services that is authorized by the federal Center for Substance Abuse Treatment to exercise the responsibility and authority for governing the treatment of opiate addiction with an opioid drug.

"Substance abuse (substance use disorders)" means the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

"Substance abuse intensive outpatient service" means structured treatment provided ~~in a concentrated manner for two or more consecutive hours per day to groups of individuals in a nonresidential setting. This service is provided over a period of time for individuals requiring~~ to individuals who require more intensive services than is normally provided in an outpatient service ~~can provide. Substance abuse intensive outpatient services include multiple group therapy sessions during the week, individual and family therapy, individual monitoring, and case management.~~ but do not require inpatient services. Treatment consists primarily of counseling and education about addiction-related and mental health challenges delivered a minimum of nine to 19 hours of services per week for adults or six to 19 hours of services per week for children and adolescents. Within this level of care, an individual's needs for psychiatric and medical services are generally addressed through consultation and referrals.

"Substance abuse outpatient services" means a center based substance abuse treatment delivered to individuals for fewer than nine hours of service per weeks for adults or fewer than six hours per week for adolescents on an individual, group or family basis. Substance abuse outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Substance abuse outpatient service includes substance abuse services or an office practice that provides professionally directed aftercare, individual, and other addiction services to individuals according to a predetermined regular schedule of fewer than nine contact hours a week. Substance abuse outpatient service also includes:

1. Substance abuse services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;

2. Substance abuse services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;

3. Substance abuse services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Substance abuse partial hospitalization services" means a short-term, nonresidential substance use treatment program provided for a minimum of 20 hours a week that uses multidisciplinary staff and is provided for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment. This level of care is designed to offer highly structured intensive treatment to those individual whose condition is sufficiently stable so as not to require 24-hour-per-day monitoring and care, but whose illness has progressed so as to require consistent near-daily treatment intervention.

"Substance abuse residential treatment for women with children service" means a 24-hour residential service providing an intensive and highly structured substance abuse service for women with children who live in the same facility.

"Suicide attempt" means a nonfatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior regardless of whether it results in injury.

"Supervised living residential service" means the provision of significant direct supervision and community support services to individuals living in apartments or other residential settings. These services differ from supportive in-home service because the provider assumes responsibility for management of the physical environment of the residence, and staff supervision and monitoring are daily and available on a 24-hour basis. Services are provided based on the needs of the individual in areas such as food preparation, housekeeping, medication administration, personal hygiene, treatment, counseling, and budgeting.

"Supportive in-home service" (formerly supportive residential) means the provision of community support services and other structured services to assist individuals, to strengthen individual skills, and that provide environmental supports necessary to attain and sustain independent community residential living. Services include drop-in or friendly-visitor support and counseling to more intensive support, monitoring, training, in-home support, respite care, and family support services. Services are based on the needs of the individual and include training and assistance. These services normally do not involve overnight care by the provider; however, due to the flexible nature of these services, overnight care may be provided on an occasional basis.

"Systemic deficiency" means violations of regulations documented by the department that demonstrate multiple or repeat defects in the operation of one or more services.

"Therapeutic day treatment for children and adolescents" means a treatment program that serves (i) children and adolescents from birth through 17 years of age and under certain circumstances up to 21 years of age with serious emotional disturbances, substance use, or co-occurring disorders or (ii) children from birth through seven years of age who are at risk of serious emotional disturbance, in order to combine psychotherapeutic interventions with education and mental health or substance abuse treatment. Services include: evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills; and individual, group, and family counseling.

"Time out" means the involuntary removal of an individual by a staff person from a source of reinforcement to a different, open location for a specified period of time or until the problem behavior has subsided to discontinue or reduce the frequency of problematic behavior.

"Volunteer" means a person who, without financial remuneration, provides services to individuals on behalf of the provider.

12VAC35-105-30. Licenses.

A. Licenses are issued to providers who offer services to individuals who have mental illness, a developmental disability, or substance abuse (substance use disorders) or have brain injury and are receiving residential services.

B. Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. These services include:

1. Assertive community treatment (ACT);

2. Case management;

~~2. Community gero-psychiatric residential;~~ 3. ICF/IID;

~~3.~~ 4. Community intermediate care facility-MR;

~~4.~~ 5. Residential crisis stabilization;

~~5.~~ 6. Nonresidential crisis stabilization;

~~6.~~ 7. Day support;

~~7.~~ 8. Day treatment, includes therapeutic day treatment for children and adolescents;

~~8. Group home and community residential;~~

9. Emergency;

10. Group home and community residential;

11. Inpatient psychiatric;

~~10. Intensive community treatment (ICT);~~

~~11.~~ 12. Intensive in-home;

~~12.~~ 13. Managed withdrawal, including medical detoxification and social detoxification;

~~13.~~ 14. Mental health community support;

~~14.~~ 15. Mental health intensive outpatient;

16. Mental health outpatient;

17. Mental health partial hospitalization;

18. Opioid treatment/medication assisted treatment;

~~15. Emergency;~~

~~16. Outpatient;~~

~~17. Partial hospitalization;~~

~~18. Program of assertive community treatment (PACT);~~

19. Psychosocial rehabilitation;

~~20.~~ 20. Residential treatment;

~~21.~~ 21. Respite care;

~~22.~~ 22. Sponsored residential home;

~~23. Substance abuse residential treatment for women with children;~~

~~24.~~ 23. Substance abuse intensive outpatient;

24. Substance abuse outpatient;

25. Substance abuse partial hospitalization;

26. Substance abuse residential treatment for women with children;

27. Supervised living residential; and

~~26.~~ 28. Supportive in-home.

C. A license addendum shall describe the services licensed, the disabilities of individuals who may be served, the specific locations where services are to be provided or administered, and the terms and conditions for each service offered by a licensed provider. For residential and inpatient services, the license identifies the number of individuals each residential location may serve at a given time.

Article 7

~~Intensive Community Treatment and Program of~~ Assertive Community Treatment Services

12VAC35-105-1360. Admission and discharge criteria.

A. Individuals must meet the following admission criteria:

1. Diagnosis of a severe and persistent mental illness, predominantly schizophrenia, other psychotic disorder, or bipolar disorder that seriously impairs functioning in the community. Individuals with a sole diagnosis of a substance ~~addiction or abuse~~ use disorder or developmental disability ~~are not eligible for services~~, personality disorder, traumatic brain injury, or an autism spectrum disorder are not the intended service recipients and should not be referred to ACT if they do not have a co-occurring psychiatric disorder.

2. Significant challenges to community integration without intensive community support including persistent or recurrent difficulty with one or more of the following:

a. Performing practical daily living tasks;

b. Maintaining employment at a self-sustaining level or consistently carrying out homemaker roles; or

c. Maintaining a safe living situation.

3. High service needs indicated due to one or more of the following:

a. Residence in a state hospital or other psychiatric hospital but clinically assessed to be able to live in a more independent situation if intensive services were provided or anticipated to require extended hospitalization, if more intensive services are not available;

b. Multiple admissions to or at least one recent long-term stay (30 days or more) in a state hospital or other acute psychiatric hospital inpatient setting within the past two years; or a recent history of more than four interventions by psychiatric emergency services per year;

c. Persistent or very recurrent severe major symptoms (e.g., affective, psychotic, suicidal);

d. Co-occurring substance addiction or abuse of significant duration (e.g., greater than six months);

e. High risk or a recent history (within the past six months) of criminal justice involvement (e.g., arrest or incarceration);

f. Ongoing difficulty meeting basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless; or

g. Inability to consistently participate in traditional office-based services.

B. Individuals receiving ~~PACT or ICT~~ ACT services should not be discharged for failure to comply with treatment plans or other expectations of the provider, except in certain circumstances as outlined. Individuals must meet at least one of the following criteria to be discharged:

1. Change in the individual's residence to a location out of the service area;

~~2. Death of the individual;~~

~~3.~~ 2. Incarceration of the individual for a period to exceed a year or long-term hospitalization (more than one year); however, the provider is expected to prioritize these individuals for ~~PACT or ICT~~ ACT services upon the individual's anticipated return to the community if the individual wishes to return to services and the service level is appropriate to his needs;

~~4. Choice of the individual with the provider responsible for revising the ISP to meet any concerns of the individual leading to the choice of discharge~~ 3. The individual and, if appropriate, the legally responsible person, choose to withdraw from services and documented attempts by the program to re-engage the individual with the service have not been successful; or

~~5. Significant sustained recovery by the individual in all major role areas with minimal team contact and support for at least two years as determined by both the individual and ICT or PACT team~~ 4. The individual and team determine that ACT services are no longer needed based on the attainment of goals as identified in the person centered plan and a less intensive level of care would adequately address current goals.

12VAC35-105-1370. Treatment team and staffing plan.

A. ~~Services~~ ACT services are delivered by interdisciplinary teams.

~~1. PACT and ICT teams shall include the following positions:~~

~~a. Team Leader - one full-time QMHP-A with at least three years experience in the provision of mental health services to adults with serious mental illness. The team leader shall oversee all aspects of team operations and shall routinely provide direct services to individuals in the community.~~

~~b. Nurses - PACT and ICT nurses shall be full-time employees or contractors with the following minimum qualifications: A registered nurse (RN) shall have one year of experience in the provision of mental health services to adults with serious mental illness. A licensed practical nurse (LPN) shall have three years of experience in the provision of mental health services to adults with serious mental illness. ICT teams shall have at least one qualified full-time nurse. PACT~~

teams shall have at least three qualified full-time nurses at least one of whom shall be a qualified RN.

c. One full-time vocational specialist and one full-time substance abuse specialist. These staff members shall provide direct services to individuals in their area of specialty and provide leadership to other team members to also assist individuals with their self-identified employment or substance abuse recovery goals.

d. Peer specialists - one or more full-time equivalent QPPMH or QMHP-A who is or has been a recipient of mental health services for severe and persistent mental illness. The peer specialist shall be a fully integrated team member who provides peer support directly to individuals and provides leadership to other team members in understanding and supporting individuals' recovery goals.

e. Program assistant - one full-time person with skills and abilities in medical records management shall operate and coordinate the management information system, maintain accounts and budget records for individual and program expenditures, and provide receptionist activities.

f. Psychiatrist - one physician who is board certified in psychiatry or who is board eligible in psychiatry and is licensed to practice medicine in Virginia. An equivalent ratio to 20 minutes (.008 FTE) of psychiatric time for each individual served must be maintained. The psychiatrist shall be a fully integrated team member who attends team meetings and actively participates in developing and implementing each individual ISP.

2. QMHP-A and mental health professional standards:

a. At least 80% of the clinical employees or contractors not including the program assistant or psychiatrist, shall be QMHP-As qualified to provide the services described in 12VAC35-105-1410.

b. Mental health professionals - At least half of the clinical employees or contractors not including the team leader or nurses and including the peer specialist if that person holds such a degree, shall hold a master's degree in a human service field.

3. Staffing capacity:

a. An ICT team shall have at least five full-time equivalent clinical employees or contractors. A PACT team shall have at least 10 full-time equivalent clinical employees or contractors.

b. ICT and PACT teams shall include a minimum number of employees (counting contractors but not counting the psychiatrist and program assistant) to maintain an employee to individual ratio of at least 1:10.

c. ICT teams may serve no more than 80 individuals. PACT teams may serve no more than 120 individuals.

d. A transition plan shall be required of PACT teams that will allow for "start-up" when newly forming teams are not in full compliance with the PACT model relative to staffing patterns and individuals receiving services capacity.

~~B. ICT and PACT teams shall meet daily Monday through Friday or at least four days per week to review and plan routine services and to address or prevent emergency and crisis situations.~~

1. ACT teams shall have sufficient staffing composition to meet the varying needs of individuals served by the team as required by this section. Each ACT team shall meet the following minimum position and staffing requirements:

a. Team leader. There shall be one full-time LMHP with three years of work experience in the provision of mental health services to adults with serious mental illness; a resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; a supervisee, in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; or one full-time registered QMHP-A with at least three years of experience in the provision of mental health services to adults with serious mental illness who was employed by the provider as a team leader prior to July 1, 2020. The team leader shall oversee all aspects of team operations and shall provide direct services to individuals in the community.

b. Nurses. ACT nurses shall be full-time employees or contractors with the following minimum qualifications: a registered nurse shall have one year of experience in the provision of mental health services to adults with serious mental illness; or a licensed practical nurse shall have three years of experience in the provision of mental health services to adults with serious mental illness.

(1) Small ACT teams shall have at least one full-time nurse, who shall be either an RN or an LPN;

(2) Medium ACT teams shall have at least one full-time RN, and at least one additional full-time nurse who shall be an LPN or RN; and

(3) Large ACT teams shall have at least one full-time RN and at least two additional full-time nurses who shall be LPNs or RNs.

c. Vocational specialist. There shall be one or more full-time vocational specialist, who shall be a registered QMHP with demonstrated expertise in vocational services through experience or education.

d. Co-occurring disorder specialist. There shall be one or more full-time co-occurring disorder specialists, who shall be a LMHP; a resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; a resident in psychology who is under supervision of a licensed clinical

psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; a supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10; registered QMHP; or certified substance abuse specialist (CSAC) with training or experience working with adults with co-occurring serious mental illness and substance use disorder.

e. ACT peer specialists. There shall be one full-time equivalent peer recovery specialists who is or has been a recipient of mental health services for severe and persistent mental illness. The peer specialist shall be certified as a peer recovery specialist in accordance with 12VAC35-250, or shall become certified in the first year of employment. The peer specialist shall be a fully integrated team member who provides peer support directly to individuals and provides leadership to other team members in understanding and supporting each individual's recovery goals.

f. Program assistant. There shall be one full-time or two part-time program assistants with skills and abilities in medical records management shall operate and coordinate the management information system, maintain accounts and budget records for individual and program expenditures, and perform administrative support activities.

g. Psychiatric care provider. There shall be one physician who is board certified in psychiatry or who is board eligible in psychiatry and is licensed to practice medicine in Virginia or a psychiatric nurse practitioner practicing within the scope of practice as defined in 18VAC90-30-120. An equivalent ratio of 16 hours of psychiatric time per 50 individuals served must be maintained. The psychiatric care provider shall be a fully integrated team member who attends team meetings and actively participates in developing and implementing each individual ISP.

h. Generalist clinical staff. There shall be additional clinical staff with the knowledge, skill, and ability required, based on the population and age of individuals being served, to carry out rehabilitation and support functions, at least 50% of whom shall be LMHPs, QMHP-As, QMHP-Es, or QPPMHs.

(1) Small ACT teams shall have at least one generalist clinical staff;

(2) Medium ACT teams shall have at least two generalist clinical staff; and

(3) Large ACT teams shall have at least three generalist clinical staff.

2. Staff-to-individual ratios for ACT Teams:

a. Small ACT teams shall maintain a caseload of no more than 50 individuals and shall maintain at least one staff member per eight individuals, in addition to a psychiatric care provider and a program assistant.

b. Medium ACT teams shall maintain a caseload of no more than 74 individuals and shall maintain at least one staff member per nine individuals, in addition to a psychiatric care provider and a program assistant.

c. Large ACT teams shall maintain a caseload of no more than 120 individuals and shall maintain at least one staff member per nine individuals, in addition to a psychiatric care provider and a program assistant.

~~C. ICT teams shall operate a minimum of eight hours per day, five days per week and shall provide services on a case-by-case basis in the evenings and on weekends. PACT~~ B. ACT teams shall be available to individuals 24 hours per day and shall operate a minimum of 12 hours each weekday and eight hours each weekend day and each holiday.

~~D.~~ C. The ~~ICT or PACT~~ ACT team shall make crisis services directly available 24 hours a day but may arrange coverage through another crisis services provider if the team coordinates with the crisis services provider daily.

D. The ~~PACT~~ ACT team shall operate an after-hours on-call system and shall be available to individuals by telephone ~~or~~ and in person when needed as determined by the team.

E. ACT teams in development may submit a transition plan to the department for approval that will allow for "start-up" when newly forming teams are not in full compliance with the ACT model relative to staffing patterns and individuals receiving services capacity. Approved transition plans shall be limited to a six-month period.

12VAC35-105-1380. Contacts.

A. The ~~ICT and PACT~~ ACT team shall ~~have the capacity to~~ provide multiple contacts per week to individuals experiencing severe symptoms or significant problems in daily living~~, for an aggregate average of three contacts per individual per week~~.

B. Each individual receiving ~~ICT or PACT~~ ACT services shall be seen face-to-face by an employee or contractor~~; or the employee or contractor should attempt to make contact~~ as specified in the individual's ISP. Providers shall document all attempts to make contact, and if contact is not made, the reasons why contact was not made.

12VAC35-105-1390. ~~ICT and PACT~~ ACT service daily operation and progress notes.

A. ~~ICT teams and PACT~~ ACT teams shall conduct ~~daily~~ organizational meetings Monday through Friday at least four days per week at a regularly scheduled time to review the status of all individuals and the outcome of the most recent employee or contractor contact, assign daily and weekly tasks to employees and contractors, revise treatment plans as needed, plan for emergency and crisis situations, and to add service contacts that are identified as needed.

B. A daily log that provides a roster of individuals served in the ~~ICT or PACT~~ ACT services program and documentation of services provided and contacts made with them shall be maintained and utilized in the ~~daily~~ team meeting. Daily logs shall not be considered progress notes.

C. There shall also be ~~at least a weekly~~ individual progress ~~note~~ notes documenting services provided in accordance with the ISP ~~or attempts to engage the individual in services.~~ each time the individual receives services, which shall be included within the individual's record. ACT teams shall also document within the individual's record attempts at outreach and engagement.

12VAC35-105-1410. Service requirements.

~~Providers~~ ACT teams shall document that the following services are provided consistent with the individual's assessment and ISP.

1. Ongoing assessment to ascertain the needs, strengths, and preferences of the individual;

2. Case management;

3. Nursing;

4. Support for wellness self-management, including the development and implementation of individual recovery plans, symptom assessment, and recovery education;

5. Psychopharmacological treatment, administration, and monitoring;

6. ~~Substance abuse assessment and treatment for individuals with a co-occurring diagnosis of mental illness and substance abuse~~ Co-occurring diagnosis substance use disorder services that are nonconfrontational, trauma informed, person-centered, consider interactions of mental illness and substance use, and have goals determined by the individual;

7. ~~Individual supportive therapy~~ Empirically supported interventions and psychotherapy;

8. ~~Skills training in activities of daily living, social skills, interpersonal relationships, and leisure time~~ Psychiatric rehabilitation, which may include skill-building, coaching, and facilitating access to necessary resources to help individuals with personal care, safety skills, money management, grocery shopping, cooking, food safety and storage, purchasing and caring for clothing, household maintenance and cleaning skills, social skills, and use of transportation and other community resources;

9. ~~Supportive in-home services; 10.~~ Work-related services ~~to help find and maintain employment~~ that follow evidence-based supported employment principles, such as direct assistance with job development, locating preferred jobs, assisting the individual through the application process, and communicating with employers;

~~11.~~ 10. Support for resuming education;

~~12.~~ 11. Support, education, consultation, and skill-teaching to family members ~~and~~, significant others, and broader natural support systems, which shall be directed exclusively to the well-being and benefit of the individual;

~~13.~~ 12. Collaboration with families and ~~assistance to individuals with children~~ development of family and other natural supports;

13. Assistance in obtaining and maintaining safe, decent, and affordable housing that follows the individual's preferences in level of independence and location, consistent with an evidence-based supportive housing model;

14. Direct support to help individuals ~~secure and maintain decent, affordable housing that is integrated into the broader community and to~~ obtain legal and advocacy services, financial support, money-management services, medical and dental services, transportation, and natural supports in the community; ~~and~~

15. ~~Mobile crisis~~ Crisis assessment, interventions to prevent or resolve potential crises, and admission to and discharge from psychiatric hospitals;

16. Assistance in developing and maintaining natural supports and social relationships;

17. Medication education, assistance, and support; and

18. Peer support services, such as coaching, mentoring, assistance with self-advocacy and self-direction, and modeling recovery practices.

III. Petition for Rulemaking

DBHDS RECOMMENDATION: PETITION FOR RULEMAKING #336

(See a chart of the petition process here: https://townhall.virginia.gov/um/chartpetitionstate.pdf)

Petitioner's Request and Public Comments Received	DBHDS Staff Recommendation and Rationale
See below.	***Deny request*** The changes sought by the petitioner would require legislative changes to state law. Specifically, the requirements around prescreeners are in Chapter 8 of Title 37.2 (primarily Sections 808 and 809, as the petitioner cited in part;) and also, Chapter 11 of Title 16.1 (namely Sections 345 and 339), and in agreement between the department and CSBs through administrative memos and in the annual Performance Contract. These requirements for who is a prescreener and who must have a certification for them are not in regulation. The recommendation for amendment to "Enhanced Qualifications for Certified Preadmission Screening Clinicians Beginning 01 July 2016" is an administrative memo. Such administrative action is outside the purview of this board. Until the Code of Virginia is changed, the changes requested are not possible, nor could they be made in regulation as law must precede regulatory change. Therefore, the recommendation is to deny this request as it is outside of the scope of the authority of the State Board.

Petition Title	Amendments to Incorporate Requirements for Certified Preadmission Screening Clinicians
Date Filed	5/3/2022
Petitioner	Willard Vaughn, MA, LPC, CTMH
Petitioner's Request	REQUESTED CHANGE: To clarify and amend the training and certification requirements for Preadmission Screening Providers to allow for coordination of care with private providers under the Marcus Alert Act. This petition for rulemaking is brought to the State Board of Behavioral Health and Developmental Services (DBHDS) under its legal authority to take the action requested pursuant to VA Codes 37.2-203, 37.2-311.3, and 12VAC35-105-30. This petition for

rulemaking is filed in accordance with VA Code 2.2-4007 is to clarify and amend the Enhanced Qualifications for Preadmission Screening Clinicians and expand its reach in the spirit of public-private cooperation under the Marcus-David Peters Act.

INTRODUCTION
The Department of Behavioral Health and Developmental Services first published a memorandum explaining that the agency would be mandating enhanced qualifications for "Community Services Boards and Behavioral Health Authorities evaluators who provide recommendations and prepare preadmission screening reports…" on March 29, 2016. On July 1, 2016, DBHDS published a document entitled *Certification of Preadmission Screening Clinicians* which states in part
[see https://dbhds.virginia.gov/behavioral-health/mental-health-services/protocols-and-procedures/]:

"Effective July 1, 2016, anyone conducting a preadmission screening evaluation pursuant to requirements in the Code of Virginia must hold a valid certification from DBHDS as a Certified Preadmission Prescreening Clinician…

Application for this certification must be submitted…using the designated forms and approved before the individual may independently conduct preadmission screening evaluations…

Upon submission and review of a completed application, DBHDS will issue a Certificate. The certification will be valid for one or two years and must be renewed annually or biannually as specified below. Recertification must be requested prior to the expiration of a current certificate."

The document goes on to outline educational and precepting requirements, requirements for supervision, the need for continuing education, and quality assurance practices. DBHDS created these regulations presumably under statutory authority found in VA Code 37.2-203 and 37.2-404.

In 2021 the Marcus-David Peters Act was passed by the General Assembly and is codified in VA Code 37.2-311.1 to 37.2-312. This law mandates that DBHDS take the lead in organizing and implementing the tenants of the act including

"...The Department shall establish additional Marcus alert and community care teams…[and] No later than July 1, 2026 all community services board and behavioral health authority geographical areas shall have established Marcus alert system that uses a community care or mobile crisis team"
–VA Code 37.2-311.1(c)3

Which allows for DBHDS to explore the use of public-private partnerships to achieve the mission set forth in the Marcus-David Peters Act. However, this is already provided for in the Community Services Performance Contract that is completed between the department and CSBs every two years under section twelve regarding contracting and

subcontracting. Until the passage of the Marcus Alert Act, this was under utilized for crisis intervention services, even to the detriment of the population served by the particular Community Services Board.

Finally, multiple code sections reference the requirement of an evaluation needing to be completed by "The community services board or *its designee*"(emphasis added) including:

- 16.1-340
- 16.1-340.1
- 16.1-340.1:1
- 37.2-808(b),(c),(l)
- 37.2-809(a),(d),(e),(g),(l),

Now, having established that DBHDS has and exercised statutory authority to stipulate the requirements necessary for an individual to become a Certified Preadmission Screening Clinician, that DBHDS has the responsibility under the law to form public-private partnerships for the good of the citizens of the Commonwealth, and that the law can allow for such partnerships, the present author hereby requests the Enhanced Qualifications for Preadmission Screening Clinicians be amended.

PETITION FOR RULE CHANGE

Page 1, Section 2 entitled "Enhanced Qualifications for Certified Preadmission Screening Clinicians Beginning 01 July 2016

Present author requests that this section be amended to include a stipulation for providers that are not employed directly by a Community Services Board and requests that it read as follows:

Any licensed professional (LMHP), Qualified Mental Health Provider (QMHP), Certified Substance Abuse Clinician (CSAC), or Certified Peer Specialist(CPS) that is not employed directly by a Community Services Board may have their employer apply for certification under these guidelines provided that the employer is licensed by DBHDS as a provider of mobile crisis response, crisis stabilization, partial hospitalization, or is a licensed psychiatric hospital, and has a signed written agreement with the regional crisis hub that would serve their geographic location.

In addition, the employer must show that the individual has held a CPSC certification within the past ten years and/or that they have completed all of the other requirements set forth herein. Further, an agency that is not a Community Services Board but is licensed as a provider of mobile crisis response, crisis stabilization, partial hospitalization, or a licensed psychiatric hospital must have any employee desiring certification by this standard supervised by an LMHP and have such an individual available 24/7 to the perspective clinician regardless of their length of time serving in this capacity.

If certified, the individual will be considered a designee of the Community Services Board that serves the area where the client is physically located during the time of

	assessment, or that provides outpatient treatment to the client with all powers granted under applicable law. Amendments in General Petitioner asks that any reference to "the Board", CSB, or Community Services Board mentioned in the document be replaced by more neutral language such as "agency", "clinic", or "facility".
Agency's Plan	The State Board will consider this petition at its next regular quarterly meeting on July 13, 2022, at the DBHDS Central Office, Richmond, VA.
Comment Period	Ended 6/12/2022 8 comments

COMMENTS RECEIVED FROM THE PUBLIC

5/23/22 11:08 am
Commenter: Beth Engelhorn

Difficult for CSB
There are some significant issues with the change that this proposes. The first issue is that prescreeners outside of the CSB system are not connected to the services provided by the CSB and other community partners the way a CSB currently is. The CSB system has access to multiple avenues of services and funding streams that provides direct care regardless of the individual's ability to pay. It is also concerning in regard to the potential increase in hospitalizations if private entities are prescreening. CSB prescreeners are very sensitive to the hospitalization criteria and often have to intervene now to prevent unneeded hospitalizations requested by private providers. However the area that concerns me the most is that the individual in the community as a private provider being "*a designee of the Community Services Board that serves the area where the client is physically located during the time of assessment, or that provides outpatient treatment to the client with all powers granted under applicable law."* Having worked with private providers within other services, there is little control over the quality of the services being provided and the outcomes of those services. I am fully opposed to this change as it would not improve the prescreening system, but would further complicate and already complex process and system for the community.

5/23/22 1:32 pm
Commenter: Bob Horne

Conflict of interest
This petition is especially concerning for me as well as the public behavioral healthcare system in Virginia, especially as regards some significant changes proposed in this petition. The first issue is that this petition includes private psychiatric hospitals as included in providing prescreening assessments. This presents to me as a conflict of interest since prescreeners are making decisions that directly impact hospital admissions. If private entities are allowed to perform prescreenings, this has the potential to significantly increase hospitalizations. The

public behavioral healthcare system is constantly working to reduce unnecessary inpatient admissions.

Furthermore, any prescreeners outside of the CSB system are not connected to the services provided through the public behavioral healthcare system and other community partners the way a CSB currently is. This is part and parcel of the mission of the CSB system in Virginia. The public behavioral healthcare system has access to multiple programs of services and various funding streams that provides direct care regardless of the individual's ability to pay. This is not the case for the private sector.

Public sector behavioral healthcare prescreeners at the CSBs are very sensitive to medical necessity criteria for involuntary hospitalization and often have to intervene now to prevent unneeded hospitalizations requested by private providers. Furthermore, this petition, if approved, removes the ability of the public behavioral healthcare system to hire, screen, perform quality reviews, hold accountable, or discipline prescreening providers providing prescreenings outside of the CSBs.

Overarching these concerns is that this petition, if approved, will designate the individual in the community as a private provider being "*a designee of the Community Services Board that serves the area where the client is physically located during the time of assessment, or that provides outpatient treatment to the client with all powers granted under applicable law."* This essentially removes these private providers from under the direct authority of the CSB and sets them up a "a designee of the CSB" without any accountability to that CSB. This is to me, unconscionable.

Having worked with private providers within other services, and as a private provider myself, I would opine that there is little control over the quality of the services being provided and the outcomes of those services (outside of the marketplace). This is not the case with the public behavioral healthcare system which labors under multiple administrative and reporting burdens that do not apply to the private sector. I am diametrically opposed to the approval of the changes proposed in this petition. They would not improve the prescreening system, but would further complicate and already complex process and system for the community and result in an increase in hospitalizations.

I would alternatively proposed that individuals in the private sector wishing to work with the CSBs in providing prescreening assessments could instead become involved in providing these services through temporary service agencies. Alternatively, they along with the public behavioral healthcare system in the state could explore other contractual vehicles to expand the staffing capacity and ability of the CSB system to provide prescreening assessments.

5/24/22 2:37 pm
Commenter: Terrelle Stewart

Amendments to Incorporate Requirements for Certified Preadmission Screening Clinicians-Opposed

I am opposed to this amendment as conflating private providers and CSB prescreeners represents a significant conflict of interest, undo hardship on CSB's to have private providers conducting

prescreens as CSB designee's without the oversight and administrative authority CSBs currently have over staff employed at the boards/behavioral health authority, and the training and credentialing requirements etc. that CSBs currently meet to have well qualified prescreeners on their teams, as a start. Also the MARCUS Alert legislation by no means requires private providers who are a part of the Crisis continuum to also be prescreeners. The goal of the Marcus Alert, STEP-VA Crisis step, and the implementation of the regional call centers is to provide services in the community and if the crisis requires a prescreen, the CSB will conduct the prescreen if community based crisis interventions are unsuccessful or do not met the client's level of acuity.

The amendment also does not speak to the intense work that goes into the civil commitment process including: bed searching for involuntary individuals, petitioning for TDO's, alternative transportation and other processes, facilitating and/or participating in hearings, facilitating MOT when ordered, liaison duties if the individual is placed at a state facility, and access to regional/ DBHDS funds to obtain certain funding and program resources. As Virginia moves towards a more comprehensive crisis system all providers both public and private are needed to have this goal actualized. However, data has proven, CSBs are able to decrease unnecessary hospitalizations by following the stringent civil commitment laws, DBHDS polices, and other guidance that CSB prescreeners adhere to while providing emergency services regardless of an individuals ability to pay or specific to MCO/insurance carrier.

5/31/22 12:36 pm

Commenter: Ren A. Thorne, LCSW

Private Providers becoming Preadmission Screening evaluators is a bad idea.

I am strongly opposed to this proposed petition. Preadmission Screeners need to be independent to make decisions that are least restrictive to the client. Private Companies have to consider liability more so than a public sector CSB. They will be more likely to recommend hospitalization to cover that liability. Additionally, there is a lot more to the preadmission screening process than just the evaluation. The follow-up responsibilities after the preadmission screen are more arduous that the evaluation itself. Developing Safety plans require a lot of coordination to ensure that the person can be safely released. When the evaluator determines that the individual needs to be hospitalized, voluntarily or under a TDO, the onus is on the CSB to obtain an appropriate bed. Preadmission Screeners need to be employed by a CSB because it is a public organization which is able to take calculated risks to place an individual in the least restrictive option.

6/2/22 11:38 am

Commenter: Robert Tucker, Ed.S., LPC, LMFT

Amendments to Incorporate Requirements for Certified Preadmission Screening Clinicians-Opposed

The other comments I believe cover the basic concerns and it is indeed a bad idea. The other major concern is that a "memo" cannot be amended to change the COV.

6/2/22 12:19 pm

Commenter: M. Stosh Kalinsky, LPC

Amendments to Incorporate Requirements for Certified Preadmission Screening Clinicians-Opposed
I stand in agreement with those opposed to this petition as the comments appear to cover the major issues. In addition, I would add, the mentioning of the Marcus Alert somehow being related to this justification for the petition is unclear at best. Mobile crisis responders do not need to be Certified Preadmission Screening Clinicians.

6/10/22 12:28 pm
Commenter: Jonina Moskowitz, Virginia Beach Dept. of Human Services

Re Petition: Amendments to Incorporate Requirements for Certified Preadmission Screening Clinicians
Virginia Beach Behavioral Health and Developmental Services has concerns regarding Mr. Vaughn's petition. While we recognize his goal of improving the flow of the assessment process, we believe the negative impacts outweigh the benefits. Clinically, this would work against the aims of the new crisis continuum of care as it would likely increase the number of TDOs and would increase, vs. decrease, the need to involve law enforcement officials in the process. Specifically, if an individual located in the community and a Mobile Crisis Response staff member supports a TDO, who would provide security and monitor the individual while the crisis worker looks for a TDO bed

Allowing this change would also create an undue burden and risk to the CSB system. This process would have an unknown number of people employed by an unknown number of providers considered to be designees of a CSB. Which CSB? For example, if an agency provides Mobile Crisis Response to residents of Chesapeake, Norfolk, and Virginia Beach, are their employees considered designees of each CSB? When employees of an independent agency are considered designees of a CSB, there are numerous complexities, related to matters such as clinical oversight, training and personnel records, ownership of clinical documentation, reporting of incidents (i.e., reporting in CHRIS) and risk management, and state reporting requirements unique to the CSBs. Providers of Developmental Services Case Management have already learned the complexities involved in attempting to do this. These would be magnified when working within the context of crisis services. We respectful request that this petition not be supported.

ADDITIONAL COMMENT MADE BY THE PETITIONER IN THE PUBLIC COMMENT FORUM
6/12/22 6:23 am
Commenter: Willard Vaughn

The Final Word...
I want to begin by saying thanks to the few of you that read and commented on my petition.

As someone who has been a preadmission screener for the better part of twenty years and now owning my own practice, with this new opportunity arising from the integration of private

providers into the public system, I wanted to be able to provide the complete spectrum of services to my clients.

To clarify for some that misunderstood, this rule change would only apply to agencies (providers) that are fully licensed by DBHDS...just like CSBs have to be fully licensed by DBHDS. Licensed providers have oversight and are fully within the authority granted to DBHDS by VA Code. At present, those that are Certified Preadmission Screening Clinicians can take that certification and perform this task anywhere in the state. My proposal makes that impossible, and gives ownership (as well as warranties) to the individual's employer. If an agency employs experienced people as I have suggested that properly train and prepare their clinicians, this could be an innovative way to solve the current workforce shortage and raise the standard of care for everyone.

With that said, I will concede to one point that a couple of you made regarding hospitals. One of the things that work in our mental health system is that there is always an objective third party to evaluate a person in crisis and make a decision. When assessors employed by a hospital have the ability to insist that a client stay at their hospital, that does seem to create a conflict.

Another of you made reference to ownership of documentation, and there is a simple solution to that...use one system that all licensed entities are forced to use. Other states do it quite successfully. But that is an entirely different rant.

To be frank, CSBs have insisted on a monopoly over a multitude of services for the past 56 years with crisis services being one of the few strongholds. This makes many of your comments not surprising because more than anything else, monopolies fear competition in a free market that can provide a better quality of service and bring innovative ideas to the table. Competition also forces a monopoly to be accountable for the failings of the system which is not something that any public system excels at. All jabs aside, I am sincerely afraid that the Marcus Alert system will go from the most progressive and innovative thing that this state has seen in many years, to what is simply a more complex elaboration on business as usual in Virginia's mental health system with an easier to remember phone number. As a trench worker turned business owner, I think there is a place in all of this for me and those like me: providers who are truly client focused that want to provide quality and compassionate care to anyone that needs it. I would hate to see a public system turn us away out of fear of creating something great.

IV. Emergency/NOIRA for the Individual and Family Support Program and Periodic Review

This is a new action to comply with a mandate by the General Assembly in the 2022 Special Session 1 to facilitate compliance with the U.S. Department of Justice's Settlement Agreement with Virginia.

townhall.virginia.gov

Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC35-230
VAC Chapter title(s)	Operation of the Individual and Family Support Program
Action title	Amendments to establish criteria and annual funding priorities through the Annual Funding Program Guidelines and to ensure public input (to facilitate compliance with DOJ)
Date this document prepared	June 28, 2022

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of the subject matter, intent, and goals of this this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

The Department of Behavioral Health and Developmental Services (DBDHS) was directed by the 2022 General Assembly within Item 313.NN. of the 2022 *Appropriation Act* (Chapter 2, 2022 Special Session 1 Acts of Assembly) to utilize emergency authority to promulgate regulations that change the current distribution of annual Individual and Family Support Program (IFSP) funds from a 'first-come-first-served' basis to one based on program categories and set criteria. Specifically, DBHDS is authorized to create an annual public input process that shall include a survey of needs and satisfaction in order to establish plans for the disbursement of IFSP funding in consultation with the IFSP State Council. Based on the Council's recommendation and information gathered during the public input period, the department will draft program guidelines to establish annual funding priorities. The department will establish program criteria for each of the required program categories and publish them as part of annual IFSP guidelines developed collaboratively by the department and the department's IFSP State Council. Additionally, program guidelines shall establish eligibility criteria, the award process, appeals processes, and any other protocols necessary for ensuring the effective use of state funds. All criteria will be published prior to opening the funding opportunity. The goal of this regulatory action is to facilitate compliance with the U. S. Department of Justice's Settlement Agreement with Virginia (United States of America v. Commonwealth of Virginia, Civil Action No. 3:12cv059-JAG) (https://dbhds.virginia.gov/doj-settlement-agreement/).

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

Council – IFSP State Council.
DBHDS – Department of Behavioral Health and Developmental Services.
DD – Developmental disabilities.
IFSP – Individual and Family Support Program.
Settlement Agreement – the U. S. Department of Justice's Settlement Agreement with Virginia (United States of America v. Commonwealth of Virginia, Civil Action No. 3:12cv059-JAG).

Mandate and Impetus (Necessity for Emergency)

Explain why this rulemaking is an emergency situation in accordance with § 2.2-4011 A and B of the Code of Virginia. In doing so, either:

a) Indicate whether the Governor's Office has already approved the use of emergency regulatory authority for this regulatory change.
b) Provide specific citations to Virginia statutory law, the appropriation act, federal law, or federal regulation that require that a regulation be effective in 280 days or less from its enactment.

As required by § 2.2-4011, also describe the nature of the emergency and of the necessity for this regulatory change. In addition, delineate any potential issues that may need to be addressed as part of this regulatory change

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This action is brought in compliance with Code of Virginia § 2.2- 4011.B. in accordance the mandate from the 2022 General Assembly within Item 313.NN. of the 2022 *Appropriation Act* (Chapter 2, 2022 Special Session 1 Acts of Assembly).

The purpose of this regulation is to facilitate compliance with the U.S. Department of Justice's Settlement Agreement with Virginia for the development of a comprehensive and coordinated set of strategies that are designed to ensure that families who are assisting family members with ["developmental disabilities" ("DD")] or individuals with [DD] who live independently have access to person-centered and family-centered resources, supports, services and other assistance. (See Section II.D.) The program is

intended to support the continued residence of any individual with DD on the waiting list for a Medicaid Home and Community-Based Services (HCBS) DD Waiver in his own or the family home, which includes the home of the principal caregiver.

The court appointed Independent Reviewer has stated that while the Commonwealth continues to make progress, it is not fully meeting requirements related to individual and family supports. (See his 18th Report to the Court, p.55.) These amendments provide updated formal 'documentation of authority and functioning' for the IFSP program through the use of the annual Guidelines document.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia or Acts and Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The 2022 General Assembly, within Item 313.NN. of the 2022 *Appropriation Act* (Chapter 2, 2022 Special Session 1 Acts of Assembly), mandated the department to utilize emergency authority to promulgate regulations. Section 37.2-203 of the Code of Virginia authorizes the State Board of Behavioral Health and Developmental Services to adopt regulations that may be necessary to carry out the provisions of Title 37.2 and other laws of the Commonwealth administered by the commissioner and the department. At its meeting on July 13, 2022, the State Board voted to initiate this emergency action and notice of intended regulation for permanent adoption.

Purpose

Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.

These amendments are essential to protect the health, safety, and welfare of individuals with DD who are on the waiting list for a Medicaid Waiver HCBS DD Waiver and who reside in their own or their family homes, which include the home of the principal caregiver. The change from the current distribution of annual funds from a 'first-come-first-served' basis will be to one based on program categories and set criteria that will be more needs-based and that has significant stakeholder input. The program guidelines shall establish eligibility criteria, the award process, appeals processes, and any other protocols necessary for ensuring the effective use of state funds. The goal of this regulatory action is to facilitate compliance with the U. S. Department of Justice's Settlement Agreement with Virginia (United States of America v. Commonwealth of Virginia, Civil Action No. 3:12cv059-JAG) and any amendments must remain in alignment as the action moves through the regulatory adoption process.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

IFSP program overview and purpose
The Individual and Family Support Program (IFSP) assists individuals on Virginia's Medicaid Home and Community-Based Services (HCBS) DD Waivers Waiting List and their families with accessing short term,

person- and family- centered resources, supports, and services. The purpose of the program is to support individuals with DD in living in their own home or family home in the community.

IFSP consists of four components: 1) a funding program, 2) community coordination program, 3) information and referral, and 4) connections to family and peer mentoring supports.

IFSP-Funding Program Background
Since 2013, DBHDS's IFSP Program, through the use of state funds allocated by the Virginia General Assembly, has provided direct financial assistance to Virginians on the Medicaid HCBS DD Waivers waitlist. The assistance supports individuals and their families with the purchase of services or items described in the application and approved by the department. The funding program is restricted to assisting individuals on the DD waiver waiting list who are living in their own home or in their family home per 12VAC35-230-20.

Prioritization of Individuals Seeking Assistance Initial Stakeholder Input
Traditionally, the IFSP both assessed applications and provided assistance to individuals solely on a first-come first-served basis. Per the terms of the Settlement Agreement, DBHDS is required to target assistance to people who are at highest risk of being institutionalized. Therefore, beginning in 2019, the IFSP began engaging with the IFSP State Council, the department's formally identified advisory group on family supports, to establish a list of priorities for the funding program. A key take away from engaging with the state and regional councils is the guiding principle that priority categories should consider both the individual circumstances of the applicant and their family and the type of request.

Review of Existing Measures of Risk and Past IFSP Data
In order to create a framework for identifying and supporting those most at risk of institutionalization, the IFSP established the program's funding categories through discussion with subject matter experts and a review of internally used intake and assessment tools across DBHDS divisions. IFSP also reviewed past IFSP funding outcome data including requested need categories to understand what needs are typically requested and how changes to the program may impact assistance for those needs.

Regulatory Changes
Amendments to this chapter eliminate unnecessary language related to the 'first-come-first-served' funding award process used to date. It makes clear the use of a formal Guidelines document for the details of the criteria for annual awards and that the document must be reviewed and updated annually, sets out that the IFSP State Council will work in consultation with DBHDS to develop the Guidelines, that additional stakeholder comment must be sought, and makes clear the following expectations for DBHDS in regard to community coordination:

1. Engage with the public and stakeholders to establish programming that encourages the continued residence of individuals with DD in community settings.
2. Establish the IFSP State Council.
3. Coordinate the development of strategic plans and activities that are consistent with the IFSP goals through the work of the Council.
4. Provide technical assistance to individuals or family members for the purpose of facilitating the purchase services that are intended to enhance or improve an individual's or family's quality of life and promote the independence and continued residence of an individual with DD in his own home or the family home, which include the home of a principal caregiver.

Additionally, amendments make clear the department's responsibility regarding the establishment of procedures for eligibility determination, the award process, appeals process, and any other protocols necessary for ensuring the effective use of state funds. All procedures shall be published annually in the Individual and Family Support Program Guidelines prior to opening the funding opportunity each year.

For each funding period, the department shall develop and publish the following information on the IFSP:

1. Applicant eligibility criteria;
2. A summary of allowable expenditures;
3. Maximum award amount per applicant;

4. Application deadlines;
5. Award notification schedules;
6. Award review criteria; and
7. Requirements for expenditure substantiation.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

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1) The primary advantage to the public is that those most in need of assistance will be considered based on defined categories of need. Also, the public will have the opportunity to comment annually on draft revisions of the Guidelines document. The primary disadvantage to the public of implementing the amended provisions is that individuals on the waiting list for the Medicaid Home and Community-Based Services (HCBS) DD Waivers and their families will have to learn the new procedures for application for funding. Those who previously benefited from the 'first-come-first-served' basis potentially may be categorized differently with the new structure. Additionally, a redesigned application portal will be available to the public that is intended to be more user-friendly.

2) The primary advantage to DBHDS and the Commonwealth is the assurance that the funds are distributed in a targeted manner. Also, these changes more thoroughly comply with the requirements of the Settlement Agreement. Though some resources are being used to redesign the portal, there are no disadvantages to the agency or the Commonwealth.

3) A pertinent matter of interest to the regulated community, government officials, and the public is that there will be an annual Guidelines document circulated for public comment and finalized before any funds are distributed each year. There are no disadvantages to the public or the Commonwealth as these changes will ensure more public input and more targeted use of state funds.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

In response to the requirements of the Settlement Agreement, the Department of Behavioral Health and Developmental Services (DBDHS) was directed by the 2022 General Assembly within Item 313.NN. of the 2022 *Appropriation Act* (Chapter 2, 2022 Special Session 1 Acts of Assembly)to utilize emergency authority to promulgate regulations. Therefore, there is no alternative to this mandate.

Periodic Review and Small Business Impact Review Announcement

If you wish to use this regulatory action to conduct, and this Emergency/NOIRA to announce, a periodic review (pursuant to § 2.2-4017 of the Code of Virginia and Executive Order 14 (as amended, July 16,

2018)), and a small business impact review (§ 2.2-4007.1 of the Code of Virginia) of this regulation, keep the following text. Modify as necessary for your agency. Otherwise, delete the paragraph below and insert "This NOIRA is not being used to announce a periodic review or a small business impact review."

This NOIRA is not being used to announce a periodic review or a small business impact review. A periodic review was conducted in 2021.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

DBHDS is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, and (iii) the potential impacts of the regulation. Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail, email, or fax to Stephanie Mote, DBHDS IFSP Manager, Division of Developmental Services, P.O. Box 1797, Richmond, VA 23218-1797, ifspsupport@dbhds.virginia.gov, and fax 804-692-0077. If emailed, it would be helpful if the subject line could state 'Comments on IFSP Emergency Action.' In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will not be held following the publication of the proposed stage of this regulatory action.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

If an existing VAC Chapter(s) is being amended or repealed, use Table 1 to describe the changes between existing VAC Chapter(s) and the emergency regulation. If existing VAC Chapter(s) or sections are being repealed and replaced, ensure Table 1 clearly shows both the current number and the new number for each repealed section and the replacement section.

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
10			New definitions are added for clarity: ▪ "Custodial family member" is added to make clear which family member is appropriate to apply, or assist an individual in applying, for funds. "Custodial family member" means a family member who has primary authority

			to make all major decisions affecting the individual and with whom the individual primarily resides. ▪ "Developmental disability" was updated in the Code of Virginia in 2015 (37.2-100).
		"Developmental disability" or "DD" means a severe, chronic disability of an individual that: 1. Is attributable to a mental or physical impairment or combination of mental and physical impairments; 2. Is manifested before the individual attains age 22; 3. Is likely to continue indefinitely; 4. Results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care; (ii) receptive and expressive language; (iii) learning; (iv) mobility; (v) self-direction; (vi) capacity for independent living; and (vii) economic self-sufficiency; and 5. Reflects the individual's need for a combination and sequence of special, interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. (42 USC § 15002)	"Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual, without services and supports, has a high probability of meeting those criteria later in life.
		"Family member" means an immediate family member of an individual receiving services or the principal caregiver of that individual. A principal caregiver is a person who acts in the place of an immediate family member, including other relatives and foster care providers, but does not have	(No change; showing for context with added term above, "custodial family member.")

		a proprietary interest in the care of the individual receiving services. (§ 37.2-100 of the Code of Virginia) "Individual and Family Support" means an array of individualized items and services that are intended to support the continued residence of an individual with intellectual or developmental disabilities (ID/DD) in his own or the family home.	▪ This definition incorporates and expands on the IFS definition using language from the Settlement Agreement: "Individual and Family Support Program" or "IFSP" or "Program" means an array of individualized person-centered and family-centered resources, supports, items, services, and other assistance approved by the department that are intended to support the continued residence of an individual with developmental disabilities (DD) who is on the waiting list for a Medicaid Home and Community-Based Services (HCBS) DD Waiver in his own or the family home, which includes the home of the principal caregiver. ▪ This definition is added to reflect current practice and to be in line with the Settlement Agreement: "Individual and Family Support Program State Council" or "IFSP State Council" or "Council" means an advisory group of stakeholders selected by the department that shall provide consultation to the department on creating a family support program intended to increase the resources for individuals and families and promote community engagement and coordination. The Council shall include individuals with DD and family members of individuals with DD. ▪ One definition is removed because it is not used in the regulation; the definition of 'developmental disability' was updated in the Code of Virginia in 2015 (37.2-100) (ID is a type of DD); and related, three of the existing home and community-based waivers were redesigned in 2021 combining the target populations of individuals with intellectual disabilities and other developmental disabilities. The phrase 'a Medicaid Home and Community-Based Services (HCBS) DD Waiver' is used to capture the correct waivers regardless of the specific title.

		"Intellectual disability" or "ID" means a disability, originating before the age of 18 years, characterized concurrently by (i) significantly subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean; and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. (§ 37.2-100 of the Code of Virginia)	~~"Intellectual disability" or "ID" means a disability, originating before the age of 18 years, characterized concurrently by (i) significantly subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean; and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. (§ 37.2-100 of the Code of Virginia)~~
20		A. The Individual and Family Support Program assists individuals with intellectual disability or developmental disabilities and their family members to access needed person-centered and family-centered resources, supports, services and other assistance as approved by the department. As such, Individual and Family Support Program funds shall be distributed directly to the requesting individual or family member or a third party designated by the individual or family member. B. The overall objective of the Individual and Family Support Program is to support the continued residence of an individual with intellectual or developmental disabilities in his own home or the family	▪ References to intellectual disability are removed, language is streamlined and clarified to be in line with the Settlement Agreement, and the roles the Council and the guidelines are inserted: A. The Individual and Family Support Program assists individuals with ~~intellectual disability or~~ developmental disabilities and their family members to access needed person-centered and family-centered resources, supports, services, and other assistance ~~as approved by the department. As such, Individual and Family Support Program funds shall be distributed directly to the requesting individual or family member or a third party designated by the individual or family member~~. The ~~overall objective~~ purpose of the ~~Individual and Family Support Program~~ IFSP is to support the continued residence of an individual with ~~intellectual or~~ developmental disabilities in his own home or the family home, which includes the home of a principal caregiver. B. ~~The overall objective of the Individual and Family Support Program is to support the continued residence of an individual with intellectual or developmental disabilities in his own home or the family home, which include the home of a principal caregiver.~~ The

		home, which include the home of a principal caregiver. C. Individual and Family Support Program funds shall not supplant or in any way limit the availability of services provided through a Medicaid Home and Community-Based Waiver, Early and Periodic Screening, Diagnosis and Treatment, or similar programs.	department shall operate the IFSP directly or through a third party designated by the department to administer all or part of the Program, based on guidelines developed collaboratively by the department and the department's IFSP State Council. C. IFSP funds shall be distributed directly to the requesting individual or custodial family member or a third party designated by the individual or custodial family member. ~~Individual and Family Support Program~~ IFSP funds shall not supplant or in any way limit the availability of services provided through a Medicaid ~~Home and Community-Based~~ HCBS DD Waiver~~,~~; Early and Periodic Screening, Diagnosis, and Treatment~~,~~; or similar programs.
New 30		(Language moved to Section 40.)	▪ New text is inserted in a renamed section; the previous text is now in Section 40. These changes clarify the overall structure for the work of the department: ~~**Program eligibility requirements**~~ **Community coordination.** The department shall: 1. Ensure an annual public input process that encourages the continued residence of individuals on the waiting list for a Medicaid HCBS DD Waiver in community settings. 2. Establish the IFSP State Council. 3. Develop, in coordination with the Council, a strategic plan that is consistent with these regulations and the purpose of the IFSP and that is updated as necessary as determined by the department. 4. Provide technical assistance to individuals or family members to facilitate their access to covered services and supports listed in 12VAC35-230-50, that are intended to enhance or improve their quality of life and promote the independence and continued residence of an individual with DD in his own home or the family home, which includes the home of a principal caregiver.
40		(Previously Section 30.)	▪ Language moved from 30 now 40 A; new clarifying language regarding public input and the generic reference to Waivers (see above); puts the regulation in line with the Settlement Agreement; the roles of

			the Council and the annual guidelines are inserted: **Program eligibility requirements and policies.** A. Eligibility for ~~Individual and Family Support Program~~ IFSP funds shall be limited to individuals who are living in their own or a family home and are on the statewide waiting list for ~~the~~ a ~~Intellectual Disability (ID) Medicaid Waiver or the Individual and Family Developmental Disabilities Support (IFDDS)~~ Medicaid HCBS DD Waiver and their custodial family members who are assisting those individuals. B. The department, based on information gathered through public input and in collaboration with the IFSP State Council shall establish eligibility criteria as published in the Individual and Family Support Program Guidelines ("Guidelines"), the award process, the appeals process, and any other protocols necessary for ensuring the effective use of state funds. All procedures shall be published annually in the Guidelines prior to opening the funding opportunity. C. For each funding period, the department shall develop and publish the following information on the IFSP: 1. Criteria for prioritized funding categories; 2. A summary of allowable expenditures; 3. Application deadlines; and 4. Award notification schedules. D. The Guidelines shall be reviewed and updated annually.
		Eligibility for Individual and Family Support Program funds shall be limited to individuals who are living in their own or a family home and are on the statewide waiting list for the Intellectual Disability (ID) Medicaid Waiver or the Individual and Family Developmental Disabilities Support (IFDDS) Medicaid Waiver and family members who are assisting those individuals.	
50		(Previously Section 40.) **Program implementation.**	▪ Renumbered from Section 40 to 50. Changes emphasize the public input process, remove the funding limit and 'first come first served' structure, insert the focus on prioritized funding categories as established in the annual guidelines, and move any other information in deleted text to be addressed elsewhere in the revised regulation or shall be addressed in the guidelines.
		A. Individual and Family Support Program funds shall be limited by the amount of funds allocated to the program by the General Assembly. Department approval of funding requests	A. ~~Individual and Family Support Program~~ IFSP funds shall be limited by the amount of funds allocated to the Program by the General Assembly. The ~~D~~department approval of funding requests shall not exceed the funding available for the fiscal year. Based on

		shall not exceed the funding available for the fiscal year. B. Based on funding availability, the department shall establish an annual individual financial support limit, which is the maximum annual amount of funding that can be provided to support an eligible individual during the applicable fiscal year. C. Individual and Family Support Program funds may be provided to individuals or family members in varying amounts, as requested and approved by the department, up to the established annual individual financial support limit. D. On an annual basis, the department shall announce Individual and Family Support Program total funding availability and the annual individual financial support limit for the applicable fiscal year. This announcement shall include a summary of covered services, the application, and the application review criteria. E. Individuals and family members may submit applications for Individual and Family Support Program funding as needs arise throughout the year. Applications shall be considered by the department on a first-come, first-served basis until the annual allocation appropriated to the program by the General Assembly for the applicable fiscal year has been expended. F. Individuals and their family members may apply for Individual and Family Support Program funding each year and may submit more than one application in a single year; however, the	information gathered through relevant data and public input, and in collaboration with the IFSP State Council, the department shall establish annual funding categories. B. ~~Based on funding availability, the department shall establish an annual individual financial support limit, which is the maximum annual amount of funding that can be provided to support an eligible individual during the applicable fiscal year.~~ ~~C.~~ ~~Individual and Family Support Program~~ IFSP funds may be provided to individuals or custodial family members in varying amounts, as ~~requested and approved~~ determined by the department's prioritized funding categories~~, up to the established annual individual financial support limit~~. ~~D. On an annual basis, the department shall announce Individual and Family Support Program total funding availability and the annual individual financial support limit for the applicable fiscal year. This announcement shall include a summary of covered services, the application, and the application review criteria.~~ ~~E. Individuals and family members may submit applications for Individual and Family Support Program funding as needs arise throughout the year. Applications shall be considered by the department on a first-come, first-served basis until the annual allocation appropriated to the program by the General Assembly for the applicable fiscal year has been expended.~~ ~~F. Individuals and their family members may apply for Individual and Family Support Program funding each year and may submit more than one application in a single year; however, the total amount approved during the year shall not exceed the annual individual financial support limit.~~

		total amount approved during the year shall not exceed the annual individual financial support limit.	
60		(Previously Section 50.) **50. Covered services and supports.** Services and items funded through the Individual and Family Support Program are intended to support the continued residence of an individual in his own or the family home and may include: 1. Professionally provided services and supports, such as respite, transportation services, behavioral consultation, and behavior management; 2. Assistive technology and home modifications, goods, or products that directly support the individual; 3. Temporary rental assistance or deposits; 4. Fees for summer camp and other recreation services; 5. Temporary assistance with utilities or deposits; 6. Dental or medical expenses of the individual; 7. Family education, information, and training; 8. Peer mentoring and family-to-family supports; 9. Emergency assistance and crisis support; or 10. Other direct support services as approved by the department.	▪ Renumbered from Section 50 to 60; removes language and instead focuses on the three categories of covered services and points to the guidelines for any list of fundable services and items. Services and items funded through the ~~Individual and Family Support Program~~ IFSP as published in the Guidelines are intended to support the continued residence of an individual in his own or the family home and may include: (i) safe community living; (ii) improved health outcomes; and (iii) community integration~~:~~ ~~1. Professionally provided services and supports, such as respite, transportation services, behavioral consultation, and behavior management;~~ ~~2. Assistive technology and home modifications, goods, or products that directly support the individual;~~ ~~3. Temporary rental assistance or deposits;~~ ~~4. Fees for summer camp and other recreation services;~~ ~~5. Temporary assistance with utilities or deposits;~~ ~~6. Dental or medical expenses of the individual;~~ ~~7. Family education, information, and training;~~ ~~8. Peer mentoring and family-to-family supports;~~ ~~9. Emergency assistance and crisis support; or~~ ~~10. Other direct support services as approved by the department~~. No services or items shall be funded by the Program if not listed in the Guidelines or if covered by another entity.
70		(Previously Section 60.)	▪ Renumbered from Section 60 to 70; removes the requirement to submit receipts but requires that any such documentation be available on request; changes the information about need to an attestation rather than more formal documentation (the only requirement is if the individual is

		A. Eligible individuals or family members who choose to apply for Individual and Family Support Program funds shall submit a completed application to the department. B. Completed applications shall include the following information: 1. A detailed description of the services or items for which funding is requested; 2. Documentation that the requested services or items are needed to support the continued residence of the individual with ID/DD in his own or the family home and no other public funding sources are available; 3. The requested funding amount and frequency of payment; and 4. A statement in which the individual or family member: a. Agrees to provide the department with documentation to establish that the requested funds were used to purchase only approved services or items; and b. Acknowledges that failure to provide documentation that the requested funds were used to purchase only approved services or items may result in recovery of such funds and denial of subsequent funding requests. C. The application shall be signed by the individual or family member requesting the funding.	on the waiting list); adds "custodial" where appropriate before "family member." A. Eligible individuals or custodial family members who choose to apply for ~~Individual and Family Support Program~~ IFSP funds shall submit a completed application to the department. B. Completed applications shall include the following information: 1. A ~~detailed~~ description of the services or items for which funding is requested; 2. ~~Documentation~~ Acknowledgement that the requested services or items are needed to support the continued residence of the individual with ~~ID/~~DD in his own or the family home and no other public funding sources are available; 3. The requested funding amount ~~and frequency of payment~~; and 4. A statement in which the individual or custodial family member: a. Agrees to provide to the department, if requested, ~~with~~ documentation ~~to establish~~ that the requested funds were used to purchase only ~~approved~~ services or items described in the application and approved by the department; and b. Acknowledges that failure to provide documentation, when requested, that the ~~requested~~ funds applied for were used to purchase only ~~approved~~ services or items described in the application and approved by the department may result in recovery of such funds and denial of subsequent funding requests. C. The application shall be signed by the individual or custodial family member requesting the funding.
80		(Previously Section 70.)	▪ Renumbered from Section 70 to 80; removes unnecessary language regarding the application process and review as such detail will be included in the guidelines document, and updated for the new process;

			requires the department to produce two reports, one of basic data and information post-funding season, and one on a summary of accomplishments towards meeting stated goals.
		70. Application review criteria. Upon receipt of a completed application, the department shall: 1. Verify that the individual is on the statewide ID or IFDDS Medicaid Waiver waiting list; 2. Confirm that the services or items for which funding is requested are eligible for funding in accordance with 12VAC35-230-50;. 3. Determine that the services or items for which funding is requested are needed to support the continued residence of the individual with ID/DD in his own or the family home; 4. Determine that other public funding sources have been fully explored and utilized and are not available to purchase or provide the requested services or items; 5. Evaluate the cost of the requested services or items; and 6. Consider past performance of the individual and family members regarding compliance with this chapter.	**80. ~~Application Review Criteria~~ Reporting.** ~~Upon receipt of a completed application, the department shall:~~ ~~1. Verify that the individual is on the statewide ID or IFDDS Medicaid Waiver waiting list;~~ ~~2. Confirm that the services or items for which funding is requested are eligible for funding in accordance with 12VAC35-230-50;~~ ~~3. Determine that the services or items for which funding is requested are needed to support the continued residence of the individual with ID/DD in his own or the family home;~~ ~~4. Determine that other public funding sources have been fully explored and utilized and are not available to purchase or provide the requested services or items;~~ ~~5. Evaluate the cost of the requested services or items; and~~ ~~6. Consider past performance of the individual and family members regarding compliance with this chapter.~~ A. For each funding period, the department shall develop and publish a summary that details the total dollar amount of funded awards, a summary of expenditure requests, the number of applications received, and the number of applications and individuals approved for receipt of IFSP funds. B. The department, with input from the IFSP State Council, shall develop an annual summary of accomplishments towards meeting the goals of the Virginia State Plan to Increase Individual and Family Supports.
90		(Previously Section 80.) **80. Funding decision-making process.** A. Applications may be approved at a reduced amount when the amount requested exceeds a reasonable amount as	▪ Renumbered Section 80 to 90; streamlined language. A. ~~Applications may be approved at a reduced amount when the amount requested exceeds a reasonable amount as determined by department staff as~~

		determined by department staff as being necessary to purchase the services or items. B. Applications shall be denied if the department determines that: 1. The service or item for which funding is requested is not eligible for funding in accordance with 12VAC35-230-50; 2. The request exceeds the maximum annual individual financial support limit for the applicable fiscal year; 3. Other viable public funding sources have not been fully explored or utilized; 4. The requesting individual or family member has not used previously received Individual and Family Support Program funds in accordance with the department's written notice approving the request or has failed to comply with these regulations; or 5. The total annual Individual and Family Support Program funding appropriated by the General Assembly has been expended for the applicable fiscal year. C. The department shall provide a written notice to the individual or family member who submitted the application indicating the funding decision. 1. Approval notices shall include: a. The services, supports, or other items for which funding is approved; b. The amount and time frame of the financial allocation; c. The expected date that the funds should be released; and d. Financial expenditure documentation requirements, and the date or dates by which this documentation	~~being necessary to purchase the services or items.~~ ~~B.~~ Applications shall be denied if the department determines that~~:~~ ~~1. The~~ the service or item for which funding is requested is not eligible for funding in accordance with 12VAC35-230-~~50~~ 60, other public funding sources are available, or the total annual IFSP funding appropriated by the General Assembly has been expended for the applicable fiscal year~~;~~. ~~2. The request exceeds the maximum annual individual financial support limit for the applicable fiscal year;~~ ~~3. Other viable public funding sources have not been fully explored or utilized;~~ ~~4. The~~ B. Additionally, potential grounds for denial shall include if the requesting individual or custodial family member has not used previously received ~~Individual and Family Support~~ Program funds in accordance with the department's written notice approving the request or has failed to comply with these regulations~~;~~ ~~or~~. ~~5.~~ B. ~~The total annual Individual and Family Support Program~~ IFSP funding ~~appropriated by the General Assembly has been expended for the applicable fiscal year.~~ C. The department shall provide a written notice to the individual or custodial family member who submitted the application indicating the funding decision, including the reason for denial of funding, if applicable. ~~1. Approval notices shall include:~~ ~~a. The services, supports, or other items for which funding is approved;~~ ~~b. The amount and time frame of the financial allocation;~~ ~~c. The expected date that the funds should be released; and~~ ~~d. Financial expenditure documentation requirements, and the date or dates by which this documentation shall be provided to the department.~~ ~~2. For applications where funding is denied or approved at a reduced amount, the department's notice shall state the reason or reasons why the requested services, supports, or other items were denied or were approved at a reduced amount and the process~~

		shall be provided to the department. 2. For applications where funding is denied or approved at a reduced amount, the department's notice shall state the reason or reasons why the requested services, supports, or other items were denied or were approved at a reduced amount and the process for requesting the department to reconsider its funding decision.	~~for requesting the department to reconsider its funding decision.~~
100		(Previously Section 90.) A. Individuals or family members who disagree with the determination of the department may submit a written request for reconsideration to the commissioner, or his designee, within 30 days of the date of the written notice of denial or approval at a reduced amount.	▪ Renumbered Section 90 to 100; one word addition to specify "custodial" family members as those to be involved with the application process. A. Individuals or custodial family members who disagree with the determination of the department may submit a written request for reconsideration to the commissioner, or his designee, within 30 days of the date of the written notice of denial or approval at a reduced amount.
110		(Previously Section 100.) D. Failure to use funds in accordance with the department's written notice or provide documentation that the funds were used to purchase only approved services or items may result in recovery of such by the department.	▪ Renumbered Section 100 to 110; points to the guidelines document for specification on how funds may be spent; changes documentation to 'if requested' as in another section; and also, points to the applicant's description of services in order to simplify the review process. D. Failure to use funds in accordance with the department's ~~written notice~~ Guidelines or provide documentation, if requested, that the funds were used to purchase only ~~approved~~ services or items as described in the application and approved by the department may result in recovery of such by the department.
120		(Previously Section 110.) Funding through the Individual and Family Support Program shall be terminated when the	▪ Renumbered Section 110 to 120; clarifying edits. Funding through the ~~Individual and Family Support Program~~ IFSP shall be terminated when the individual is enrolled in ~~the~~ a ~~ID or IFDDS~~ Medicaid

		individual is enrolled in the ID or IFDDS Medicaid Waiver or if approved funds are used for purposes not approved by the department in its written notice. Any funds approved, but not released, will be forfeited in such circumstances.	HCBS DD Waiver, if the individual is found to be no longer eligible to be on a waiting list for a Medicaid HCBS DD Waiver in accordance with 12VAC30-122-90 and any appeal has been exhausted, or if approved funds are used for purposes not approved by the department in its written notice. Any funds approved, but not released, will be forfeited in such circumstances.

Amendments to establish criteria and annual funding priorities through the Annual Funding Program Guidelines and to ensure public input (to facilitate compliance with DOJ)

12VAC35-230-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Commissioner" means the Commissioner of the Department of Behavioral Health and Developmental Services.

"Custodial family member" means a family member who has primary authority to make all major decisions affecting the individual and with whom the individual primarily resides.

"Department" means the Department of Behavioral Health and Developmental Services.

~~"Developmental disability" or "DD" means a severe, chronic disability of an individual that:~~

~~1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;~~

~~2. Is manifested before the individual attains age 22;~~

~~3. Is likely to continue indefinitely;~~

~~4. Results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care; (ii) receptive and expressive language; (iii) learning; (iv) mobility; (v) self-direction; (vi) capacity for independent living; and (vii) economic self-sufficiency; and~~

~~5. Reflects the individual's need for a combination and sequence of special, interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. (42 USC § 15002)~~

"Developmental disability" or “DD” means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested

before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

"Family member" means an immediate family member of an individual receiving services or the principal caregiver of that individual. A principal caregiver is a person who acts in the place of an immediate family member, including other relatives and foster care providers, but does not have a proprietary interest in the care of the individual receiving services. (§ 37.2-100 of the Code of Virginia)

"Individual and Family Support Program" or “IFSP” or “Program” means an array of individualized person-centered and family-centered resources, supports, items, services, and other assistance approved by the department that are intended to support the continued residence of an individual with developmental disabilities (DD) who is on the waiting list for a Medicaid Home and Community-Based Services (HCBS) DD Waiver in his own or the family home, which includes the home of the principal caregiver.

“Individual and Family Support Program State Council” or “IFSP State Council” or “Council” means an advisory group of stakeholders selected by the department that shall provide consultation to the department on creating a family support program intended to increase the resources for individuals and families and promote community engagement and coordination. The Council shall include individuals with DD and family members of individuals with DD.

~~"Intellectual disability" or "ID" means a disability, originating before the age of 18 years, characterized concurrently by (i) significantly subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean; and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. (§ 37.2-100 of the Code of Virginia)~~

12VAC35-230-20. Program description.

A. The Individual and Family Support Program assists individuals with ~~intellectual disability or~~ developmental disabilities and their family members to access needed person-centered and family-centered resources, supports, services, and other assistance ~~as approved by the department. As such, Individual and Family Support Program funds shall be distributed directly to the requesting individual or family member~~

~~or a third party designated by the individual or family member~~. The ~~overall objective~~ purpose of the ~~Individual and Family Support Program~~ IFSP is to support the continued residence of an individual with ~~intellectual or~~ developmental disabilities in his own home or the family home, which includes the home of a principal caregiver.

B. ~~The overall objective of the Individual and Family Support Program is to support the continued residence of an individual with intellectual or developmental disabilities in his own home or the family home, which include the home of a principal caregiver.~~ The department shall operate the IFSP directly or through a third party designated by the department to administer all or part of the Program, based on guidelines developed collaboratively by the department and the department's IFSP State Council.

C. ~~Individual and Family Support Program~~ IFSP funds shall be distributed directly to the requesting individual or custodial family member or a third party designated by the individual or custodial family member. IFSP funds shall not supplant or in any way limit the availability of services provided through a Medicaid ~~Home and Community-Based~~ HCBS DD Waiver~~,~~; Early and Periodic Screening, Diagnosis, and Treatment~~,~~; or similar programs.

12VAC35-230-30. ~~Program eligibility requirements~~ Community coordination.
The department shall:
1. Ensure an annual public input process that encourages the continued residence of individuals on the waiting list for a Medicaid HCBS DD Waiver in community settings.

2. Establish the IFSP State Council.

3. Develop, in coordination with the Council, a strategic plan that is consistent with these regulations and the purpose of the IFSP and that is updated as necessary as determined by the department.

4. Provide technical assistance to individuals or family members to facilitate their access to covered services and supports listed in 12VAC35-230-50, that are intended to enhance or improve their quality of life and promote the independence and continued residence of an individual with DD in his own home or the family home, which includes the home of a principal caregiver.

12VAC35-230-40. Program eligibility requirements and policies.
A. Eligibility for ~~Individual and Family Support Program~~ IFSP funds shall be limited to individuals who are living in their own or a family home and are on the statewide waiting list for ~~the~~ a ~~Intellectual Disability (ID) Medicaid Waiver or the Individual and Family Developmental Disabilities Support (IFDDS)~~ Medicaid HCBS DD Waiver and their custodial family members who are assisting those individuals.

B. The department, based on information gathered through public input and in collaboration with the IFSP State Council shall establish eligibility criteria as published in the Individual and Family Support Program Guidelines ("Guidelines"), the award process, the appeals process, and any other protocols necessary for ensuring the effective use of state funds. All procedures shall be published annually in the Guidelines prior to opening the funding opportunity.

C. For each funding period, the department shall develop and publish the following information on the IFSP:

1. Criteria for prioritized funding categories;

2. A summary of allowable expenditures;

3. Application deadlines; and

4. Award notification schedules.

D. The Guidelines shall be reviewed and updated annually.

12VAC35-230-~~40~~50. Program implementation.

A. ~~Individual and Family Support Program~~ IFSP funds shall be limited by the amount of funds allocated to the Program by the General Assembly. The ~~D~~department approval of funding requests shall not exceed the funding available for the fiscal year. Based on information gathered through relevant data and public input, and in collaboration with the IFSP State Council, the department shall establish annual funding categories.

~~B. Based on funding availability, the department shall establish an annual individual financial support limit, which is the maximum annual amount of funding that can be provided to support an eligible individual during the applicable fiscal year.~~

~~C~~. ~~Individual and Family Support Program~~ IFSP funds may be provided to individuals or custodial family members in varying amounts, as ~~requested and approved~~ determined by the department's prioritized funding categories~~, up to the established annual individual financial support limit~~.

~~D. On an annual basis, the department shall announce Individual and Family Support Program total funding availability and the annual individual financial support limit for the applicable fiscal year. This announcement shall include a summary of covered services, the application, and the application review criteria.~~

~~E. Individuals and family members may submit applications for Individual and Family Support Program funding as needs arise throughout the year. Applications shall be considered by the department on a first-come, first-served basis until the annual allocation appropriated to the program by the General Assembly for the applicable fiscal year has been expended.~~

~~F. Individuals and their family members may apply for Individual and Family Support Program funding each year and may submit more than one application in a single year; however, the total amount approved during the year shall not exceed the annual individual financial support limit.~~

12VAC35-230-~~50~~60. Covered services and supports.

Services and items funded through the ~~Individual and Family Support Program~~ IFSP as published in the Guidelines are intended to support the continued residence of an individual in his own or the family home and may include: (i) safe community living; (ii) improved health outcomes; and (iii) community integration~~:~~

~~1. Professionally provided services and supports, such as respite, transportation services, behavioral consultation, and behavior management;~~

~~2. Assistive technology and home modifications, goods, or products that directly support the individual;~~

~~3. Temporary rental assistance or deposits;~~

~~4. Fees for summer camp and other recreation services;~~

~~5. Temporary assistance with utilities or deposits;~~

~~6. Dental or medical expenses of the individual;~~

~~7. Family education, information, and training;~~

~~8. Peer mentoring and family-to-family supports;~~

~~9. Emergency assistance and crisis support; or~~

~~10. Other direct support services as approved by the department~~. No services or items shall be funded by the Program if not listed in the Guidelines or if covered by another entity.

12VAC35-230-~~60~~70. Application for funding.

A. Eligible individuals or custodial family members who choose to apply for ~~Individual and Family Support Program~~ IFSP funds shall submit a completed application to the department.

B. Completed applications shall include the following information:

1. A ~~detailed~~ description of the services or items for which funding is requested;

2. ~~Documentation~~ Acknowledgement that the requested services or items are needed to support the continued residence of the individual with ~~ID/~~DD in his own or the family home and no other public funding sources are available;

3. The requested funding amount ~~and frequency of payment~~; and

4. A statement in which the individual or custodial family member:

a. Agrees to provide to the department, if requested, ~~with~~ documentation ~~to establish~~ that the requested funds were used to purchase only ~~approved~~ services or items described in the application and approved by the department; and

b. Acknowledges that failure to provide documentation, when requested, that the ~~requested~~ funds applied for were used to purchase only ~~approved~~ services or items described in the application and approved by the department may result in recovery of such funds and denial of subsequent funding requests.

C. The application shall be signed by the individual or custodial family member requesting the funding.

12VAC35-230-~~70~~ 80. ~~Application Review Criteria~~ Reporting.

~~Upon receipt of a completed application, the department shall:~~
~~1. Verify that the individual is on the statewide ID or IFDDS Medicaid Waiver waiting list;~~
~~2. Confirm that the services or items for which funding is requested are eligible for funding in accordance with 12VAC35-230-50;~~
~~3. Determine that the services or items for which funding is requested are needed to support the continued residence of the individual with ID/DD in his own or the family home;~~
~~4. Determine that other public funding sources have been fully explored and utilized and are not available to purchase or provide the requested services or items;~~
~~5. Evaluate the cost of the requested services or items; and~~
~~6. Consider past performance of the individual and family members regarding compliance with this chapter.~~

A. For each funding period, the department shall develop and publish a summary that details the total dollar amount of funded awards, a summary of expenditure requests, the number of applications received, and the number of applications and individuals approved for receipt of IFSP funds.

B. The department, with input from the IFSP State Council, shall develop an annual summary of accomplishments towards meeting the goals of the Virginia State Plan to Increase Individual and Family Supports.

12VAC35-230-~~80~~ 90. Funding decision-making process.

A. ~~Applications may be approved at a reduced amount when the amount requested exceeds a reasonable amount as determined by department staff as being necessary to purchase the services or items.~~

~~B.~~ Applications shall be denied if the department determines that~~:~~

~~1. T~~the service or item for which funding is requested is not eligible for funding in accordance with 12VAC35-230-~~50~~ 60, other public funding sources are available, or the total annual IFSP funding appropriated by the General Assembly has been expended for the applicable fiscal year~~;~~.

~~2. The request exceeds the maximum annual individual financial support limit for the applicable fiscal year;~~

~~3. Other viable public funding sources have not been fully explored or utilized;~~

~~4. The~~ B. Additionally, potential grounds for denial shall include if the requesting individual or custodial family member has not used previously received ~~Individual and Family Support~~ Program funds in accordance with the department's written notice approving the request or has failed to comply with these regulations~~; or~~.

~~5.~~ B. ~~The total annual Individual and Family Support Program~~ IFSP ~~funding appropriated by the General Assembly has been expended for the applicable fiscal year.~~

C. The department shall provide a written notice to the individual or custodial family member who submitted the application indicating the funding decision, including the reason for denial of funding, if applicable.

~~1. Approval notices shall include:~~

~~a. The services, supports, or other items for which funding is approved;~~

~~b. The amount and time frame of the financial allocation;~~

~~c. The expected date that the funds should be released; and~~

~~d. Financial expenditure documentation requirements, and the date or dates by which this documentation shall be provided to the department.~~

~~2. For applications where funding is denied or approved at a reduced amount, the department's notice shall state the reason or reasons why the requested services, supports, or other items were denied or were approved at a reduced amount and the process for requesting the department to reconsider its funding decision.~~

12VAC35-230-~~90~~ 100. Requests for reconsideration.

A. Individuals or custodial family members who disagree with the determination of the department may submit a written request for reconsideration to the commissioner, or his designee, within 30 days of the date of the written notice of denial or approval at a reduced amount.

B. The commissioner, or his designee, shall provide an opportunity for the person requesting reconsideration to submit for review any additional information or reasons why the funding should be approved as originally requested.

C. The commissioner, or his designee, after reviewing all submitted materials shall render a written decision on the request for reconsideration within 30 calendar days of the receipt of the request and shall notify all involved parties in writing. The commissioner's decision shall be binding.

D. Applicants may obtain further review of the decision in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

12VAC35-230-~~100~~ 110. Post-funding review.

A. Utilization review of documentation or verification of funds expended may be undertaken by department staff. Reviews may include home visits to view items purchased or services delivered.

B. Individuals and family members receiving ~~Individual and Family Support Program~~ IFSP funds shall permit the department representatives to conduct utilization reviews, including home visits.

C. Individuals and family members receiving ~~Individual and Family Support Program~~ IFSP funds shall fully cooperate with such reviews and provide all information requested by the department.

D. Failure to use funds in accordance with the department's ~~written notice~~ Guidelines or provide documentation, if requested, that the funds were used to purchase only ~~approved~~ services or items as described in the application and approved by the department may result in recovery of such by the department.

12VAC35-230-~~110~~ 120. Termination of funding for services, supports, or other assistance.

Funding through the ~~Individual and Family Support Program~~ IFSP shall be terminated when the individual is enrolled in ~~the~~ a ~~ID or IFDDS~~ Medicaid HCBS DD Waiver, if the individual is found to be no longer eligible to be on a waiting list for a Medicaid HCBS DD Waiver in accordance with 12VAC30-122-90 and any appeal has been exhausted, or if approved funds are used for purposes not approved by the department in its written notice. Any funds approved, but not released, will be forfeited in such circumstances.

DIRECTIONS

Wednesday, July 13, 2022

Virginia Department of Behavioral Health and Developmental Services,
13th Floor Large Conference Room, Jefferson Building, 1220 Bank Street, Richmond, VA 23219

Time: **Committees~~ at 8:30 a.m.~~**, Regular Board Meeting at 9:30 a.m.

- **Planning and Budget Committee** will meet in the 13th Floor Large Conference Room.
- ~~**Policy and Evaluation Committee** will meet in Room 844 on the 8th Floor.~~ **CANCELED**

Regular Meeting Location: **Virginia Department of Behavioral Health and Developmental Services, 13th Floor Large Conference Room, Jefferson Building, 1220 Bank Street, Richmond, VA 23219**

This page has **driving directions to the DBHDS Central Office in the Jefferson Building**, 1220 Bank Street. Below are general directions based on your starting point. View a Capitol area site plan (http://www.dbhds.virginia.gov/documents/sitePlan-RichCapitol.pdf) that you can adjust for magnification.

FROM I-64 EAST AND WEST OF RICHMOND

- Driving on I-64 towards Richmond, get onto I-95 South and continue into the downtown area on I-95.
- Take Exit 74B, Franklin Street.
- Follow Directions Below: 'Continue Downtown'

FROM I-95 NORTH OF RICHMOND

- Continue south on I-95 into the downtown area.
- Take Exit 74B, Franklin Street.
- Follow Directions Below: 'Continue Downtown'

FROM I-95 SOUTH OF RICHMOND

- Cross the bridge over the James River.
- Exit to your Right on exit 74C– Route 360 (17th Street is one-way) and continue to Broad Street.
- Turn Right onto Broad Street
- Turn Left onto 14th Street (first light after crossing over I-95)
- Follow Directions Below: 'Continue Downtown'

➢ CONTINUE DOWNTOWN - DIRECTIONS AFTER EXITING I-95

- Turn Right onto Franklin Street at the traffic light at the bottom of the exit.
- Cross through the next light at 14th Street (Franklin Street becomes Bank Street)
- Look for on-street meter parking in the block between 14th and 13th Streets, or on 14th or Main streets. If you do not see parking on this block other parking options are available. View the parking map and parking fee table for the area.

➢ **The location for the committee meetings and Regular Board Meeting is in the Jefferson Building** on the south-east corner of Capitol Square, at the intersection of 13th/Governor Street and Bank Streets.

If you have any questions about the information in this meeting packet,
contact Ruth Anne Walker, ruthanne.walker@dbhds.virginia.gov, 804.225-2252.