COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

DRAFT MEETING AGENDA

Wednesday, December 7, 2022
DBHDS Central Office, Jefferson Building*
1220 Bank Street, Richmond, VA

CONCURRENT COMMITTEE MEETINGS

Wednesday, December 7, 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 **Zoom Meeting:*** https://dbhds-virginia-gov.zoomgov.com/j/1619321933?pwd=TCt1aE1OQTVacW8yamErSVk2djBlUT09 *Meeting ID: 161 932 1933* *Passcode: 491459* ***OR*** *Phone: 1 646 828 7666 US (New York)* *Meeting ID: 161 932 1933* *Passcode: 491459* • **Planning and Budget Committee** ***13th Floor Large Conference Room*** OR see main meeting info below (same login↓)	Josie Mace *Legislative Manager* **Agenda p.62** Ruth Anne Walker *Board Liaison* **Agenda p.61**
9:25	**Adjourn**	

CONTINUED -

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

REGULAR MEETING

Wednesday, December 7, 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 Zoom Meeting: https://dbhds-virginia-gov.zoomgov.com/j/1603289347?pwd=OXNYNXBqRm5EQk82MjhrR1ISMDlsZz09
(this login is used for the Planning Committee)
Meeting ID: 160 328 9347
Passcode: 345010

OR
By Phone: +1 646 828 7666 US
Meeting ID: 160 328 9347
Passcode: 345010

1.	9:30	**Call to Order and Introductions** **Approval of December 7, 2022, Agenda** ➢ *Action Required* **Approval of Draft Minutes** **Regular Meeting, September 28, 2022** ➢ *Action Required*	Elizabeth Hilscher *Chair*	**4**
2.	9:45	**Public Comment** (*3 minute limit per speaker*) *Notice:* Public comment will not be accepted on petitions for rulemaking or regulatory actions in which the comment period has closed. It is *preferred but not required* that persons wishing to give comment email ruthanne.walker@dbhds.virginia.gov no later than 5:00 p.m., December 6, 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 presented at the meeting or sent by email to ruthanne.walker@dbhds.virginia.gov no later than 10:00 p.m. on December 6, 2022.		
3.	10:00	**Commissioner's Report**	Nelson Smith	
4.	10:45	**Regulatory Business** **A. Exempt Action: Licensing Regulations, [12VAC35-105]: Mobile Medication Assisted Treatment (MAT)** ➢ *Action requested.* **B. Fast Track Action: Certified Recovery Residences [12VAC35-260]**	Ruth Anne Walker *Regulatory Affairs Director* Jae Benz *Licensing Director* Susan Puglisi *Regulatory Research Specialist* Mark Blackwell *Recovery Services Director*	**20** **23** **40**

		➢ *Action requested.* **C. Initiate Periodic Review: Peer Recovery Specialists [12 VAC 35-250].** ➢ *Action requested.* **D. Regulatory Updates.**		**59**
5.	11:15	**Update: Community-based Crisis Services**	Bill Howard *Assistant Commissioner* *Crisis Services*	
6.	11:35	**Update: SOAR Grant (Opioid Crisis)**	Michael Zohab *Grant Manager* *Virginia State Opioid Response*	
7.	12:00	**Lunch: Break and Collect Lunch**		
8.	12:30	**Update: DD Services (across the life span)**	Heather Norton *Assistant Commissioner* *Developmental Disabilities*	
9.	12:50	**Board Member Spotlight**	Varun Choudhary	
10.	1:00	**Virginia Association of Community Services Boards**	Jennifer Faison *VACSB Executive Director*	
11.	1:30	**2023 General Assembly Legislative and Budget**	Nathan Miles *Budget Director* Josie Mace *Legislative Affairs Manager*	
12.	2:00	**Committee Reports** **A. Policy and Evaluation** **B. Planning and Budget**	 Josie Mace Ruth Anne Walker	 **18** **15**
13.	2:15	**Miscellaneous** **A. Liaison Updates** **C. Other Business** **a. Annual Executive Summary**	Elizabeth Hilscher	
14.	2:30	**Adjournment**		

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

2023 REGULAR MEETING SCHEDULE	
March 29. 2023	DBHDS SWVMHI, Marion
July 11, 2023 afternoon July 12, 2023	DBHDS Central Office (Biennial Planning Meeting), Richmond DBHDS CSH, Petersburg
September 27, 2023	DBHDS PGH and VCBR, Burkeville
December ?, 2023	DBHDS Central Office, Richmond

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Regular Meeting
DRAFT MEETING MINUTES
9:30 a.m., Wednesday, September 28, 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; R. Blake Andis; Rebecca Graser, Vice Chair; Kendall Lee (electronic); Moira Mazzi; Christopher Olivo; Sandra Price-Stroble.
Members Absent	Varun Choudhary.
Staff Present	• Eric Billings, Deputy Director, Office of Fiscal and Grants Management. • Dillon Gannon, Federal Grants Manager. • Catherine Hancock, Early Intervention (Part C) Program Manager. • Ellen Harrison, Chief Deputy Commissioner. • Cort Kirkley, Deputy Commissioner for Administration. • Madelyn Lent, Policy Manager. • Josie Mace, Legislative Affairs Manager. • Meghan McGuire, Deputy Commissioner for Policy and Public Affairs. • Dev Nair, Assistant Commissioner, Provider Management. • Susan Puglisi, Regulatory Research Specialist. • Ruth Anne Walker, Regulatory Affairs Director and State Board Liaison. • Michael Zohab, Grant Manager, Virginia State Opioid Response. • Mark Blackwell, Recovery Services Director.
Guests Present	Invited Guests: • Erin Close Austin, Parent and Early Intervention professional. • Jennifer Faison, Executive Director, Virginia Association of Community Services Boards. Other Guests in Person: • Leah Mills, Deputy Secretary, Office of the Secretary of Health and Human Resources (HHR). Other Guests Attending Electronically: • Ginger Barbour; Chris Peterson; Teddy Peterson; Michele Satterlund; one phone number unidentified.

Call to Order and Introductions	At 9:30 a.m., Elizabeth Hilscher, Chair, called the meeting to order and welcomed those present. A quorum of six members was physically present, and a seventh member participated electronically.
Approval of Agenda	*At 9:34 a.m. the State Board voted to adopt the September 28, 2022, agenda. On a motion by Rebecca Graser and a second by Sandra Price-Stroble, the agenda was approved.*
Approval of Draft Minutes	Nominating Committee Meeting, July 12, 2022 *At 9:31 a.m., on a motion by Christopher Olivo and second by Kendall Lee, the July 12, 2022, Nominating Committee minutes were approved as final.* Regular Meeting, July 13, 2022 *On a motion by Blake Andis and a second by Rebecca Graser, the July minutes were approved as final.*
Public Comment	At 9:35 a.m., Ms. Hilscher stated a period for public comment was included on the draft agenda, but there were no citizens that signed up to speak. She welcomed invited guest Erin Close Austin, LCSW, RPT-S, Children's Services Manager, Developmental Services, Richmond Behavioral Health Authority (RBHA). In addition to her role at RBHA, Ms. Austin is a parent of three children, two of whom have benefited from Early Intervention services in Henrico (Connor and Colton), and spoke to the impact of services on her sons' development. Her journey started 9 years ago when Connor was born at 27 weeks old weighing just over 2 pounds, and spent three months in intensive care before coming home. At the time, Ms. Austin had a toddler at home but felt like a new parent all over again having more questions than answers. She struggled with depression and feelings of inadequacies after he was born. Connor's service coordinator through Henrico's Early Intervention program became a lifeline for the family from the moment he was discharged from the hospital until he graduated from early intervention 3 years later. Connor had the gamut of early intervention services – occupational, physical, and speech therapy. Thankfully, these services are affordable and accessible. Connor was able to catch up to most of his peers by the time he discharged and is now a happy 9 year old in the 4th grade. After this experience, she jumped at the chance to work in the field when a position became available. Over the years she's been able to empathize with other parents from the juggling act of appointments to the heartache of accepting your child's support needs.

	Colton was 1 lb. 14 oz. when born in December at 26 weeks old and he came home after three months in the NICU. Since then, the family has been in and out of doctors' offices, coping with what feels like never-ending recommendations, weekly appointments, feeding struggles and more. While she will forever wish her son's outcome had been different, more typical, they are working towards a new normal. With his early intervention services, she's able to just be his mom and focus on his development. He is receiving occupational therapy, speech therapy, and social work services. Ms. Austin values Colton's early intervention team and is once again relying on early intervention professionals to be with her and her family along this journey. She is passionate about making sure families know the services can be made affordable for children. Ms. Hilscher stated she felt it was wonderful that she has been able to take her experience and blend it in her work life, as a peer to other parents.
Regulatory Actions	At 9:46 a.m., Ruth Anne Walker asked members to take action on the following: **Initiate Periodic Review: Regulations to Ensure the Protection of Subjects in Human Research [12VAC35-180].** *On a motion by Christopher Olivo and a second by Rebecca Graser, the board unanimously approved initiation of the periodic review.* Ms. Walker then provided a review of regulatory actions and drafts in process as listed in the matrix on page 18 of the packet, including planned actions to come before the State Board in December and in the spring 2023. Susan Puglisi provided a brief overview of the plans for a planned exempt action in December to amend Chapter 105 regarding mobile medication addiction treatment (MAT) programs. Ms. Walker mentioned briefly to think of the current overhaul drafting effort to restructure the Licensing regulations (both Chapter 46 and Chapter 105) in terms of 3, 2, and 1: Three of the new revised draft chapters have gone out for public comment and responses to comments were developed; two new draft chapters were currently out for comment; and one was coming along in development.
Commissioner's Report	At 9:55 a.m., members of the Executive Team gave the commissioner's report. New Chief Deputy Commissioner Ellen Harrison introduced Leah Mills, Deputy Secretary. Ms.

	Harrison introduced herself giving a brief background of her professional background. She worked in the community side of the system for about 25 years, including six different times in different positions at Harrisonburg Rockingham Community Services Board. Ms. Harrison also served at a local private hospital and five years at DBHDS' Western State Hospital, as Director of Quality Assurance. She enjoyed being an integral part of the 18 month process to move to the new hospital. This was her fourth week in this new role. She has a passion for the work, which has focused on services for people with serious mental illness. In particular, in the area of criminal justice and mental health, she spent a number of years with cross-systems mapping. She likes policies and seeing how systems work. Board members introduced themselves to Ms. Harrison. Referencing an article from the previous week regarding Governor Youngkin's new Chief Transformation Officer Eric Moeller who is looking for proposals about the structure and operation of the department's mental health hospitals and regional delivery of services for individuals with mental illness, Ms. Harrison indicated that there will also be a focus on the department's services for people with developmental disabilities. Meghan McGuire, Deputy Commissioner, Policy and Public Affairs, provided an update on the Behavioral Health Redesign initiative. She referenced Commissioner Smith's comments at the July board meeting regarding the work of the department aligning with the Administration's goals. This effort would look at what is known already regarding what that stakeholders are saying about the system and make meaningful changes. Through internal meetings, critical issues were identified across the individual's path through the system of services. Additionally, Item 283 required a workgroup to study the structure of DBHDS, made up of a few state agencies. A series of regional listening sessions are expected to gain community input that will inform the Governor's plan. Ms. McGuire indicated staff would inform the board when those regional meetings would be held. An outline for an interim step is the goal for this calendar year. Ms. Mills added that the Secretary and Governor are committed to receiving feedback from the public. Ms. Hilscher asked a clarifying question on the agencies named in the workgroup and the involvement of the Behavioral Health Commission. Ms. Mills stated initial recommendations to

	implement changes are expected for the General Assembly and Behavioral Health Commission. Ms. Graser commented that there has been talk for years about dismantling the community services boards, and she finds that they are somewhat 'clunky.' For example, moving from the clinical model to the recovery model has been rather difficult in the current clinical culture. Ms. Harrison stated there are some things with the objectives and key results (OKRs) of the strategic plan that will cascade down to the community regarding peer recovery services that will add value to community services. For example, barriers to peers being hired. Ms. Graser has seen the value at the state level and even from the General Assembly, but at the local level it seems there must be 'buy in' with understanding of the value of peer services as nonclinical. She is interested in the regional listening sessions to get the word out. At 10:20 a.m., Cort Kirkley, Deputy Commissioner, Administration, provided an update on the North Star strategic plan including objectives and key results. He explained the use of OKRs is a very good tool for driving change, with a lot of detail. They are the intersection of strategic planning and project management. Staff last fall moved towards the use of OKRs and the new Administration also wanted to use the same tool. Transformation is encompassed in the plan in the three domains: strengthening the workforce system-wide, expanding a comprehensive continuum of care, and modernizing systems and processes. Ms. Harrison stated that the day before she visited Mt. Rogers CSB, which encompasses an area of five localities and 15 law enforcement agencies, where there has been a 287% increase in the use of the five beds in the crisis receiving centers where assessments can be done, avoiding hospital visits, and allowing law enforcement to return to their other duties. Mr. Olivo is excited about the use of key results with measurable progress results. He asked about the timeframe on how often progress will be checked. Mr. Kirkley reported there are eight key results flagged by the Administration that are reported up to the Administration monthly, and internally quarterly updates will be given to the commissioner. A consultant will be utilized to assist in refinement and development of the dashboards for reporting. Mr. Olivo asked if the board would be able to receive the quarterly updates and Mr. Kirkley confirmed that.

	Sheriff Andis asked if CSBs have policies and procedures individual to each CSB on their services. Ms. Harrison responded there are state regulations, and also those through Department of Medical Assistance Services for the federal Medicaid primary billing source for services, and related regulatory credentialing and expectations. For example, the Harrisonburg-Rockingham CSB's budget is 43% Medicaid funding, which drives business and service decisions. There is also local funding, and state funds. The area for any CSB is also defined by the taxpayer base (how many are on Medicaid, underinsured, or insured), or for instance, if there is a university in the area graduating licensed or license-eligible people, that can impact hiring for certain services. All those pieces together drive the delivery system. The goal with the North Star Plan and the Behavioral Health Redesign is to have services accessible in every locality; this is key for healthy living, recovery, and reducing use of hospitals. The Commonwealth is good at delivering state hospital services, but there is a need to push money into the community to build out that end of the services system. Ms. Graser asked for more information about the barrier crimes initiative. Mr. Kirkley responded that there is legislation in development. Ms. McGuire stated that legislation is still under review (there is some barrier crime legislation almost every year). Ms. Graser then mentioned the issue of out of state training hours for licensure, mentioning her own experience getting her MSW from the University of New England. She needed 600 hours for an internship in Virginia, but the rest of the country had 500 hours. This can be a barrier to having more workforce across state lines. Ms. Mills reported on a regulatory action in process from the Department of Health Professions and other possible amendments under review to try to reduce such barriers. Ms. Hilscher also mentioned the financial burden of getting the required supervised hours for licensure; her daughter ended up moving to another state to move forward after working at a CSB for nine months without supervision. Ms. Harrison mentioned training to get the 'S' that indicates someone has served long enough in a role to act as a supervisor. Mr. Kirkley mentioned a pilot program with the Virginia Healthcare Foundation to fund and coordinate the supervision for licenses. Funding helps to cover compensation for the supervisor.

	Ms. McGuire introduced Madelyn Lent, the new Policy Manager. Ms. Lent was a Fellow with the Virginia Management Program; she will be working more with the State Board in coming months. Ms. Lent has a sibling with developmental disabilities; she attended the University of Richmond studying public policy. She hoped to eventually work at DBHDS. *Ms. Hilscher called for a 5 minute break at 11:05 a.m.*
Update: Opioid Crisis	At 11:15 a.m., Michael Zohab, Grant Manager, Virginia State Opioid Response. *The presentation is available upon request.*
Update: Office of Recovery Services	At 11:35 a.m., Mark Blackwell, Director, provided an update on all activities and programs within the Office of Recovery Services. *The presentation is available upon request.*
Lunch: Break and Collect Lunch	*At 12 p.m., Ms. Hilscher suspended the meeting for a 30 minute lunch break, to reconvene at 12:30 p.m.*
Update: Early Intervention (Part C)	At 12:32 p.m., Catherine Hancock, Program Manager, reported on the status of Early Intervention services across the state. *The presentation is available upon request.* Mr. Olivo said his son accessed services easily and had a positive experience; he wished children had the same level of service as they got older. Ms. Graser asked about rural infant programs. Ms. Hancock stated there are some rural infant programs that are not early intervention programs, but there are early intervention programs in every area of the state. Dr. Lee commended Ms. Hancock on her years of public service and thanked her for her help with the program over the years. He appreciated the spotlight on the program in the board meeting. He noted the focus on coaching parents and how important it is, which became very clear during the pandemic. It helped the staff to sharpen their coaching skills. Both families and providers appreciated that focus. The switch to telehealth has been very helpful. The growth of early intervention is month to month not year to year in the program he manages in Farmville serving seven Southside counties, and about 10 % more children each year. The state office resources help the local programs be successful and he is excited to see where the program will go in the future. Training more college students to become early intervention professionals is a current effort. Ms. Hancock commended her 10 staff in the state office.

Update: Virginia Association of Community Services Boards	At 1:00 p.m., Jennifer Faison, Executive Director, VACSB, reported on outcomes from community services boards (CSBs). She reminded the board that VACSB produces two advocacy documents annually, the Annual Report and the Public Policy Brochure. Sheriff Andis had questions unrelated to her comments, including legal representation of CSBs in particular situations, and counseling assistance when there is a juvenile temporary detention order. Ms. Faison and Sheriff Andis would meet after the meeting.
Semiannual Federal Grant Report	At 1:30 p.m., Eric Billings, Deputy Director, Office of Fiscal and Grants Management, and Dillon Gannon, Federal Grants Manager, provided an update on the status of federal grants. *The presentation is available upon request.* Ms. Walker asked if it was unusual to not be pursuing smaller grants and Mr. Billings responded in the past 10 years it is not unusual. Some of the smaller grants in recent years were for a limited time, sometimes 'start up' funding. Ms. Walker asked if it was typical to happen at a certain time of year to apply for grants. Mr. Billings stated that the cycle no longer always follows the federal funding cycle. Ms. Hilscher stated it is good that there are carry over pandemic related funds to use.
Board Member Spotlight	At 1:38 p.m., Rebecca Graser shared that she is a person in long-term recovery. She grew up in Richmond from the age of 5 when her parents bought a now 200 year old home in Fulton Hill; her father was in the Air Force. She attended primary school at St. Patrick's in Church Hill and then high school at St. Gertrude's. She has three older brothers, and had a fun childhood; one brother played basketball at Duke and she followed in his footsteps, attending VCU (1978-1982) on a basketball scholarship, one of the first for women. She recalls her first activism, regarding the inequality between men and women in sports and this was soon after Title IX, the federal civil rights law in the United States was enacted in 1972 prohibiting sex-based discrimination in any school or any other education program that receives funding from the federal government. Ms. Graser excelled in the sport, being the first woman nationally to get 1,000 points; she was inducted into the Hall of Fame (1990). She became a coach at Radford University, and was well-suited to the job, getting to know some of the incredible ACC coaches at the time. Yet she was very young, and was sent out on the road to recruit with icons of the sport,

	but just didn't know how to handle being in a very adult world. As a way of coping with stress and some childhood trauma – she started drinking. It is a progressive disease and Ms. Graser went through a lot of trauma in the addiction – two marriages, losing custody of her child. Her view of addiction is that it is disconnection from yourself, that a person's life becomes less and less manageable the further into the addiction a person progresses, and you lose who you are. She continued being successful in her work; however, she would reach goals but would not feel anything or feel connection to the moment. Ms. Graser entered recovery at 48 years old; and feels there is no such thing as a 'functioning' alcoholic. Her 'aha' connection moment came early in recovery, as she tried to shop for her son's favorite dinner with only $25, which she managed to do, and looked the cashier in the eye feeling connection for the first time in years. In the first year of recovery, her sister-in-law was the clinical director at the Middle Peninsula CSB and helped her move into the realm of advocacy for people in recovery. Working in the field is something you never want to leave, as it is very special to be authentically and organically equipped to connect to those needing recovery because you are the same as those needing services, and they sense it. Bridging the value of peer work to the clinical world and fighting against stigma in the system overall and even in CSBs is ongoing to counterbalance the medical service model. The profession has progressed since 2009, with the Office of Recovery Services at the CSB molded over the years to have two centers for 10 counties (in Warsaw and Gloucester; the CSB extends 2200 square miles), taking advantage of grant offerings to build the peer support network. She feels strongly about the empowering identity that comes through having a job. She realizes what they have at the CSB is pretty rare in its breadth. In her spare time she 'forest bathes' through regular hikes.
Committee Reports	At 1:55 p.m., Ms. Graser and Josie Mace reported that the Policy and Evaluation Committee met that morning and heard background information on the following DIs that would move to the revision phase next with edits expected in December: • 1008(SYS)86-3 Services for Older Adults with Mental Illness, Mental Retardation, or Substance Use Disorders in advance of the committee developing revisions. Lead staff Suzanne Mayo spoke to the committee.

	• 1040(SYS)06-3 Consumer and Family Member Involvement and Participation. A lead staff person would be identified. At the December meeting, background information would be provided on DI 1044(SYS)12-1 Employment First, along with Disaster Preparedness 1043(SYS)08-1, in order to catch up to the six year schedule. The committee will set a supplemental meeting between the December and March board meetings (likely early March). At 2:01 p.m., Ms. Hilscher reported on the discussion in the Planning and Budget Committee: consideration of the commissioner's strategic North Star Plan details; walking through the board's six biennial priorities looking for specific or general alignment between the two priority lists; the quarterly budget of the state board; new regulatory process changes (expanded economic impact information, unified regulatory plan, reducing discretionary regulatory burden); thoughts on system topics for upcoming meetings that are important to members; and possible travel locations for March and September, and possibly for July. Ms. Hilscher asked members to consider topics and possible July travel.
Miscellaneous	At 2:07 p.m., Ms. Hilscher opened the miscellaneous topics: • Liaison updates: Ms. Graser attended a VACSB conference; members were reminded that the board budget allows for certain conferences around the state. If members are interested, they should reach out to Ms. Walker to coordinate. • Ms. Walker would be sending a draft annual executive summary to send to the board for consideration of endorsement in December. • Ms. Hilscher asked that thanks be shared to Karen Dyer, Terrell Morris, and Trevon Johnson for all logistical support. • Sheriff Andis reported that the commissioner visited at a meeting of law enforcement at The Breaks, and also in Virginia Beach, as did the Governor, whose main focus was mental health. When the board visits Marion, there is a new crisis intervention team assessment center (CITAC) location opening; the Attorney General is coming to visit for the grand opening of the 12-bed, 23-hour center. He reported that the Marcus Alert data is going, also. Ms. Price-Stroble was grateful for such updates by members as they are valuable to take back to members' home communities.

Adjournment	There being no other business, Ms. Hilscher adjourned the meeting at 2:17 p.m.

2023 MEETING SCHEDULE

DATE	Location
March 29, 2023 (Wed)	DBHDS SWVMHI **Marion**
July 11, 2023 (Afternoon) **July 12, 2023 (Wed)**	DBHDS Central Office (Biennial Planning Meeting) **Richmond** DBHDS CSH **Petersburg**
September 28, 2023 (Wed)	DBHDS PGH and VCBR **Burkeville**
December ?, 2023 (?)	DBHDS Central Office **Richmond**

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Planning and Budget Committee

DRAFT MINUTES

September 28, 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; R. Blake Andis; Christopher Olivo.
Members Absent: None (one vacancy).
Staff Present: Susan Puglisi, Ruth Anne Walker.

I. Call to Order

A quorum being present, at 8:30 a.m., Elizabeth Hilscher, Chair, called the meeting to order.

II. Welcome and Introductions

At 8:31 a.m., Ms. Hilscher welcomed all present.

III. Adoption of Minutes, July 13, 2022

On a motion from Christopher Olivo and a second from Blake Andis the meeting minutes from July 13, 2022, were adopted unanimously.

IV. Standing Item: *Identification of services and support needs, critical issues, strategic responses, and resource requirements to be included in long-range plans; work with the department to obtain, review, and respond to public comments on draft plans; and monitor department progress in implementing long-range programs and plans.*

A. Update on North Star Strategic Plan
B. Discussion of Identified Priorities (within the framework of required agency strategic planning and budget development processes):
a. Review the priorities set at the Biennial Planning Meeting.

At 8:35 a.m., Ms. Hilscher asked members to review the details in the commissioner's North Star strategic plan handout that would be presented in the full meeting. The plan is based on three overarching goals of the plan: strengthening workforce, expanding the continuum of care, and modernizing systems and processes. Specifically, Ms. Hilscher walked through the board's six biennial priorities looking for specific or general alignment between the two lists.

State Board Priorities for the Biennium	North Star Strategic Plan
1. Endorse the department's strategic objective regarding maintaining the workforce at appropriate staffing levels. The state hospital crisis definitely is an immediate priority, but the board notes that workforce and pay issues are not new, and are system-wide.	Domain 1 Objective 1
2. Endorse the department's strategic objective regarding community based supports, as any previous efforts need to be completed and new efforts must be started to continue to make the community structure what it should be. (Ex. STEP-VA.)	Domain 2 Objective 3
3. Efforts to increase public awareness for how to access services, the frequency that individuals in our country need services to address mental health and substance use disorders or developmental disabilities, and encouragement to seek help. The needs have always been in our society, but the pandemic raised awareness and reduced stigma, yet simultaneously exacerbated those needs. For example, adolescent mental health needs and teen suicide increases. Also, there are windows of development for children, especially for children with developmental disabilities; those windows are missed opportunities.	Domain 2 Objective 3
4. Streamline the discharge process from state hospitals.	Domain 2 Objective 6 Domain 3 Objective 7
5. As highlighted in the board's 2019 letter, continue to prioritize waiver rates and the elimination of the waiting list for the developmental disability population.	Domain 2 Objective 4
6. Brace for the impacts of the pandemic on the system for all stages of the lifespan in regard to resources and priorities. By necessity, society has had to be reactive but hopefully things can shift to be more proactive.	Domain 3 Objective 8 Objective 9
• In addition, the board feels special consideration should be noted to the comprehensive and ongoing impacts of the pandemic over the entire system of services and across all ages.	

Ms. Hilscher asked members to consider any other areas or topics that came to mind as a major priority for the board to address, and also if there were any specific questions related to the details of the North Star Plan. The biennial priorities will be reviewed and updated at the next Biennial Planning Meeting on July 12, 2023, and voted on at the board meeting the next day.

C. Review of topic areas for board meetings through July 2023.

D. Spring and Summer 2023 Meeting Dates
At 8:50 a.m., Items C and D were considered jointly by reviewing the chart of topics by meeting through July 2023, and the decision was made to restart travel as of the March 2023 meeting. Ms. Hilscher and Ruth Anne Walker described the typical schedule for meetings outside of Richmond: a late afternoon community service location tour, a board working dinner with presentation by a local CSB, followed by a regular meeting the next day at a DBHDS facility, with a tour of the facility during the usual meeting time. A third meeting of travel in July was also discussed; the committee decided to bring that up to the full board.

V. 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.*

A. **State Board Budget Quarterly Report.** *Handout*
At 8:55 a.m., the board's quarterly budget report was reviewed.

VI. Other Business

A. Regulatory Process Changes: ED1 and EO19.
At 9:00 a.m., Ms. Walker updated members on the agency's first annual unified regulatory plan submitted as part of the new regulatory requirements for all agencies set out under the Governor's Executive Directive 1 and Executive Order 19. The plan includes expectations for regulatory reduction actions, in addition to actions brought due to federal and state mandates. Susan Puglisi gave a brief explanation of the federal rule regarding mobile medication assisted treatment (MAT).

VII. Next Steps:

A. **Standing Item: Report Out**
Updates from committee planning activities would be reported out to the Board in the regular meeting.

B. **Next Meeting:** The next meeting is scheduled for December 7, 2022.

VIII. Adjournment

At 9:10 a.m., Ms. Hilscher adjourned the meeting.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Policy and Evaluation Committee

DRAFT MINUTES
September 28, 2022
8:30 a.m. – 9:25 a.m.
DHBDS, Room 844, 8TH FLOOR
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: Rebecca Graser, Vice Chair and Committee Chair; Kendall Lee (Virtual); Moira Mazzi; Sandra Price-Stroble.
Members Absent: Varun Choudhary.
Staff: Josie Mace, Legislative Affairs Manager and Committee Staff; Suzanne Mayo, Director, DBHDS Office of Community Integration.
Guests: None.

I. Call to Order

Rebecca Graser called the committee to order at 8:45 AM.

II. Welcome and Introductions

Ms. Graser welcomed all present, and the committee members introduced themselves.

III. Review of 2022 Policy Review Plan and Presentation of Policies for Discussion

A. 1008(SYS)86-3 Services for Older Adults with Mental Illness, Mental Retardation, or Substance Use Disorders

Suzanne Mayo presented background information on this policy to the committee. After committee discussion, Moira Mazzi motioned to move this policy to the revision phase. Sandra Price-Stroble seconded the motion.

B. 1040(SYS)06-3 Consumer and Family Member Involvement and Participation

Josie Mace presented background information on this policy to the committee. After committee discussion, Sandra Price-Stroble motioned to move this policy to the revision phase and locate the appropriate subject matter expert. Moira Mazzi seconded the motion.

C. 1044(SYS)12-1 Employment First

Due to subject matter expert availability, the background phase of policy review for this item was tabled until the next meeting in December 2022.

IV. Next Meeting: December 7, 2022

continued -

V. Other Business

Ms. Mace suggested setting a stand-alone committee meeting for the beginning of March to catch up on policy review. The committee agreed. The date will be announced at the December 2022 meeting.

VI. Adjournment

The meeting adjourned at 9:10 AM

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: November 21, 2022

Regulatory Activity Status Report and Action Items:

I. Exempt Action: Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services [12VAC35-105}: Mobile Medication Assisted Treatment (MAT), see p. 23.

Background: In June 2021, the federal Drug Enforcement Administration (DEA) published a final rule permitting DEA registrants who are authorized to dispense methadone for opioid use disorder to add a "mobile component" to their existing registrations. States are not required to adopt these regulations for MAT services, but if a provider chooses to provide them, the federal regulations must be followed.

Purpose: DBDHS seeks to integrate these federal regulations into the Licensing Regulations due to provider interest in supplying these mobile medication assisted treatment (mobile MAT) services to help address the opioid crisis in Virginia. The integration of the federal rules within the Licensing Regulations will increase transparency and set administrative expectations for this optional service as required by federal law.

Action Requested: In accordance with Subsection 4.c. of § 2.2-4006 of the Code of Virginia, initiate an exempt action to amend the Licensing Regulations, 12VAC35-105.

continued -

II. Fast Track Action: Certified Recovery Residences [12VAC35-260], see p. 40.

Background: "Recovery housing" refers to safe, healthy, and substance-free living environments that support individuals in recovery from addiction. While recovery residences vary widely in structure, all are centered on peer support and a connection to services that promote long-term recovery. While many recovery residences are well-run, a national effort has been growing to bring standards to how recovery residences are operated.

Section 37.2-431.1 was codified requiring the promulgation of new regulations to specify credentialing entities and the application process through DBHDS. Since Chapter 260 became effective in March 2020, recovery residences have been held to nationally recognized standards to ensure safety and recovery through effective peer support, mutual accountability, and clear social structures. Voluntary credentialing of recovery housing is intended to make it easier to locate recovery housing for individuals needing such housing and thus create a list of available houses to be utilized by courts, community services boards, individuals, and families.

Purpose: These new amendments to Chapter 260 are intended to comply with actions by the 2022 Session of the General Assembly. A fast track action is requested as the changes are not expected to be controversial, closely following the General Assembly directives.

Action Requested: Initiate a fast track action to adopt the mandate from the 2022 General Assembly.

III. Required Periodic Review of One Regulation.

(See the flow chart of the process: http://townhall.virginia.gov/UM/chartperiodicreview.pdf)

Background: Existing regulations must be examined at least every four years to review statutory authority and assure that the regulations do not exceed the Board's statutory authority. Investigation should be conducted for any alternatives to the regulation and any need to modify the regulation to meet current needs.

Purpose: The regulation is submitted to the State Board for consideration for review as required. It sets out how individuals may be designated as "peer recovery specialists" to have a workforce pathway to provide peer services through the Virginia ARTS benefit, which became available to Medicaid members receiving addiction treatment services at all levels of care effective on July 1, 2017.

Continued -

Action Requested: Direct that a periodic review is initiated for the following regulations.

VAC Citation	Title	Last Review
12 VAC 35-250	Peer Recovery Specialists.	N/A; new in 2019

Next Steps:
If approved, staff initiates the periodic review. At the conclusion of the 21-day (minimum) comment period, staff develops recommended Board action on the regulations for. The choices for action are:
A. Propose to retain the regulation in its current form.
B. Propose to amend or abolish the regulation. (Notice of Intended Regulatory Action)
Propose to amend the regulation through an exempt action.

townhall.virginia.gov

Exempt Action: 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 ("Licensing Regulations")
Action title	Integration of the final federal rule: Registration Requirements for Narcotic Treatment Programs with Mobile Components into the Licensing Regulations
Final agency action date	
Date this document prepared	October 17, 2022

This information is required for executive branch review pursuant to Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19. In addition, this information is required by the Virginia Registrar of Regulations pursuant to the Virginia Register Act (§ 2.2-4100 et seq. of the Code of Virginia). Regulations must conform to the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), 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.

In June 2021, the federal Drug Enforcement Administration (DEA) published a final rule permitting DEA registrants who are authorized to dispense methadone for opioid use disorder to add a "mobile component" to their existing registrations. The Department of Behavioral Health and Developmental Services (DBDHS) is integrating these federal regulations into the Licensing Regulations due to provider interest in supplying these mobile medication assisted treatment (mobile MAT) services. The integration of the federal rules within the Licensing Regulations shall increase transparency and set administrative

expectations for this service. The availability of mobile MAT is expected to help address the opioid crisis in Virginia.

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, internal staff review, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in the ORM procedures, "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

The Drug Enforcement Administration implemented the "Registration Requirements for Narcotic Treatment Programs with Mobile Components" within 21 CFR Parts 1300, 1301 and 1304" in June 2021.

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 December 7, 2022, to initiate the exempt stage titled 'Integration of the final federal rule: Registration Requirements for Narcotic Treatment Programs with Mobile Components into the Licensing Regulations' to amend the Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services [12VAC35-105].

Department of Behavioral Health and Developmental Services

Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (“Licensing Regulations”)

Integration of the Final Federal Rule: Registration Requirements for Narcotic Treatment Programs with Mobile Components into the Licensing Regulations

12VAC35-105-20. Definitions.

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.

"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 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.

"Mobile medication assisted treatment program" or "mobile MAT program" means a MAT operating from a motor vehicle (conveyance) that serves as a mobile component to a licensed MAT location registered with the United States Drug Enforcement Administration ("DEA") as required by 21 C.F.R. § 1301.11 et. seq.

"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 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.

"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.

Article 8

Mobile Medication Assisted Treatment Services

12VAC35-105-1420. Application for operation of a mobile medication assisted treatment program.

Each mobile medication assisted treatment program shall operate as a component of a licensed MAT location and shall be listed on the provider's license addendum.

12VAC35-105-1430. Physical security controls; mobile MAT programs; storage areas.

A. For any conveyance operated as a mobile MAT program, a safe must be installed and used to store narcotic drugs in schedules II-V for the purpose of maintenance or detoxification treatment, when not located at the provider's DEA registered location. The safe shall:

1. Have the following specifications or the equivalent: 30 man-minutes against surreptitious entry, 10 man-minutes against forced entry, 20 man-hours against lock manipulation, and 20 man-hours against radiological techniques;

2. If it weighs less than 750 pounds, be bolted or cemented to the floor or wall in such a way that it cannot be readily removed; and

3. Be equipped with an alarm system which, upon attempted unauthorized entry, shall transmit a signal directly to a central protection company or a local or State police agency which has a legal duty to respond, or a 24-hour control station operated by the DEA registrant.

B. The controlled substance storage areas shall be accessible only to an absolute minimum number of specifically authorized employees. When it is necessary for employee maintenance personnel, nonemployee maintenance personnel, business guests, or visitors to be present in or pass through controlled substance storage areas, the registrant shall provide for adequate observation of the area by an employee specifically authorized in writing.

C. The storage area for controlled substances in a mobile MAT shall not be accessible from outside of the vehicle.

D. Personnel transporting the controlled substances on behalf of the mobile MAT are required to retain control over all controlled substances when transferring them between the DEA registered location and the conveyance, while en route to and from the dispensing location or locations, and when dispensing at the dispensing location or locations. At all other times during transportation all controlled substances shall be properly secured in the safe.

E. Upon completion of the operation of the mobile MAT on a given day, the conveyance shall be immediately returned to the DEA registered location, and all controlled substances shall be removed from the conveyance and secured within the DEA registered location. After the conveyance has returned to the DEA registered location and the controlled substances have been removed, the conveyance may be parked until its next use at the DEA registered location or any secure, fenced-in area, once the local DEA office has been notified of the location of this secure fenced-in area.

F. All mobile MATs shall establish a standard written operating procedure to ensure, if the mobile MAT becomes inoperable, that all controlled substances on the inoperable conveyance are accounted for, removed from the inoperable conveyance, and secured at the DEA registered location.

G. With regard to the requirement within subsection E, a mobile MAT may apply to the DEA for an exception to this requirement. The application for such an exception must be submitted to the DEA in accordance with 21 C.F.R. Section 1307.03. If the DEA grants an exception, the provider shall be permitted to operate in accordance with that exception. The provider shall maintain a record of the exception at the DEA registered location and in the mobile MAT conveyance.

12VAC35-105-1440. Other security controls for mobile MATs.

A. Individuals enrolled in a mobile MAT shall wait in an area that is physically separated from the narcotic storage and dispensing area by a physical entrance such as a door or other entryway. Individuals served must wait outside of a mobile MAT component if that conveyance does not have seating or a reception area that is separated from the narcotic storage and dispensing area. This requirement shall be enforced by the provider and all provider employees.

B. All mobile MATs shall comply with standards established by the United States Secretary of Health and Human Services respecting the quantities of narcotic drugs which may be provided to persons enrolled in a mobile MAT for unsupervised use.

C. The DEA may exercise discretion regarding the degree of security required in mobile MATs, based on factors as the location of a program, the number of individuals enrolled in the program, and the number of practitioners, staff members, and security guards. Provider personnel that are authorized to dispense controlled substances for narcotic treatment shall ensure proper security measures and patient dosage. Similarly, the DEA will consider such factors when evaluating existing security or requiring new security at a mobile MAT. The mobile MAT program shall comply with DEA security requirements.

D. Any controlled substances being transported for disposal from the dispensing location of a mobile MAT shall be secured and disposed of in compliance with 21 C.F.R. Part 1317 and all other applicable federal, state, tribal, and local laws and regulations.

E. A conveyance used as part of a mobile MAT may only be supplied with narcotic drugs by the DEA registered MAT that operates the conveyance. Persons permitted to dispense controlled substances to a mobile MAT shall not:

1. Receive controlled substances from other mobile MATs or any other entity;

2. Deliver controlled substances to other MATs or any other entity; or

3. Conduct reverse distribution of controlled substances on a mobile MAT.

12VAC35-105-1450. Records for mobile MATs.

A. A provider of a mobile MAT shall maintain records with the following information for each narcotic controlled substance:

1. Name of substance;

2. Strength of substance;

3. Dosage form;

4. Date dispensed;

5. Adequate identification of individuals served;

6. Amount consumed;

7. Amount and dosage form taken home by individuals served; and

8. Dispenser's initials.

B. The records required by paragraph A of this section shall be maintained in a dispensing log at the DEA registered site of the mobile MAT and shall be maintained in compliance with 21 C.F.R. Section 1304.22 without reference to Section 13.04.03.

C. As an alternative to maintaining a paper dispensing log a mobile MAT may also use an automated or computerized data processing system for the storage and retrieval of the program's dispensing records, if the following conditions are met:

1. The automated system maintains the information required in paragraph A;

2. The automated system has the capability of producing a hard copy printout of the program's dispensing records;

3. The mobile MAT prints a hard copy of each day's dispensing log, which is then initialed appropriately by each person who dispensed medication to individuals served;

4. The automated system is approved by DEA;

5. The mobile MAT maintains an off-site back-up of all computer generated program information; and

6. The automated system is capable of producing accurate summary reports for both the DEA registered site of the MAT program and any mobile MAT for any timeframe selected by department personnel during an investigation. If these summary reports are maintained in hard copy form, they must be kept in a systematically organized file located at the DEA registered site of the mobile MAT.

D. The provider shall retain all records for a minimum of six years following the last patient encounter in accordance with Section 54.1-2910.4 of the Code of Virginia.

12VAC35-105-1460. Physical plant exemption for mobile MATs.

Mobile MAT service locations are exempt from physical plant requirements located within 12VAC35-105-260 through 12VAC35-105-380.

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Fast-Track Regulation
Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC35-260
VAC Chapter title(s)	Certified Recovery Residences
Action title	Amendments to comply with Item 312 L.2. and Chapter 755 (HB277)
Date this document prepared	November 17, 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 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), 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.

Chapter 260 [12VAC35-260] was created through a fast track action in March 2020 in compliance with Chapter 220 of the 2019 Acts of Assembly (HB2045), which added a new section numbered 37.2-431.1 in the Code of Virginia creating an avenue for the certification of recovery residences through the Department of Behavioral Health and Developmental Services (DBHDS). That original regulatory action defined “recovery residences” and, as allowed by the enabling legislation, created a voluntary certification for residences that meet standards of credentialing entities specified by DBHDS. The two credentialing entities specified in the regulation are nationally recommended organizations that reportedly follow best practice standards for recovery. The legislation was developed through a stakeholder workgroup over a year and with broad community feedback that called for greater oversight for recovery housing in Virginia.

These new amendments to Chapter 260 are intended to comply with two actions by the 2022 Session of the General Assembly in Chapter 0755 (House Bill 277) of the Acts of Assembly and Item 312 L.2. of the

Appropriation Act to have DBHDS certify residences. Also, the *Appropriations Act* directed DBHDS to monitor credentialed recovery homes for regulatory compliance.

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.

DBHDS – The Department of Behavioral Health and Developmental Services.
VARR – Virginia Association of Recovery Residences.

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 mandated amendments were approved by the State Board of Behavioral Health and Developmental Services at its meeting on December 7, 2022, as a fast track action.

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in the ORM procedures, "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

Consistent with Virginia Code § 2.2-4012.1, also explain why this rulemaking is expected to be noncontroversial and therefore appropriate for the fast-track rulemaking process.

These amendments to Chapter 260 are intended to comply with two actions by the 2022 Session of the General Assembly in Chapter 0755 (House Bill 277) and Item 312 L.2. of the Appropriation Act.

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 Board 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. These amendments to Chapter 260 are intended to comply with two actions by the 2022 Session of the General Assembly in Chapter 0755 (House Bill 277) and Item 312 L.2. of the Appropriation Act.

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 is intended to solve.

As reported in a May 2019 The National Council for Behavioral Health brief, Recovery Housing Issue Brief: Information for State Policymakers:

"Recovery housing" refers to safe, healthy, and substance-free living environments that support individuals in recovery from addiction. While recovery residences vary widely in structure, all are centered on peer support and a connection to services that promote long-term recovery. Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to other peers in recovery and recovery services and supports.

Many residents live in recovery housing during and/or after outpatient addiction treatment. Length of stay is self-determined and can last for several months to years. Residents often share resources, give experiential advice about how to access health care and social services, find employment, budget and manage finances, handle legal problems, and build life skills. Many recovery homes are organized under the leadership of [a] house manager and require residents to participate in a recovery program, such as 12-step and other mutual aid groups." (https://www.thenationalcouncil.org/wp-content/uploads/2017/05/Recovery-Housing-Issue-Brief_May-2017.pdf, as excerpted from the U.S. Department of Health and Human Services (HHS), Office of the Surgeon General (2016). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. p.5-11. Washington, D.C.: HHS, Retrieved from: https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf)

While many recovery residences are well-run, a national effort has been growing to bring standards to how recovery residences are operated due to "unscrupulous actors running sober living homes who profit off the misery of their occupants." (Governing Magazine, May 14, 2018. Sober Living Homes and the Regulation They Need. Stratman and Aronberg. Retrieved from: https://www.governing.com/gov-institute/voices/col-regulation-sober-living-homes-recovery-residences-need.html).

A stakeholder workgroup was convened in Virginia to receive input from subject matter experts across the state. The legislation developed through the workgroup with broad community feedback that called for greater accountability for recovery housing to ensure the health, safety, and welfare of individuals staying in recovery residences. A compromise was developed with stakeholders to provide departmental oversight to recovery housing without being overly burdensome to these 'organic' community-based organizations. Section 37.2-431.1 was codified requiring the promulgation of regulations adopted by the State Board to specify credentialing entities and the application process through DBHDS. Since Chapter 260 became effective in March 2020, certified recovery residences have been held to nationally recognized standards to ensure safety and recovery through effective peer support, mutual accountability, and clear social structures. Voluntary credentialing of recovery housing is intended to make it easier to locate recovery housing for individuals needing such housing and thus create a list of available houses to be utilized by courts, community services boards, individuals, and families.

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 2022 Session of the General Assembly specified in the *Appropriations Act* that DBHDS "shall monitor credentialed recovery homes for regulatory compliance.

In Chapter 755 of the 2022 Acts of Assembly, the General Assembly further required that all recovery residences be certified by DBHDS and that recovery residences, as a condition of such certification, comply with minimum square footage requirements related to beds and sleeping rooms established by the credentialing entity (VARR or Oxford House) or the Uniform Statewide Building Code, whichever is greater. Chapter 755 of the Acts of Assembly required every person who operates a recovery residence to disclose to potential residents its credentialing entity. If the credentialing entity is the National Alliance for Recovery Residences, the recovery residence is required to disclose the level of support provided by the recovery residence and, if the credentialing entity is Oxford House, Inc., the recovery residence is required to disclose that the recovery residence is self-governed and unstaffed. DBHDS must now include such information on the list of all recovery residences maintained on its website. Recovery residences were exempted from the provisions of the Virginia Landlord and Tenant Act.

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.

There are no identified disadvantages to the public or the Commonwealth in making these amendments. The amendments to the regulation will allow for individuals and families to have more understanding about the recovery options available

Certified recovery residences will continue to be held to nationally recognized standards to ensure safety and recovery through effective peer support, mutual accountability, and clear social structures. Voluntary credentialing of recovery housing and certification by DBHDS is intended to make it easier to locate recovery housing for individuals needing such housing and thus create a list of available houses to be utilized by courts, community services boards, individuals, and families.

Requirements More Restrictive than Federal

Identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements, or no requirements that exceed applicable federal requirements, include a specific statement to that effect.

There are no federal requirements for recovery residences. The National Association of Recovery Residences set national standards in 2011, and the two credentialing entities (VARR and Oxford House) named in the regulation are models identified by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) (https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/affordable-housing-models-recovery).

Agencies, Localities, and Other Entities Particularly Affected

Consistent with § 2.2-4007.04 of the Code of Virginia, identify any other state agencies, localities, or other entities particularly affected by the regulatory change. Other entities could include local partners such as tribal governments, school boards, community services boards, and similar regional organizations. "Particularly affected" are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

Other State Agencies Particularly Affected

There are no other state agencies particularly affected.

Localities Particularly Affected

There are no localities particularly affected.

Other Entities Particularly Affected

There are no other entities particularly affected.

Economic Impact

Consistent with § 2.2-4007.04 of the Code of Virginia, identify all specific economic impacts (costs and/or benefits), anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Keep in mind that this is the proposed change versus the status quo.

Impact on State Agencies

For your agency: projected costs, savings, fees, or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources	N/A
For other state agencies: projected costs, savings, fees, or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.	N/A
For all agencies: Benefits the regulatory change is designed to produce.	N/A

Impact on Localities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a or 2) on which it was reported. Information provided on that form need not be repeated here.

Projected costs, savings, fees, or revenues resulting from the regulatory change.	Table 2

Benefits the regulatory change is designed to produce.	Table 2

Impact on Other Entities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a, 3, or 4) on which it was reported. Information provided on that form need not be repeated here.

Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.	Tables 1a, 3 and 4
Agency's best estimate of the number of such entities that will be affected. Include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	Tables 1a, 3 and 4
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	Tables 1a, 3 and 4
Benefits the regulatory change is designed to produce.	Tables 1a, 3 and 4

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.

As these amendments are mandated by the General Assembly, there are no alternatives.

Regulatory Flexibility Analysis

Consistent with § 2.2-4007.1 B of the Code of Virginia, describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the regulatory change.

As these amendments were mandated by the General Assembly, there are no less stringent requirements, schedules, deadlines, compliance, reporting, consolidation, or simplification possible, including for small businesses.

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.

Consistent with § 2.2-4011 of the Code of Virginia, if an objection to the use of the fast-track process is received within the 30-day public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the agency shall: 1) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register and 2) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

If you are objecting to the use of the fast-track process as the means of promulgating this regulation, please clearly indicate your objection in your comment. Please also indicate the nature of, and reason for, your objection to using this process.

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 and any alternative approaches, (ii) the potential impacts of the regulation, and (iii) the agency's regulatory flexibility analysis stated in this background document.

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: Mark Blackwell, Director, DBHDS Office of Recovery Services, PO Box 1797, Richmond, Virginia, 23218-1797; mark.blackwell@dbhds.virginia.gov; fax (804) 371-6638. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

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 proposed 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		"Certified recovery residence" means a recovery residence that has been certified by a credentialing entity and is on the certification list maintained by DBHDS. "Credentialing entity" means a nonprofit organization that develops and administers professional certification programs according to nationally recognized recovery housing standards. "DBHDS" means the Virginia Department of Behavioral Health and Developmental Services. "Recovery residence" means a housing facility that (i) provides alcohol-free and illicit-drug-free housing to individuals with substance abuse disorders and individuals with co-occurring mental illnesses and substance abuse disorders and (ii) does not include clinical treatment services.	• Removes one definition, adds another, and modifies two. All changes are to shift the 'certification' to DBHDS rather than with the 'credentialing entities.' There will be little to no impact from this change. ~~"Certified recovery residence" means a recovery residence that has been certified by a credentialing entity and is on the certification list maintained by DBHDS.~~ "Credentialing entity" means a nonprofit organization that develops and administers professional ~~certification~~ credentialing programs according to ~~nationally recognized recovery housing standards~~ of the National Alliance for Recovery Residences or standards endorsed by Oxford House, Inc. "DBHDS" means the Virginia Department of Behavioral Health and Developmental Services. "Level of support" means the level of support and structure that a recovery residence provides to residents, as specified in the standards of the National Alliance for Recovery Residences. "Recovery residence" means a housing facility that (i) is certified by DBHDS in accordance with this chapter; (ii) provides alcohol-free and illicit-drug-free housing to individuals with substance abuse disorders and individuals with co-occurring mental illnesses and substance abuse disorders and ~~(ii)~~ (iii) does not include clinical treatment services.
20			• Adds a new subsection B, moving some language from 30 into this

		Any person, nonprofit organization, or business entity seeking to operate a certified recovery residence under this chapter shall for each location (i) meet the qualifications, policies, and practices established by a credentialing entity and (ii) be certified or accredited by or hold a charter from one of the following credentialing entities: 1. The Virginia Association of Recovery Residences; or 2. Oxford House.	section, and adding (in #3) General Assembly requirements about square footage. There will be little to no impact from these changes. A. Any person, nonprofit organization, or business entity seeking to operate a certified recovery residence under this chapter shall for each location (i) meet the qualifications, policies, and practices of ~~established by~~ a credentialing entity and ~~(ii) be certified or accredited~~ hold a credential, accreditation, ~~by~~ or ~~hold a~~ charter from ~~one of the following credentialing entities: 1. The~~ the Virginia Association of Recovery Residences~~;~~ or ~~2.~~ Oxford House; and (ii) be certified by DBHDS. B. A certified recovery residence seeking to be certified by DBHDS shall: 1. Submit a completed application on a form provided by DBHDS; 2. Provide evidence of accreditation by, a charter from, or membership in a credentialing entity listed in this section; and 3. Provide evidence that the recovery residence complies with any minimum square footage requirements related to beds and sleeping rooms established by the credentialing entity or the square footage requirements set forth in § 36-105.4, whichever is greater.
30		**List of certified recovery residences.** A. DBHDS shall maintain a list of certified recovery residences on its website. B. A certified recovery residence seeking to be included on the certification list shall submit a completed application on a form provided by DBHDS. C. A certified recovery residence seeking to be included on the certification	• Amends section title; adds new language per the legislative mandate for DBHDS to monitor compliance; strikes language in C that is moved to Section 20. There will be little to no impact from these changes. **List of ~~certified~~ recovery residences.** A. DBHDS shall maintain a list of ~~certified~~ recovery residences on its website. B. ~~A certified recovery residence seeking to be included on the certification list shall submit a completed application on a form provided by~~ DBHDS shall monitor recovery residences for regulatory compliance.

		list shall provide evidence of accreditation or certification by, a charter from, or membership in a credentialing entity listed in 12VAC35-260-20.	~~C. A certified recovery residence seeking to be included on the certification list shall provide evidence of accreditation or certification by, a charter from, or membership in a credentialing entity listed in 12VAC35-260-20.~~
40		**Restrictions and violations.** A. No person shall advertise, represent, or otherwise imply to the public that a recovery residence or other housing facility is a certified recovery residence unless such recovery residence or other housing facility has been placed on the certification list by DBHDS in accordance with this chapter. B. Any recovery residence that fails to maintain accreditation or certification by, a charter from, or membership in a credentialing entity as required by this chapter shall be removed from the certification list. C. DBHDS may institute civil proceedings in the name of the Commonwealth to enjoin any person from violating the provisions of this chapter and to recover a civil penalty of at least $200 but no more than $1,000 for each violation. Such proceedings shall be brought in the general district or circuit court for the county or city in which the violation occurred or where the defendant resides. Civil penalties assessed under this section shall be paid into the Behavioral Health and Developmental Services Trust Fund established in § 37.2-318 of the Code of Virginia.	• Amend section title; amendments to make clear that certification is from DBHDS; and mandated language regarding disclosures. There will be little to no impact from these changes, except that the disclosures will help citizens seeking to reside in a recovery residence be fully informed of the living situation. **Disclosures, ~~Restrictions~~ restrictions, and violations.** A. No person shall operate a recovery residence or advertise, represent, or otherwise imply to the public that a recovery residence or other housing facility is ~~a~~ certified ~~recovery residence~~ by DBHDS unless such recovery residence or other housing facility has ~~been placed on the certification list by DBHDS in accordance with this chapter~~ received certification from DBHDS. B. Any recovery residence that fails to maintain ~~accreditation or certification by, a charter from, or membership in a credentialing entity~~ the requirements for certification by DBHDS as required by this chapter shall have the certification revoked and be removed from the certification list. C. Every recovery residence shall disclose to each prospective resident its credentialing entity. If the credentialing entity is the National Alliance for Recovery Residences, the recovery residence shall disclose the level of support provided by the recovery residence. If the credentialing entity is Oxford House, Inc., the recovery residence shall disclose that the recovery residence is self-governed and unstaffed. D.

Economic Review Form

Agency name	Department of Behavioral Health and Developmental Services
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC35-260
VAC Chapter title(s)	Certified Recovery Residences
Action title	Amendments to comply with Item 312 L.2. and Chapter 755 (HB277)
Date this document prepared	December 7, 2022

Cost Benefit Analysis

Table 1a: Costs and Benefits of the Proposed Changes (Primary Option)

(1) Direct Costs & Benefits	**Mandated Change:** Amend 12VAC35-260-10 to amend the definition of "Credentialing Entity" to specify that credentialing standards must be aligned with standards of the National Alliance for Recovery Residences (NARR) or standards endorsed by Oxford House. Previously the definition of "Credentialing Entity" stated that certification programs must be in accordance with nationally recognized recovery housing standards. However, both Virginia chapters of NARR and Oxford House were named in 12VAC35-20 as the two entities meeting this definition. • Direct Costs: This proposed regulatory change does not have any direct costs on providers. DBHDS staff is not aware of any recovery residence credentialing entity besides the National Alliance for Recovery Residences (NARR) and Oxford House, therefore this proposed change is not expected to have a substantive impact on the definition of "Credentialing Entity," but is intended to provide greater clarity regarding the credentialing standards that residences are required to meet. • Direct Benefits: The proposed change is expected to provide greater transparency and clarity to providers and prospective residents regarding the standards that recovery residences are required to meet. Greater clarity and transparency is beneficial to providers and Virginians seeking recovery services, however, this benefit cannot be financially quantified. **Mandated Change:** Amend 12VAC35-260-10 to amend the definition of "Recovery Residence" to include the requirement that the residence be certified by DBHDS.

	• Direct Costs: This mandated regulatory change requires any facility operating under the title of "Recovery Residence" to be certified by DBHDS. Previously, currently, the definition of "Recovery Residence" as defined in 12VAC35-260-10 is "means a housing facility that (i) provides alcohol-free and illicit-drug-free housing to individuals with substance abuse disorders and individuals with co-occurring mental illnesses and substance abuse disorders and (ii) does not include clinical treatment services." This definition would include group homes and other sober living residences that did not meet the standards of a "certified recovery residence". This regulatory change does not result in any cost to providers. Recovery residences that are "certified" as defined in 12VAC35-260-10 will not be impacted. This definitional change does not prohibit sober living residences, or other alcohol and drug free residences from operating, but excludes them from the regulatory definition of "recovery residence," and therefore, no other businesses will be impacted. • **Direct Benefits:** The mandated regulatory change would increase transparency for potential individuals needing recovery services. Individuals will benefit in having the assurance that any entity called a "recovery residence," by definition, must adhere to a set of standards outlined in 12VAC35-260-20. This change will provide a benefit to individuals in improving market awareness; however, this benefit is difficult to quantify and therefore, cannot be calculated. **Mandated Change:** Amend 12VAC35-260-20 to require that any person seeking to operate a certified recovery residence be certified by DBHDS. Certification by DBHDS requires a potential recovery residence to provide evidence of credentialing in the form of a charter or membership with one of the organizations listed in 12VAC35-260-10, and that the recovery residence complies with any minimum square footage requirements related to beds and sleeping rooms established by the credentialing entity or the square footage requirements set forth in § 36-105.4 of the Code of Virginia, whichever is greater. • **Direct Costs:** There are no estimated costs to this mandated regulatory change. All recovery residences certified by NARR or Oxford House already meet the square footage requirement, which is equal to the requirements set out in § 36-105.4 of the Code of Virginia; therefore, no certified residences will be impacted. Any new residences that enter the market will already be subject to the square footage requirements of Virginia's Uniform Statewide

	Building Code, and therefore, are not likely to experience any impact as a result of this mandated regulation. • **Direct Benefits:** The mandated regulatory change will increase transparency for potential residents of certified recovery residences. This change will provide a benefit to individuals in improving market awareness; however, this benefit is difficult to quantify and therefore, cannot be calculated. **Mandated Change:** Amend 12VAC35-260-30 to require DBHDS to monitor recovery residences for their regulatory compliance. • Direct Costs: This mandated regulatory change will not result in any costs for providers. The requirement that DBHDS monitor regulatory to verify the accuracy of the list of residences may result in some administrative costs for DBHDS, however DBHDS believes that this requirement can be absorbed through existing staff resources. • Direct Benefits: This change will provide a benefit to individuals by improving market awareness, as they will be certain that residences on the list maintained by DBHDS meet the requirements set out in this chapter. **Mandatory Change:** Amend 12VAC35-260-40 to require recovery residences to disclose its credentialing entity to each prospective resident. If the credentialing entity is NARR, the residence shall disclose the level of support provided by the recovery residence. If the credentialing entity is Oxford House, Inc., the recovery residence shall disclose that the recovery residence is self-governed and unstaffed. • **Direct Costs** – Under this proposed regulatory action, each recovery residences will be required to attest that the disclosure has been made to residents. DBHDS estimates that the disclosure to potential residents can be absorbed through existing provider resources, such as administrative resources for onboarding new residents. Therefore, there is no estimated cost of this proposed regulatory action. • **Direct Benefits:** SB622/HB277 was intended to provide greater transparency to prospective residents of recovery residents regarding the credentials of each recovery residence and the level or professional staff support available to residents. This regulatory action will increase accountability and transparency of recovery residences, which is likely to improve the quality of life at the recovery homes. While this change is beneficial, it is difficult to quantify the financial benefit of transparency and consumer education; therefore an exact benefit cannot be calculated.

(2) Quantitative Factors	Estimated Dollar Amount	Present Value	
Direct Costs	(a) $	(c) $	
Direct Benefits	(b) $	(d) $	
(3) Benefits-Costs Ratio		(4) Net Benefit	$
(5) Indirect Costs & Benefits			
(6) Information Sources			
(7) Optional			

Table 1b: Costs and Benefits under the Status Quo (No change to the regulation)

(1) Direct Costs & Benefits	This table is not necessary as this regulatory action was mandated by SB622/HB277 of the 2022 Session of the General Assembly. As such, the department did not exercise any discretion in the drafting of this regulatory action.		
(2) Quantitative Factors	Estimated Dollar Amount	Present Value	
Direct Costs	(a) $0	(c) $0	
Direct Benefits	(b) $0	(d) $0	
(3) Benefits-Costs Ratio		(4) Net Benefit	$0
(5) Indirect Costs & Benefits			
(6) Information Sources			
(7) Optional			

Table 1c: Costs and Benefits under an Alternative Approach

(1) Direct Costs & Benefits	This table is not necessary as this regulatory action was mandated by SB622/HB277 of the 2022 Session of the General Assembly. As such, the

	department did not exercise any discretion in the drafting of this regulatory action.		
(2) Quantitative Factors	Estimated Dollar Amount	Present Value	
Direct Costs	(a)	(c)	
Direct Benefits	(b)	(d)	
(3) Benefits-Costs Ratio		(4) Net Benefit	
(5) Indirect Costs & Benefits			
(6) Information Sources			
(7) Optional			

Impact on Local Partners

Table 2: Impact on Local Partners

(1) Direct Costs & Benefits	This regulatory action is not expected to result in any direct costs or benefits to local partners.
(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a) $0
Direct Benefits	(b) $0
(3) Indirect Costs & Benefits	
(4) Information Sources	
(5) Assistance	
(6) Optional	

Economic Impacts on Families

Table 3: Impact on Families

(1) Direct Costs & Benefits	• **Costs**: This regulatory action is not expected to result in any costs for families. • **Benefits**: This regulation is expected to have a positive impact on Virginia families with family members suffering from substance use disorder by providing greater transparency in the recovery residence industry. Additional data is needed to determine if greater transparency is expected to result in an economic benefit to families, therefore, an economic benefit cannot be calculated.
(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a) $0
Direct Benefits	(b) $0
(3) Indirect Costs & Benefits	
(4) Information Sources	
(5) Optional	

Impacts on Small Businesses

Table 4: Impact on Small Businesses

(1) Direct Costs & Benefits	It is not known how many currently certified recovery residences meet the definition of small business as defined in § 2.2-1604. However, due to the typical size of recovery homes and the number of providers in Virginia, DBHDS estimates that the majority of providers likely meet the criteria of "small business" as defined in § 2.2-1604. Therefore, small businesses regulated by 12VAC35-260 would experience the same costs and benefits outlined in table 1a.
(2) Quantitative Factors	Estimated Dollar Amount
Direct Costs	(a) $0
Direct Benefits	(b) $0
(3) Indirect Costs & Benefits	
(4) Alternatives	

(5) Information Sources	
(6) Optional	

Changes to Number of Regulatory Requirements

Table 5: Total Number of Requirements

	Number of Requirements			
Chapter number	**Initial Count**	**Additions**	**Subtractions**	**Net Change**
12VAC35-260	0	0	0	0

(Discretionary requirements on the agency remains one.)

Department of Behavioral Health and Developmental Services

Certified Recovery Residences.

Amendments to comply with Item 312 L.2. and Chapter 755 (HB277)

12VAC35-260-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings, except when the context clearly indicated otherwise:

"Certification list" means the list of certified recovery residences maintained by DBHDS.

~~"Certified recovery residence" means a recovery residence that has been certified by a credentialing entity and is on the certification list maintained by DBHDS.~~

"Credentialing entity" means a nonprofit organization that develops and administers professional ~~certification~~ credentialing programs according to ~~nationally recognized recovery housing standards~~ of the National Alliance for Recovery Residences or standards endorsed by Oxford House, Inc.

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

"Level of support" means the level of support and structure that a recovery residence provides to residents, as specified in the standards of the National Alliance for Recovery Residences.

"Recovery residence" means a housing facility that (i) is certified by DBHDS in accordance with this chapter; (ii) provides alcohol-free and illicit-drug-free housing to individuals with substance abuse disorders and individuals with co-occurring mental illnesses and substance abuse disorders and ~~(ii)~~ (iii) does not include clinical treatment services.

12VAC35-260-20. Recovery residence.

A. Any person, nonprofit organization, or business entity seeking to operate a certified recovery residence under this chapter shall for each location (i) meet the qualifications, policies, and practices of ~~established by~~ a credentialing entity and ~~(ii) be certified or accredited~~ hold a credential, accreditation, ~~by~~ or ~~hold a~~ charter from ~~one of the following credentialing entities:~~

~~1. The~~ the Virginia Association of Recovery Residences~~;~~ or ~~2.~~ Oxford House; and (ii) be certified by DBHDS.

B. A certified recovery residence seeking to be certified by DBHDS shall:

1. Submit a completed application on a form provided by DBHDS;

2. Provide evidence of accreditation by, a charter from, or membership in a credentialing entity listed in this section; and

3. Provide evidence that the recovery residence complies with any minimum square footage requirements related to beds and sleeping rooms established by the credentialing entity or the square footage requirements set forth in § 36-105.4, whichever is greater.

12VAC35-260-30. List of ~~certified~~ recovery residences.

A. DBHDS shall maintain a list of ~~certified~~ recovery residences on its website.

B. ~~A certified recovery residence seeking to be included on the certification list shall submit a completed application on a form provided by~~ DBHDS shall monitor recovery residences for regulatory compliance.

~~C. A certified recovery residence seeking to be included on the certification list shall provide evidence of accreditation or certification by, a charter from, or membership in a credentialing entity listed in 12VAC35-260-20.~~

12VAC35-260-40. Disclosures, ~~Restrictions~~ restrictions, and violations.

A. No person shall operate a recovery residence or advertise, represent, or otherwise imply to the public that a recovery residence or other housing facility is ~~a~~ certified ~~recovery residence~~ by DBHDS unless such recovery residence or other housing facility has ~~been placed on the certification list by DBHDS in accordance with this chapter~~ received certification from DBHDS.

B. Any recovery residence that fails to maintain ~~accreditation or certification by, a charter from, or membership in a credentialing entity~~ the requirements for certification by DBHDS as required by this chapter shall have the certification revoked and be removed from the certification list.

C. Every recovery residence shall disclose to each prospective resident its credentialing entity. If the credentialing entity is the National Alliance for Recovery Residences, the recovery residence shall disclose the level of support provided by the recovery residence. If the credentialing entity is Oxford House, Inc., the recovery residence shall disclose that the recovery residence is self-governed and unstaffed.

D. DBHDS may institute civil proceedings in the name of the Commonwealth to enjoin any person from violating the provisions of this chapter and to recover a civil penalty of at least $200 but no more than $1,000 for each violation. Such proceedings shall be brought in the general district or circuit court for the county or city in which the violation occurred or where the defendant resides. Civil penalties assessed under this section shall be paid into the Behavioral Health and Developmental Services Trust Fund established in § 37.2-318 of the Code of Virginia.

FORMS (12VAC35-260)

~~Application for Inclusion on the DBHDS Recovery Residences Certification List, Office of Recovery Service Form (eff. 3/2020)~~

Application for Inclusion on the DBHDS Recovery Residences Certification List, Office of Recovery Service Form (ver. 10/2022)

IV. REGULATORY ACTIVITY STATUS REPORT: DECEMBER 2022 (REVISED 11/17/22)

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 s**ections.	**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; in final stage.***	• Effective 2/20/2021; extended to 02/18/2023. Final stage filed 7/14/2022; with HHR.
12 VAC 35-46 Certain sections **and NEW s**ections.	*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; in proposed stage.***	• Effective 01/10/22. Expires 07/09/23. Proposed stage filed 3/31/2022; with HHR.
12 VAC 35-46 Certain sections	*same*	*Regulatory reduction of discretionary mandates.*	• ***TBD.***	• *Expect in March.*
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; in final stage.***	• Effective 2/20/2021; extended to 02/18/2023. Final stage filed 7/14/2022; with HHR.
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; in final stage.***	• Effective 2/20/2021; extended to 02/18/2023. Final stage filed 7/14/2022; with HHR.
*12 VAC 35-105 Certain sections **and NEW** sections.*	*same*	*In accordance with federal regulation, amendments for mobile medication assisted treatment programs in Virginia.*	• ***Exempt.***	➢ *Action Requested.*
12 VAC 35-105 Certain sections	*same*	*Regulatory reduction of discretionary mandates.*	• ***TBD.***	• *Expect in March.*
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***	*Clarifying and updating; reduction of discretionary mandates.*	• ***TBD.***	• *Response to periodic review; expect in March.*

12 VAC 35-180	**Regulations to Assure the Protection of Participants in Human Research**	To protect individuals who are participants in human research performed by facilities or programs operated, funded, or licensed by DBHDS	• **Periodic review.**	• Public comment forum closed 11/21/2022.
12 VAC 35-190	***Regulations for Voluntary Admissions to State Training Centers***		• *Fast Track*	• *Draft in progress; expect in March.*
12 VAC 35-200	***Regulations for Emergency and Respite Care Admission to State Training Centers***		• *Fast Track*	• *Draft in progress; expect in March.*
12 VAC 35-210	***Regulations to Govern Temporary Leave from State Facilities***		• ***Fast Track.***	• *Draft in progress; expect in March.*
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 Act* 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.***	• Emergency/NOIRA and periodic review filed on 07/15/2022; with DPB 11/15/2022.
12 VAC 34-260	***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.*	• ***Fast Track.***	➢ *Action Requested.*

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Planning and Budget Committee
DRAFT AGENDA

December 7, 2022
8:30 a.m. – 9:25 a.m.

DBHDS Central Office
13th Floor Conference Room

This meeting will be held in person and virtually. Log in information is the same as for the regular meeting of the State Board on page 2 of the meeting packet.

I. Call to Order

II. Welcome and Introductions

III. Adoption of Minutes, September 28, 2022
- *Action Required*

IV. Standing Items:

Identification of services and support needs, critical issues, strategic responses, and resource requirements to be included in long-range plans; work with the department to obtain, review, and respond to public comments on draft plans; and monitor department progress in implementing long-range programs and plans.

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.

A. Certified Community Behavioral Health Clinics (CCBHCs) and Virginia
Lisa Jobe-Shields
Assistant Commissioner, Behavioral Health Services

B. Review the priorities set at the Biennial Planning Meeting and topic areas for board meetings through September 2023.

V. Other Business
A. State Board Quarterly Budget Report. *handout*
B. Update: Regulatory Process Changes: ED1 and EO19.

VI. Next Steps:
A. Standing Item: *Provide updates on committee planning activities to the Board.*
B. Next Meeting *(March 29, 2023)*

VII. Adjournment

Other Standing Item (addressed September 2022)
Semi Annual Federal Grant Report: *The department shall provide a semi-annual report of all federal grants currently under consideration as well as those being actively pursued. Additionally, the report will include all grants that have been submitted in the last six months. Finally, the reward status of all submitted grants will be outlined to the Board.*

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Policy and Evaluation Committee
DRAFT AGENDA
DECEMBER 7, 2022
8:30-9:25 AM
RICHMOND, VA
This meeting will be held in person and virtually.
Log in information is on page 1 of the meeting packet.

I. Call to Order

II. Welcome and Introductions

III. Review of 2022 Policy Review Plan and Presentation of Policies for Discussion

A. 1008(SYS)86-3 Services for Older Adults with Mental Illness, Mental Retardation, or Substance Use Disorders (Revisions)

B. 1040(SYS)06-3 Consumer and Family Member Involvement and Participation (Revisions)

C. 1043(SYS)08-1 Disaster Preparedness (Background, Craig Camidge)

D. 1044(SYS)12-1 Employment First (Background, Heather Norton)

IV. Next Quarterly Meeting: March 29, 2023

V. Other Business

VI. Adjournment

DIRECTIONS

Wednesday, December 7, 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.

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.

Future meeting dates are listed after the agenda and after the minutes.