COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

DRAFT MEETING AGENDA

SPECIAL CALLED MEETING

Tuesday, May 14, 2024
9:00 a.m. –9:30 a.m.

This meeting will be all-virtual as deemed as necessary and convenient for the Board by the chair on April 3, 2024. The method by which the Board chooses to meet shall not be changed unless the Board provides a new meeting notice in accordance with the provisions of § 2.2-3707.

To alert the Board if the audio or video transmission of the meeting provided by the Board fails, call 804-385-6549.

***This meeting will be all virtual with electronic or phone connection is available:**

Microsoft Teams meeting
Join on your computer, mobile app or room device
Click here to join the meeting
Meeting ID: 263 690 958 420
Passcode: JEbStG

Or call in (audio only)
+1 434-230-0065,,84698106#
Phone Conference ID: 846 981 06#
Find a local number

1.	9:00	**Call to Order and Introductions** **Approval of May 14, 2024, Agenda** ➢ *Action Required* **Approval of Draft Minutes** **Dinner Meeting, April 2, 2024** **Regular Meeting, April 3, 2024** ➢ *Action Required*	Elizabeth Hilscher *Chair*	**3** **4**

2.	9:05	**Public Comment** (*3 minute limit per speaker*) *Notice:* 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., May 13, 2024, indicating they wish to provide 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 9:00 a.m. on May 14, 2024.		
3.	9:15	**Regulatory Actions** **A. Action with Periodic Review: Operation of the Individual and Family Support Program, 12VAC35-230.** **Final Stage: Mandate to facilitate compliance (Item 313.NN., 2002).** ➢ *Action requested: Authorize promulgation of the final stage.* **B. Final Exempt Action: High-Quality Crisis Services; appropriate and safe use of seclusion (SB569), Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services [12VAC35-105] AND Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services [12VAC35-115]** ➢ *Action requested: Authorize promulgation of the final exempt stage.* **Note: Explanatory chart**	Ruth Anne Walker *Director of Regulatory Affairs and Board Liaison* Heather Norton *Assistant Commissioner, Developmental Services Division* Dev Nair *Assistant Commissioner, Division of Provider Management* Susan Puglisi *Regulatory Research Specialist*	**25** **28** **70** **123**
4.	9:25	**Miscellaneous** **A. Other Business** **B. Next Meeting:** July 17, 2024, Eastern State Hospital, Williamsburg.	Elizabeth Hilscher	
5.	9:30	**Adjournment**		

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

MEETING SCHEDULE

DATE*	Location
2024	
July 17 (Wed)	Eastern State Hospital **Williamsburg**
September 25 (Wed)	SVMHI **Danville**
December 11 (Wed)	Central Office **Richmond**
2025	
April 2 (Wed)	Western State Hospital **Staunton**
July 9 (Wed)	Central Office **Richmond**

BOARD DINNER MEETING
DRAFT MINUTES

Tuesday, April 2, 2024
6:00 p.m. – 7:30 p.m.
Blue Ridge Behavioral Health
1315 Franklin Road SW (Walnut Street entrance; Thomasson Room)
Roanoke, VA 24016

	Members Present: Elizabeth Hilscher, Chair; Kendall Lee, Vice Chair;; Rebecca Graser; Cindy Lamb; Christopher Olivo; Sandra Price-Stroble. **Members Absent:** Blake Andis Varun Choudhary; Moira Mazzi. **Staff Present:** Cassie Grillon; Ellen Harrison; Charles Law; Madelyn Lent; Ruth Anne Walker. **Invited Guests:** Mark Chadwick; Susan Rieves-Austin; Leigh Frazier; Helen Lang.
6:00	**Welcome and Introductions** At 6:00 p.m., Elizabeth Hilscher, Chair, called the meeting to order and welcomed everyone present. She thanked Helen Lang for the location tour immediately prior to the meeting.
6:10	**Dinner**
6:25	**Presentation – Blue Ridge Behavioral Health** Mark Chadwick provided an overview of the portfolio of services provided by Blue Ridge Behavioral Health. Mr. Chadwick, Susan Rieves-Austin, and Leigh Frazier provided an in depth look at services for children and youth. A video was shared of comments by staff, “Hope Spoken Here.”
7:00	**Comments/Discussion** Members asked a few clarifying comments of the BRBH team regarding information presented.
7:25	**Closing Remarks** Ms. Hilscher thanked Mr. Chadwick, Ms. Rieves-Austin, and Ms. Frazier for their presentation to the members.
7:30	**Adjournment** Ms. Hilscher adjourned the dinner meeting at 7:30 p.m.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Regular Meeting
DRAFT MINUTES
Wednesday, April 3, 2024
DBHDS Catawba Hospital – Building 24 Administration,
5525 Catawba Hospital Dr, Catawba, VA 24070
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; Kendall Lee, Vice Chair; R. Blake Andis; Rebecca Graser; Cindy Lamb; Moira Mazzi; and Christopher Olivo; Sandra Price-Stroble.
Members Absent	Varun Choudhary.
Staff Present	• Colleen Grady, Executive Budget Manager. • Cassie Grillon, Marketing and Communications Manager. • Ellen Harrison, Chief Deputy Commissioner. • Charles Law, Catawba Hospital Facility Director. • Madelyn Lent, Policy Manager. • Josie Mace, Legislative Affairs Director. • Nathan Miles, Chief Financial Officer. • Chaye Neal-Jones, Deputy Director, Office of Enterprise Management Services. • Susan Puglisi, Regulatory Research Specialist. • Kari Savage, Director, Office of Child and Family Services • Ruth Anne Walker, Regulatory Affairs Director and State Board Liaison.
Invited Guests:	• Jennifer Faison, Executive Director, Virginia Association of Community Services Boards.
Other Guests:	In Person: • Teresa Smith, OSIG. • Mary Ottinot. Virtual: • Charlotte Arbogast, DARS. • Cara Kaufman, DARS. • Anjali Jarral, GOV. • Mindy Monay, GOV. • Sofia Tortolero, GOV. • LeVar Bowers. • Katie Boyle. • Martin Mash. • Jan Nelson. • Amanda Stone.

Call to Order and Introductions	At 9:31 a.m., Elizabeth Hilscher, Chair, called the meeting to order and welcomed those present. A quorum of eight members was physically present. Ms. Hilscher noted that since December, some significant things had happened to some members and staff; yet they were present and she noted the tremendous dedication to the board and the work of the board. She reminded everyone to take care of themselves in the midst of difficulties as we all can forget to do that. Ms. Hilscher welcomed back Susan Puglisi from maternity leave, and congratulated her on the beautiful baby. Ms. Hilscher called for introductions of all present.
Approval of Agenda	*At 9:38 a.m. the State Board voted to adopt the April 3, 2024, agenda. On a motion by Christopher Olivo and a second by Rebecca Graser, the agenda was approved.*
Approval of Draft Minutes	At 9:39 a.m., o*n a motion by Moira Mazzi and a second by Mr. Olivo, the December 6, 2023, regular meeting minutes were approved as final with one amendment to correct the policy numbers listed in the report of the Policy and Evaluation Committee.*
Public Comment	At 9:41 a.m., Ms. Hilscher stated a period for public comment was included on the draft agenda, one citizen was present to speak: Mary Ottinot stated that she came with good news. She is a registered nurse. She reviewed that she was abducted by police officers who are 'bad actors' and put into a mental health hospital. They did not realize she was a policymaker. She has since traveled around the state and made positive recommendations going forward. There is no policy when something like this really happens; no one knows what to do. Ms. Ottinot quoted Viola Davis, "If you would've done better, I would have done better." Ms. Ottinot declared that the story of unlawful placement in state hospitals and sex trafficking will be told. She also reported that the people of Virginia are good people. Ms. Ottinot was ready to get to work. She thanked the board for the time.
Regulatory Actions	**A. Initiate periodic review: Certified Recovery Residences [12VAC35-260]** At 9:45 a.m., Ruth Anne Walker provided a summary explanation on the periodic review process. This will be the first review of this regulation since it took effect. Ms. Walker gave a brief review of the impetus for and purpose of the regulations. *On a motion by Sandra Price-Stroble and a second by Cindy Lamb, initiation of the periodic review was approved.* **B. Regulatory Activity Status Update.**

	Ms. Walker directed members to the status matrix of all current actions and drafts in progress. She suggested that members consider all the regulatory work in three categories and summarized all pending projects and actions: organic, internally-developed project (ex. the overhaul of the licensing regulations); Administration-required efforts to reduce regulatory mandates (two 'low hanging fruit' of noncontroversial reductions); and General Assembly-mandated. Ms. Walker paused to acknowledge the contributions of Ms. Puglisi on the overhaul project in the development of six new chapters, in conjunction with the Office of Licensing and other agency experts. She also spotlighted the current draft excerpt from the full overhaul crisis chapter to be an exempt action to add to the current licensing and human rights regulations. This will meet the mandate in SB569. The full overhaul chapter will be updated with the language from that upcoming action. Ms. Walker answered a question from Rebecca Graser on upcoming changes regarding opioid treatment services as passed at the federal level, and a question from Kendall Lee regarding changes from the General Assembly regarding qualified mental health professionals.
Commissioner's Report	At 10:04 a.m., Chief Deputy Commissioner Ellen Harrison gave a report on behalf of Commissioner Nelson Smith, providing the State Board details on some of major efforts happening across the community services division, which includes developmental services, child and family services, crisis services, adult behavioral health services, licensing, human rights, regulatory affairs, and enterprise management. She noted that when the commissioner reorganized the department almost two years ago, he described this division as the epicenter of external transformation for DBHDS. Ms. Harrison stated that subject matter experts from this division are playing key roles in Right Help, Right Now, and in DBHDS strategic plan efforts including: • Ensuring same day care for persons in a behavioral health crisis. • Relieving law enforcement's burden and working to reduce criminalization of individuals with mental illness. • Developing capacity in community-based services. • Providing targeted support for substance use disorder services and efforts to prevent overdoses. • Prioritization of behavioral health workforce initiatives.

- Service innovations and best practices that close gaps in service capacity.

Ms. Harrison spoke about key agency initiatives under the division:

- **Crisis** (FY2024 $195.7M)
  - 988 - Averaging over 8,000 calls per month; 80% can be resolved on the phone.
  - Mobile Crisis – 98 teams statewide, continuing to grow to ensure a team is available to respond to any Virginian in an hour or less.
  - Crisis Centers –228 active community beds and chairs, with 278 more in development. More projects are anticipated later this year.

- **DOJ** –
  - Governor's proposal for FY2026 for:
    - Waitlist – elimination of Priority 1 ($300M)
    - Community Living – Total slots by FY2026 12,520
    - Family Individual Support – Total slots by FY2026 8,559
  - Contempt Hearing – May 23-24
    - 222 Core Indicators "met in sustained compliance"
    - 29 Core Indicators "met in compliance"
    - 31 Core Indicators "not yet met"

- **Permanent Supportive Housing**

DBHDS received over $40M in requests to expand existing programs and establish four new programs.
Ms. Mazzi asked if landlords were pushing back because the amount of money that the agency is able to offer is too low or is it because of something like property damage or they feel like odd things are happening in their units. Ms. Harrison responded that certainly a set amount available for rent, tax incentives and x % will be for low-income housing (building out for the entire community). Sometimes damage is an issue, so the agency has said that a deposit will be provided to cover any issues because some of those folks have had hard lives and a hard time staying in their housing, and so they come with a less than stellar record. To continue to have people in the permanent supportive housing program, staff go out and check on them. There are annual checks to make sure that things are going along alright. You don't have to engage in treatment if you're in permanent supportive housing, but the idea is that you will develop relationships that then lead to options for treatment should you choose to.

At the end of her remarks, Ms. Hilscher stated the report covered some amazing things. Ms. Harrison attributed the positive activity to many good people at work with energy,

passion, and their full attention. And, that it makes a difference when the Governor endorsed a strategic plan.

- **Enhanced STEP-VA and CCBHCs**

STEP-VA outcomes (both individual and program) are clarified in the Performance Contract with performance 'floors' and the costs of STEP-VA. This will lead to cost reports being completed by all 40 CSBs (using the CCBHC model) to derive current and expected costs for a full investment of STEP-VA based on meeting the demands for each community.

- Site visits for all 40 CSBs started in February and will be finished in May. Block Grant (mandatory) site visits are being combined with STEP-VA technical assistance site visits. This helps understanding, post-pandemic, of the challenges with building out and operations of all nine core services.
- There is a collective conversation around evaluating assessment tools to be used by CSBs for outcomes.
- All of the above items feed into Performance Contract changes that will incorporate greater accountability and stepped consequences for substantial non-compliance by CSBs as delineated by the contract. There is not yet a definition of substantial non-compliance.

- **Virginia Mental Health Access Program (VMAP)**

FY2024 - Additional $3.9 million to buildout of the pregnant and postpartum moms' portion, including hiring adult perinatal psychiatrists, LMHP's, adult care navigators, and technical assistance for OBGYN's.

- The VMAP for Moms+ is a perinatal-focused training, consultation, and referral program designed to increase capacity for primary care providers (PCPs), to treat and respond to common perinatal mental health conditions including depression, anxiety, bipolar and obsessive-compulsive disorder (OCD). The VMAP Moms+ (VMAP Perinatal and Post Partum Pregnant Individuals) will be an expansion but separate arm of VMAP that will provide services to maternal health providers.
- The VMAP for Moms+ Line will connect PCPs and other maternal health providers to expert specialists to provide support with maternal mental health. The VMAP for Moms+ Line team will consist of regional hubs that include perinatal psychiatrists (PP), LMHPs, and care navigators providing rapid clinical telephonic consultation and support services to PCPs. Services will be available to all five regional hubs once the buildout is complete. The PP will not provide ongoing therapy or direct patient assessment.

- **Mental Health Group Homes**
  - DBHDS received responses for 72 beds, which exceeds the goal of 50. Contracts are currently with procurement and are nearly complete.
  - An RFP will be announced specific to bringing and developing some services for bipolar disorder as this is a specific area of concern in our facilities and finding community care to address it is challenging.

- **Learning Collaborative for Complex Discharges**
  - The final session for the learning collaborative was April 2, 2024. There were discussions of how to expand and keep the momentum of the learning piece that people are excited about.
  - The pilot for the funding: DBHDS will send an interest form to providers to determine who wants to participate. Ideally, the pilot will start in July and run through December to look at outcomes (specifically an increase in TDO acceptance to these facilities as a result of the available funding was seen).

- **Licensing**

Since redesigning the licensing application process, the average time to approval was shortened to ≤30 days for new and ≤20 for modifications, with over 98% of new applications approved in <90 days. As DBHDS is building out the entire system of care for all three disability areas, in terms of providers and services, there was a 45% increase in providers and a 25% increase in services in 2023 alone. This includes many providers offering multiple, complementing services.

	2018	2023
Licensed Providers	1,071	2,080
Licensed Services	2,780	4,583
Licensed Locations	8,778	11,211

This growth in services continued in 2024, with a total of 2,143 licensed providers and 4,770 licensed services as of March 28, 2024. This represents an increase of 100% and 82% in the number of licensed services and providers since 2018, respectively.

- **Alternative Transportation and Custody**
  - A pilot for custody and transport by Special Conservators of the Peace (SCOPs) is set to begin by this month, covering law enforcement catchment areas for New River Valley, Mount Rogers, and Cumberland Mountain CSBs and will provide a team of two SCOPs to maintain custody and a driver around the clock for

	each catchment area (total of 36 staff). New River and Mount Rogers are providing CIT training to these employees of the contracted transportation provider. o Specific training with Region 1 is underway with staff regarding use of restraints and transportation of individuals who present with higher levels of acuity with 20 transports to date. o Discharge transportation is available through the existing contract for all DBHDS state facilities. Ms. Lamb reported she was able to see one of the non-law enforcement transportation vehicles used and it was very uplifting to see that for the benefit to the individuals, and for law enforcement. Ms. Hilscher is grateful for the dignity such transportation provides. Ms. Graser stated she liked the model of having multiple types of crisis services in one location, and diversion even before a prescreening. Ms. Harrison concurred on both points.
Facility Tours	At 10:43 a.m., Ms. Hilscher announced that the meeting would suspend while board members toured Catawba Hospital with Dr. Charles Law, Director and CEO. The meeting would resume at approximately 11:30 a.m. following the tour.
Facility Presentation: Catawba	At 11:30 a.m., Charles Law, Director and CEO of Catawba, provided a background of the history of the campus that sits on 672 acres. Catawba Hospital serves adult patients ages 18-64, and geriatric patients ages 65 and up from a variety of cities and counties covering a service area approximately 9,151 square miles and with over 1,375,968 people. All admissions for FY 2023 totaled 581. The average hospital length of stay is 14 days; the median is different by adult and geriatric populations (adult = 33 days; geriatric = 64 days). That is still incredibly fast. Individuals come to the hospital from all five regions of the state. Sometimes, for continuity of care at discharge, it requires that a public safety officer is used to take an individual to an appointment in the individual's locality of origin across the state; yet it ensures continuity at discharge. Dr. Law reviewed the mission, to support the continuous process of recovery by providing quality psychiatric services to those individuals entrusted to [Catawba's] care. He highlighted the goals and objectives of the Joint Commission's five pillars of excellence: quality, people, patient experience, growth, and financial. Dr. Law stated the staff live out the mission promoting a positive work culture that will lead to improved patient engagement and outcomes. He proudly reported that it is the only state hospital that often has no staff openings.

That's a problem of a different sort as staff are promoted internally (a good problem to have).

The restoration process has been growing in length of time as sometimes after the hospital reports to the court that an individual is restored to competency, the court seeks another opinion. While that evaluator is arranged, the individual must remain at the hospital. There were recently three restorations that took more than 300 days. Each day at the hospital is $1135/day. Ms. Graser asked how long restoration takes. Dr. Law stated that it is different at each facility because it is somewhat person-specific. It varies by individual need, then varies by the courts acceptance of what is reported by the hospital. Generally, at Catawba, they are about six months but are sometimes less time. There are times when individuals from the court are assigned to the hospital that have no mental illness.

Dr. Law reported that he was very pleased with the results of the Patient Perception of Care Survey, including the number returned. One of our discharge barriers is families who do not want to take their family members away from the care received at Catawba.

The hospital's quality matrix was reviewed; the mantra is that if you measure it, you can manage it. If you don't measure it, you don't know. Because while it is a caring service, running a hospital is also an analytical business.

Catawba is constantly reviewing a list of performance improvement projects. The hospital does not seclude anyone at any time for any reason; it is a matter of human rights.

Ms. Price-Stroble asked if any alarm systems were used for beds or chairs for individuals with a high fall risk. Dr. Law replied that they do not use alarms, but use low beds, helmets and other protective gear, or a high staff ratio.

Catawba Hospital serves the following patient populations, and accepts patients from other state hospitals:

- Geriatric psychiatric
- Adult psychiatric
- Intellectual & Developmental Disabilities (ID/DD)
- Forensic
- Substance Abuse/Severe Mental Illness (SA/SMI)

Bed Usage

- Licensed for 270 beds
- Funded for 110 beds
- For FY 2023, 587 were admitted and 583 discharged.

	Dr. Law indicated that the hospital was tasked to figure out how to get certified to bill and collect revenue, and accomplished it. Every year since the first, it doubled revenue collection. Note that 100% of all admissions and all discharges are audited for required elements of documentation, and 100% of all records audited for routine medical documentation regardless of payor source. Dr. Law highlighted the current and planned construction projects: new HVAC system, the roof was just replaced, new water lines. In response to a question from Ms. Graser regarding discussion of services for substance used disorder at the hospital, Dr. Law reported that 80% of the forensic patients have a cooccurring substance use disorder; therefore, substance abuse treatment already occurs. The first part of the study conducted in response to budget language and regarding interest in transforming Catawba Hospital into a facility at which a continuum of substance abuse treatment including recovery services is provided in addition to the array of behavioral health services currently provided, was complete and the second part regarding community partners would be finalized by July 1, 2024.
Lunch: Break and Collect Lunch	*A brief lunch break was held from 12 p.m. to 12:20 p.m.*
Update: School-based and other youth services from birth to transition age.	Kari Savage, Director, DBHDS Office of Child and Family Services (OFS), reported the following from a 2023 national report: o Virginia ranks 48th in the country for mental health care for children under 18 years of age. o Of Virginia's children with major depressive episode 61,000 did not receive mental health services. o Of those who received treatment, only 34.90% received consistent treatment. o 44,000 youth in Virginia have a reported substance use disorder. o Virginia ranks 39 out of 51 for mental health workforce availability. Ms. Savage reviewed OFS policy and funding oversight across three categories: o Substance Abuse and Mental Health Services Administration (SAMHSA) grants. o State General Fund dollars. o Early Intervention/Part C. Within in those areas, key initiatives or 'bright spots' include:

	○ Virginia Mental Health Access Program. During FY 2023, more than 6552 new providers were registered. ○ School-based Mental Health. IN FY 2023, six school divisions received funding for services and technical assistance. ○ Center for Evidence-based Partnerships. A single, integrated statewide resource for the implementation of evidence-based practices (EBPs). ○ Adolescent Substance Use Disorder Services. Numerous projects were mentioned by Ms. Savage, including youth peer support specialists embedded in CSBs. ○ TRAC-IT (for Early Intervention/Part C). A new statewide case management and data system for services that follows the child and family through the process that will help understand how to improve outcomes. Next steps for OCFS initiatives include expanding: ○ VMAP. ○ School-based mental health. ○ Recovery high school. ○ Youth SUD screening, referral, brief intervention, and referral to treatment. (YSBIRT) *Presentation available upon request.*
2024 General Assembly Legislation and Budget	**A. Budget** At 12:40 p.m., Nathan Miles, Chief Financial Officer, reported on the pending budget as passed by the legislature and under consideration by the Governor. Mr. Miles reviewed the process of the biennial budget. He reported on new behavioral health funding in the joint conference report, $344M in FY 2025 and $353M in FY 2026. Also, that there was a proposed decrease in funding for crisis services by the legislature compared to what the Governor submitted. However, the General Assembly put more funding toward continued support of STEP-VA, psychiatric and crisis response for children, permanent supportive housing, and CSB workforce development. There were some other variations regarding community services. Funding for state facility services was increased by the legislature in two areas: discharge assistance planning (DAP), and a new scheduling system. *Presentation available upon request.* **B. Legislative** At 12:58 p.m., Ms. Josie Mace, Legislative Affairs Director, reported that the team tracked 150 bills including about 50 that DBHDS was assigned as the lead agency. As expected, there was a lot of activity with all of the new delegates and senators

	that resulted in many new members coming wanting to quickly see change in the system and put in bills accordingly. Ms. Mace noted that as of this meeting, the Governor had acted on a number of pieces of legislation requiring his action by April 8th. She highlighted the following bills: Agency and Administration Bills • HB 601/SB 543 Health insurance; patient access to emergency services, mobile crisis response services. • HB 823/SB 497 Temporary detention order; alternative transportation. • HB 1242/SB 546 Emergency custody and temporary detention orders; evaluations, presence of others. • HB 1336/SB 568 Crisis stabilization services; facilities licensed by DBHDS, nursing homes. Other Bills of Interest • HB888/SB176 Civil commitments & temporary detention orders; definition of mental illness neurocognitive disorders. • HB1269/SB626 Barrier crimes; adult substance abuse and mental health services; exception. Ms. Graser asked about the specific crimes that were removed. Ms. Mace said it is a very complex section of the law, but misdemeanor assault and battery was removed as a barrier after four years and some offenses with controlled substances. • SB34 Certified evaluators; report. The office will be sending out the annual update with more details after all legislation is acted on and after the Reconvened Session. Additionally, the office is in the process of beginning required legislative and budget workgroups, studies, and reports. Outreach to legislators to maintain or build new relationships is ongoing. In just a few weeks, the legislative proposal development process will begin again in preparation for the 2025 General Assembly session.
Update: Virginia Association of Community Services Boards	At 1:05 p.m., Jennifer Faison, Executive Director, VACSB, reported on the association's activities during the 2024 Session of the General Assembly. One particular current area of focus is to figure out what it is going to cost the Commonwealth to actually fully fund STEP-VA so that the CSBs and the state can successfully meet the outcome measures that are dictated. At the same time, there will be a review of those outcome measures to make sure that they match what the funding is now and what it is anticipated the funding will be in the future.

Committee Reports	**A. Policy and Evaluation** At 1:30 p.m., Dr. Lee reported that the committee had a productive meeting. After reviewing the six-year review schedule, the following policies were discussed: • 4010(CSB)83-6 Local Match Requirements for Community Services Boards (Revisions) The purpose of this policy addresses the financial support for community-based services from local governments. It also provides flexibility for CSBs and DBHDS to accommodate and preserve local matching funds, shortfalls to maintain and expand services. Mr. Miles presented background on those structures in December. More drafting will be done before the July meeting by Dr. Lee and staff. The draft revisions will be circulated via email for a field review to CSBs, with all comments collected in table with staff responses for July. • 1007(SYS)86-2 Behavioral Health and Developmental Services for Children and Adolescents and Their Families (Background) Ms. Savage provided background on this policy. There were some suggestions for edits in the initial discussion that followed. • 4023(CSB)86-24 Housing Supports (Background) Kristen Yavorsky provided an update. The committee discussed aligning this policy with STEP-VA. It is important to ensure that the CSBs are engaged in local discussions regarding the continuum of care for individuals who are homeless. Possibly adding references to the Virginia Plan To Increase Living Options and the State Action Plan. The revisions are in final draft for consideration by the committee. 4038(CSB)94-1 Department and CSB Roles in Providing Services to Children Under the Children's Services Act for At-Risk Youth and Families (Background) Ms. Savage also provided background on that policy. There were several wording changes recommended including adding language referenced by the statewide Children Services Act Practice Model. B. **Planning and Budget** Ms. Walker reported that Ms. Neal-Jones met with the committee about the role of the Office of Enterprise Management Services and the Performance Contract with CSBs. Ms. Walker explained the budget category of 'premiums' in the board's budget (gifts, recognitions like plaques, etc.).

	The committee approved a recommendation to the State Board that the Board visit the Staunton campus for the April 2025 meeting, and the SEVTC campus for the July 2025 meeting. *On a motion from Blake Andis and a second from Ms. Lamb the recommendation for the April 2025 meeting of the committee was approved.* *On a motion from Ms. Lamb and a second from Sheriff Andis the recommendation of the committee to meet outside of Richmond for the July 2025 meeting was approved.*
Update: Performance Contract	At 1:42 p.m., Chaye Neal-Jones, Deputy Director, Office of Enterprise Management Services, discussed the role of the office, and recent changes to its structure and day to day implementation of roles and responsibilities. Ms. Neal-Jones gave an overview of the intent of the DBHDS Community Services Performance Contract with community services boards (CSBs) including its content (including Exhibits A – L and Addendums I – III); the statutory and policy framework; types of CSBs; the overall content; and the process for adoption. Changes were made to the Performance Contract Exhibit D section for state- and federally- funded program services. Also, the exhibits attached to the contract have been reorganized for clarity. Work was done to minimize unnecessary procedural-based language from the Performance Contract and other 'legalese.' In regard to accountability, there are now five regional program consultants in the Behavioral Health Services Division to partner with CSBs to improve mental health and substance use disorder services by reviewing and using individual and service databased performance and outcome measures in consultations with the CSBs to improve performance and outcomes and the quality of services. The office has taken and is taking innovative steps to improve. This includes providing support internally to DBHDS staff and CSB staff with processes and procedures, templates, and training videos. Sheriff Andis asked if the new data collection efforts would track availability of beds across Virginia. Ms. Harrison said it is similar to the bed registry in that it will not say if it is a shared room, etc., that will best meet someone's needs. *Presentation available upon request.*

Miscellaneous	**C. May 14th Meeting: All Virtual** At 2:10 p.m., the State Board reviewed the miscellaneous items beginning with the confirmation of the all-virtual special called meeting at 9 a.m. on Tuesday, May 14, 2024, for the primary purpose of moving the final stage of the action to amend the Operation of the Individual and Family Support Program [12VAC35-230]. **D. Nominating Committee** In preparation for the July 2024 officer elections, Ms. Hilscher announced her appointment of the 2024 Nominating Committee: Ms. Graser as Chair, Varun Choudhary, and Blake Andis. **E. Liaison Updates** At 2:17 p.m., Ms. Lamb reported she attended three Rappahannock Area CSB meetings, and one at both Rappahannock-Rapidan CSB and Prince William CSB. As the commissioner said, each is completely different and she finds it interesting to learn about each one. However, the underlying theme is the motivated and focused staff. Dr. Lee reported traveling to Danville in mid-December to attend a Southside Behavioral Health Consortium meeting at the Danville-Pittsylvania Community Services. This consortium meets monthly and is comprised of CSB executive directors and staff members from: • Southside Community Services; • Danville-Pittsylvania Community Services; • Piedmont Community Services; and • Southern Virginia Mental Health Institute. Following the meeting, he had a tour of Danville-Pittsylvania's new 24-hour crisis center for individuals experiencing a mental health or substance use crisis. He attended that CSB's board meeting later that day. In March, Dr. Lee had a great visit with the Executive Director of Southside Behavioral Health, Beth Englehorn, and staff Alisha Wright who provided a tour of the new crisis receiving center in South Hill. It was great to see the work being done to support individuals in crisis, and the opportunity to meet staff members. The center is only open from 8 a.m. to 5 p.m., but they are building capacity to expand hours. They also shared the challenges faced with providing the needed medication to individuals in crisis. South Hill does not have a 24-hour pharmacy and they have run into the "red tape" with obtaining the medication dispensing unit they need. Finally, Dr. Lee is invited to attend Crossroads Community Services Board's annual Children's Mental Health Awareness day in May.

Other Business	**Next Meeting:** May 14, 2024 (all virtual).
Adjournment	There being no other business, Ms. Hilscher adjourned the meeting at 2:25 p.m.

MEETING SCHEDULE

DATE	Location
2024	
May 14 (Tues)	Online only
July 17 (Wed)	Eastern State Hospital **Williamsburg**
September 25 (Wed)	Southern Virginia Mental Health Institute **Danville**
December 11 (Wed)	Central Office **Richmond**
2025	
April 2 (Wed)	Western State Hospital **Staunton**
July 9 (Wed)	Southeastern Virginia Training Center **Chesapeake**

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Planning and Budget Committee

DRAFT MINUTES

APRIL 3, 2024
8:30-9:25 AM
DBHDS CATAWBA HOSPITAL, MAIN CONFERENCE ROOM
– BUILDING 24 ADMINISTRATION,
5525 CATAWBA HOSPITAL DR, CATAWBA, VA 24070

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; CINDY LAMB; CHRISTOPHER OLIVO.
MEMBERS ABSENT: (NONE).
STAFF PRESENT: ELLEN HARRISON; CHAYE NEAL-JONES; RUTH ANNE WALKER.

I. Call to Order

At 8:31 a.m., Elizabeth Hilscher called the meeting to order and announced a was quorum present.

II. Welcome and Introductions

At 8:32 a.m., Ms. Hilscher welcomed all present.

III. Adoption of Minutes, December 6, 2023

At 8:33 a.m., on a motion from Christopher Olivo and a second from Cindy Lamb the meeting minutes from December 6, 2023, were adopted unanimously.

IV. Adoption of Agenda, April 3, 2024

At 8:34 a.m., on a motion from Christopher Olivo and a second from Blake Andis the agenda was adopted unanimously.

V. 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. 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. Review from the July 11, 2023, Biennial Planning Meeting: Draft priorities for the biennium and draft topic areas for board meeting updates September 2023 - July 2025.

At 8:45 a.m. Ms. Hilscher reviewed the meeting topics spreadsheet and list of priorities developed at the biennial planning meeting. Ruth Anne Walker reviewed the past meeting dates and topics covered, and reviewed open

presentations slots in December and April. Ms. Walker also asked the committee to consider options for a recommendation on two meeting options:

- What facility to visit in April 2025; and
- Whether to continue through July 2025 of having an additional out-of-Richmond meeting to cover all facilities post-pandemic.

Considerations of those recommendations were: visiting Central State Hospital (CSH) when the new hospital is open; Southeastern Virginia Training Center (SEVTC) is the facility most due for a visit just placed on time (and there have been no admissions in five years); both the Staunton campus (where an expansion is in development with Western State Hospital (WSH) and Northern Virginia Mental Health Institute would be next after SEVTC. Another consideration was for the July meeting to stay within one hour of Richmond for the biennial planning meeting so that Central Office staff can easily attend.

After discussion, on a motion by *Mr. Olivo and a second by Ms. Lamb, the committee recommended to visit the Staunton campus for the April 2025 meeting, and the SEVTC campus for the July 2025 meeting.*

The committee agreed to leave open presentation slots as is for now and revisit at a later date.

VI. Other Business

A. State Board Budget Quarterly Report. *Handout*

At 9:03 a.m., the board's quarterly budget report was reviewed. At the inquiry of Ms. Lamb, clarification was provided on the 'Premium' category, which exists for gifts, awards, prizes, and other things of that nature for individuals and organizations. This category includes recognition plaques for members retiring from the State Board. A review of the general months and locations of conferences of the Virginia Association of Community Services Boards (VACSB) was reviewed.

B. Discussion of Performance Contract *Chaye Neal-Jones*

At 8:35 a.m., the committee heard from Chay Neal-Jones, Deputy Director, Office of Enterprise Management Services, who discussed the role of the office, and recent changes to its structure and day to day implementation of roles and responsibilities, including changes to the Performance Contract with community services boards (CSBs) and their Exhibit D's for their state- and federally- funded program services. Ms. Neal-Jones reported the office is doing a lot of internal training and development to help and assist DBHDS staff with understanding their roles and responsibilities with the CSBs, as there have been and are currently numerous longtime staff retiring. And also, her office is providing technical assistance and training for the CSBs as they are bringing on new staff as longtime CSB staff are retiring.

Sheriff Andis asked if the office monitors the local grants. Ms. Neal-Jones responded that is outside of the office's purview, though they do monitor the services under those grants, but not the grant management or tracking. OEMS may provide technical assistance or training. Ms. Hilscher wondered if part of the role of the office is to facilitate CSBs meeting a basic level of standard of care across the board, even though the services offered may vary. Ms. Neal-Jones affirmed that understanding, and that the priority now is to measure outcomes and the quality of those services, making sure individuals are getting the right services for their needs and reducing the need for admissions to state hospitals. Such information is easier to track now than in the past, even in the past couple of years due to modernization of technology at DBHDS.

Work has been done to minimize unnecessary procedural-based language from the Performance Contract and other 'legalese.' Also, the 'exhibits' attached to the contract have been reorganized a bit for clarity. The CSBs seem to like the changes. More information would be provided in the full presentation to the State Board that afternoon. *Presentation available upon request.*

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 July 17, 2024.

VIII. Adjournment

At 9:23 a.m., Ms. Hilscher adjourned the meeting.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Policy and Evaluation Committee
DRAFT MINUTES
APRIL 3, 2024
8:30-9:25 AM
DBHDS CATAWBA HOSPITAL, SMALL CONFERENCE ROOM
– BUILDING 24 ADMINISTRATION,
5525 CATAWBA HOSPITAL DR, CATAWBA, VA 24070
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: Kendall Lee, Committee Chair/Board Vice Chair, Becky Graser; ; Moira Mazzi; Sandy Price-Stroble.

MEMBERS ABSENT: Varun Choudhary.

DBHDS STAFF PRESENT: Committee Staff Josie Mace, Madelyn Lent. Heather Norton. Kari Savage. Kristin Yavorsky.

GUESTS PRESENT: In person - Mary Ottinot. Virtual – Mindy Monay, GOV; Kathryn Zimmerman, HHR; Kyle Vaught.

I. Call to Order [Kendall Lee, Committee Chair]
Dr. Kendall Lee called the meeting to order at 8:35 a.m. A quorum was present.

II. Welcome and Introductions [Kendall Lee] (5 min)

III. Adoption of Agenda, April 3, 2024, and Adoption of Minutes, December 6, 2023.

IV. Review of Committee Charge and Policy Review Plan for FY2024. [Kendall Lee and Josie Mace] (40 min)
Dr. Lee and Josie Mace reviewed the status of the policy review schedule.

V. Presentation of Policies for Discussion [Kendall and Staff] (30 min)

A. 4010(CSB)83-6 Local Match Requirements for Community Services Boards (Revisions)
Committee members requested staff reach out to the subject matter expert for additional information on this policy and include Mr. Lee on communications to the SME.

B. 1007(SYS)86-2 Behavioral Health and Developmental Services for Children and Adolescents and Their Families (Background)
Heather Norton presented background information on this policy, with assistance from Kari Savage. Suggested revisions will be provided to members before the July meeting.

C. 4023(CSB)86-24 Housing Supports (Background)
Kristin Yavorsky provided background information on this policy. Suggested revisions will be provided to members before the July meeting.

D. 4038(CSB)94-1 Department and CSB Roles in Providing Services to Children Under the Children's Services Act for At-Risk Youth and Families (Background)
Ms. Savage presented background information on this policy. Suggested revisions will be provided to members before the July meeting.

VI. Next Quarterly Meeting: July 17, 2024

VII. Other Business (10 min)
There being no further business, Dr. Lee adjourned the meeting at 9:20 a.m.

VIII. Adjournment

All current policies of the State Board are here: https://dbhds.virginia.gov/about-dbhds/Boards-Councils/state-board-of-BHDS/bhds-policies/.

DBHDS
Virginia Department of Behavioral Health and Developmental Services

MEMORANDUM

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

Fr: Ruth Anne Walker, Director of Regulatory Affairs

Date: May 1, 2024

Re: **Two Time-sensitive Regulatory Action Items**

I. Action Item. Initiation of Final Stage: Operation of the Individual and Family Support Program [12VAC35-230].

Background: The Department of Behavioral Health and Developmental Services (DBDHS) was directed by the 2022 General Assembly within Item 313.NN. of the 2022 *Appropriation Act* (Chapter 2, 2022 Special Session 1 Acts of Assembly) to utilize emergency authority to promulgate regulations that change the current distribution of annual Individual and Family Support Program (IFSP) funds from a 'first-come-first-served' basis to one based on program categories and set criteria. Specifically, DBHDS is authorized to create an annual public input process that shall include a survey of needs and satisfaction in order to establish plans for the disbursement of IFSP funding in consultation with the IFSP State Council. Based on the Council's recommendation and information gathered during the public input period, the department will draft program guidelines to establish annual funding priorities. The department will establish program criteria for each of the required program categories and publish them as part of annual IFSP guidelines developed collaboratively by the department and the department's IFSP State Council. Additionally, program guidelines shall establish eligibility criteria, the award process, appeals processes, and any other protocols necessary for ensuring the effective use of state funds. All criteria will be published prior to opening the funding opportunity.

Purpose: The goal of this regulatory action is to facilitate compliance with the U. S. Department of Justice's Settlement Agreement with Virginia (United States of America v. Commonwealth of Virginia, Civil Action No. 3:12cv059-JAG) (https://dbhds.virginia.gov/doj-settlement-agreement/). The State Board promulgated an emergency/NOIRA action July 13, 2022. An emergency regulation became effective on January 19, 2023, and will expire on July 17, 2024.

Proposed Stage Result: A total of 17 comments were received during the 60-day public comment forum, which closed on April 26, 2024. All are listed in the chart within the Town Hall form beginning on page 33. Most were concerns about overall funding for the system. **Staff determined that none warranted additional edits to the action; the final stage is unchanged from the proposed stage.**

Action Requested: Initiate the final stage of the standard process. This will allow for the changes to be effective in time for the new funding cycle.

VAC Citation	Title	Last Activity	Date
12 VAC 35-230	Operation of the Individual and Family Support Program	Proposed	04/26/2024

Next Steps: If approved, staff initiates the final stage.

II. Action Item. Initiation of Final Stage: Operation of the Individual and Family Support Program [12VAC35-230].

Background: As presented in the most recent update by the Division of Crisis Services at the December 2023 meeting (presentation attached separately), the Commonwealth is undergoing an expansion of the crisis services system. These efforts have come through STEP-VA, Project Bravo, and Right Help Right Now.

Purpose: The current draft of the licensing and human rights regulatory amendments regarding implementation of the new crisis services are in direct response to the mandate in SB569 (attached) to make changes to the system structure to have high-quality service, including to allow for seclusion in certain settings. A clause was added to the legislation to make it effective upon passage that speaks to the sense of urgency for the changes.

A detailed chart is included in this package after the regulatory language to assist you in your review. The primary change is adding a new part to the licensing regulations with several new sections that specifically addresses crisis services. That includes specifying requirements for three new licenses:

- Crisis Receiving Centers (CRCs).
- Crisis Stabilization Units (CSUs).
- Community-based Crisis Stabilization (includes mobile crisis response).

These amendments also include additional language for REACH crisis services (REACH Crisis Therapeutic Home and REACH Mobile Crisis Response). The draft also amends the human rights regulations to allow the use of seclusion in CRCs and CSUs, and amends the licensing regulations to include specific requirements for seclusion rooms.

In addition to updates to definitions, these regulations specify staffing requirements for each of the services, as well as requirements for conducting assessments and providing care. They also recognize the unique nature of crisis services and reduce some of the requirements related to assessments, individualized services plans

(ISPs), and discharge plans (as compared to the current regulations for all providers) to include only those elements that are relevant to the delivery of crisis services.

Action Requested: Initiate the final exempt stage. This will allow for the changes to be effective as quickly as possible.

VAC Citation	Title	Last Activity	Date
12VAC35-105	Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services	--	--
12VAC35-115	Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services	--	--

Next Steps: If approved, staff initiates the final exempt action.

townhall.virginia.gov

Final Regulation
Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC35-230
VAC Chapter title(s)	Operation of the Individual and Family Support Program
Action title	Amendments to establish criteria and annual funding priorities and to ensure public input.
Date this document prepared	May 1, 2024

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.

The Department of Behavioral Health and Developmental Services (DBDHS) was directed by the 2022 General Assembly within Item 313.NN. of the 2022 *Appropriation Act* (Chapter 2, 2022 Special Session 1 Acts of Assembly) to utilize emergency authority to promulgate regulations that change the current distribution of annual Individual and Family Support Program (IFSP) funds from a 'first-come-first-served' basis to one based on program categories and set criteria. Specifically, DBHDS is authorized to create an annual public input process that shall include a survey of needs and satisfaction in order to establish plans for the disbursement of IFSP funding in consultation with the IFSP State Council. Based on the Council's recommendation and information gathered during the public input period, the department will draft annual funding priorities and program criteria for each of the required program categories and publish them in draft form for public comment and in final form prior to opening the funding opportunity as part of annual IFSP review process. Additionally, the department, based on information gathered through public input and in consultation with the IFSP State Council, shall annually establish eligibility criteria, the award process, the appeals process, and any other protocols necessary for ensuring the effective use of

state funds. The goal of this regulatory action is to facilitate compliance with the U.S. Department of Justice's Settlement Agreement with Virginia (United States of America v. Commonwealth of Virginia, Civil Action No. 3:12cv059-JAG) (https://dbhds.virginia.gov/doj-settlement-agreement/). An emergency regulation became effective on January 19, 2023. A proposed stage action was published on 2/26/2024. This final action is the next step to creating the permanent amendments to Chapter 230.

Acronyms and Definitions

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

Council – IFSP State Council.
DBHDS – Department of Behavioral Health and Developmental Services.
DD – Developmental disabilities.
IFSP – Individual and Family Support Program.
Settlement Agreement – the U. S. Department of Justice's Settlement Agreement with Virginia (United States of America v. Commonwealth of Virginia, Civil Action No. 3:12cv059-JAG).

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.

On May 14, 2024, the State Board of Behavioral Health and Developmental Services approved this action to move to the final stage to amend the Operation of the Individual and Family Support Program regulations [12VAC35-230].

Mandate and Impetus

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

This action is brought in compliance with Code of Virginia § 2.2- 4011.B. in accordance the mandate from the 2022 General Assembly within Item 313.NN. of the 2022 *Appropriation Act* (Chapter 2, 2022 Special Session 1 Acts of Assembly).

The purpose of this regulation is to facilitate compliance with the U.S. Department of Justice's Settlement Agreement with Virginia for the development of a comprehensive and coordinated set of strategies that are designed to ensure that families who are assisting family members with ["developmental disabilities" ("DD")] or individuals with [DD] who live independently have access to person-centered and family-centered resources, supports, services and other assistance. (See Section II.D.) The program is intended to support the continued residence of each individual with DD on the waiting list for a Medicaid Home and Community-Based Services (HCBS) DD Waiver in the individual's own home or the family home, which includes the home of the principal caregiver.

The court appointed Independent Reviewer has stated that while the Commonwealth continues to make progress, it is not fully meeting requirements related to individual and family supports. (See his 18th Report to the Court, p.55.) These amendments provide updated formal 'documentation of authority and

functioning' for the IFSP funding awards through the use of procedures used by the department for those determinations.

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.

The 2022 General Assembly, within Item 313.NN. of the 2022 *Appropriation Act* (Chapter 2, 2022 Special Session 1 Acts of Assembly), mandated the department to utilize emergency authority to promulgate regulations. Section 37.2-203 of the Code of Virginia authorizes the State Board of Behavioral Health and Developmental Services to adopt regulations that may be necessary to carry out the provisions of Title 37.2 and other laws of the Commonwealth administered by the commissioner and the department. At its meeting on July 13, 2022, the State Board voted to initiate the emergency action and notice of intended regulation for permanent adoption. An emergency regulation became effective on January 19, 2023. This final action was approved on May 14, 2024.

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.

These amendments are essential to protect the health, safety, and welfare of individuals with DD who are on the waiting list for a Medicaid Waiver HCBS DD Waiver and who reside in their own or their family homes, which include the home of the principal caregiver. The change from the current distribution of annual funds from a 'first-come-first-served' basis will be to one based on program categories and set criteria that will be more needs-based and that has significant stakeholder input. The department, based on information gathered through public input and in consultation with the IFSP State Council, shall annually establish eligibility criteria, the award process, the appeals process, and any other protocols necessary for ensuring the effective use of state funds. The goal of this regulatory action is to facilitate compliance with the U. S. Department of Justice's Settlement Agreement with Virginia (United States of America v. Commonwealth of Virginia, Civil Action No. 3:12cv059-JAG) and any amendments must remain in alignment as the action moves through the regulatory adoption process.

Substance

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

IFSP program overview and purpose
The Individual and Family Support Program (IFSP) assists individuals on Virginia's Medicaid Home and Community-Based Services (HCBS) DD Waivers Waiting List and their families with accessing short term, person- and family- centered resources, supports, and services. The purpose of the program is to support individuals with DD in living in their own home or family home in the community.

IFSP consists of four components: 1) a funding program, 2) community coordination program, 3) information and referral, and 4) connections to family and peer mentoring supports.

IFSP-Funding Program Background
Since 2013, DBHDS's IFSP Program, through the use of state funds allocated by the Virginia General Assembly, has provided direct financial assistance to Virginians on the Medicaid HCBS DD Waivers waitlist. The assistance supports individuals and their families with the purchase of services or items described in the application and approved by the department. The funding program is restricted to assisting individuals on the DD waiver waiting list who are living in their own home or in their family home per 12VAC35-230-20.

Prioritization of Individuals Seeking Assistance Initial Stakeholder Input
Traditionally, the IFSP both assessed applications and provided assistance to individuals solely on a first-come first-served basis. Per the terms of the Settlement Agreement, DBHDS is required to target assistance to people who are at highest risk of being institutionalized. Therefore, beginning in 2019, the IFSP began engaging with the IFSP State Council, the department's formally identified advisory group on family supports, to establish a list of priorities for the funding program. A key take away from engaging with the state and regional councils is the guiding principle that priority categories should consider both the individual circumstances of the applicant and their family and the type of request.

Review of Existing Measures of Risk and Past IFSP Data
In order to create a framework for identifying and supporting those most at risk of institutionalization, the IFSP established the program's funding categories through discussion with subject matter experts and a review of internally used intake and assessment tools across DBHDS divisions. IFSP also reviewed past IFSP funding outcome data including requested need categories to understand what needs are typically requested and how changes to the program may impact assistance for those needs.

Regulatory Changes
Amendments to this chapter eliminate unnecessary language related to the 'first-come-first-served' funding award process used to date. It makes clear the use of formal procedures for funding awards that detail the criteria for annual awards and that must be reviewed annually, sets out that the IFSP State Council will work in consultation with DBHDS to establish eligibility criteria, the award process, the appeals process, and any other protocols necessary for ensuring the effective use of state funds; that additional stakeholder comment must be sought; and makes clear the following expectations for DBHDS in regard to community coordination:

1. Engage with the public and stakeholders to establish programming that encourages the continued residence of individuals with DD in community settings.
2. Establish the IFSP State Council.
3. Coordinate the development of strategic plans and activities that are consistent with the IFSP goals through the work of the Council.
4. Provide technical assistance to individuals or family members for the purpose of facilitating the purchase services that are intended to enhance or improve an individual's or family's quality of life and promote the independence and continued residence of an individual with DD in each individual's own home or the family home, which include the home of a principal caregiver.

Additionally, amendments make clear the department's responsibility regarding the establishment of procedures for eligibility determination, the award process, appeals process, and any other protocols necessary for ensuring the effective use of state funds. All procedures shall be published in draft form for public comment and in final form prior to opening the funding opportunity.

For each funding period, the department shall develop and publish the following information on the IFSP:

1. Applicant eligibility criteria;
2. A summary of allowable expenditures;
3. Maximum award amount per applicant;
4. Application deadlines;
5. Award notification schedules;
6. Award review criteria; and
7. Requirements for expenditure substantiation.

Issues

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

1) The primary advantage to the public is that those most in need of assistance will be considered based on defined categories of need. Also, the public will have the opportunity to comment annually on draft revisions of funding award procedures. The primary disadvantage to the public of implementing the amended provisions is that individuals on the waiting list for the Medicaid Home and Community-Based Services (HCBS) DD Waivers and their families will have to learn the new procedures for application for funding. Those who previously benefited from the 'first-come-first-served' basis potentially may be categorized differently with the new structure. Additionally, a redesigned application portal will be available to the public that is intended to be more user-friendly.

2) The primary advantage to DBHDS and the Commonwealth is the assurance that the funds are distributed in a targeted manner. Also, these changes more thoroughly comply with the requirements of the Settlement Agreement. Though some resources are being used to redesign the portal, there are no disadvantages to the agency or the Commonwealth.

3) A pertinent matter of interest to the regulated community, government officials, and the public is that funding procedures will be published in draft form for public comment and in final form prior to opening the funding opportunity. There are no disadvantages to the public or the Commonwealth as these changes will ensure more public input and more targeted use of state funds.

Requirements More Restrictive than Federal

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

There are no requirements more restrictive.

Agencies, Localities, and Other Entities Particularly Affected

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

Other State Agencies Particularly Affected

There are no other state agencies affected.

Localities Particularly Affected

There are no localities particularly affected.

Other Entities Particularly Affected

Any individual with a developmental disability (DD) who is on the waiting list for a Medicaid Home and Community-Based Services (HCBS) DD Waiver in his own or the family home, which includes the home of the principal caregiver, and family members of any such individual.

Public Comment

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

Commenter	Comment	Agency response
Mike Rupar	I am concerned that we're asked to vote "yes" on criteria that has not been approved or evidently decided yet. Therefore, I am against this change. Adding "criteria for participation" requires a third party to assess value for submissions, which takes time, adjudication, and picking winners and losers. this adds time to the process, and greater costs which likely have to come out of the program itself. has there been an outcry for this change? I'd suggest that if current criteria for participation is in need of correction, then the application process should be evaluated and then changed. the first-come, first-served method has the advantage of lower bureaucratic overhead. And it appears to be working fine. Even if the application process needs to change, the new process and weighing factors need to be presented for comment, rather than the open ended amendment currently proposed. thank you for the opportunity to comment.	Thank you for your comment. It is true that the first-come, first-served basis was a simpler award process. However, since the 2022 Session of the General Assembly mandated the change in the IFSP funding distribution from a first-come first-served basis to one based on program categories and established criteria, it was implemented via emergency regulation and used for determining IFSP funding for the last two cycles. This change was made to ensure that applicants on the Developmental Disability (DD) Waiver waiting list with the highest needs received funding. The process is based on each individual's priority status on the DD Waiver waiting list and their Critical Needs Summary score. The Priority Status and Critical Needs Summary score is determined through assessment completed by the support coordinator at the applicant's community services board. The process for determining funding approval was streamlined and is outlined in the IFSP Guidelines; any changes to the Guidelines must be put forward in a public comment forum before adoption. The mandate also ensured an annual public input process that includes a survey of needs and satisfaction in order to establish plans for the disbursement of IFSP funding in consultation with the IFSP State Council.
Brian Kaman	Hello. I'd like to submit a comment about the appeal process. I was denied	Thank you for your comment. There is a thorough review of all appeal submissions. The review of the funding

	funding for IFSP and told to submit an appeal if I wanted to do so. I took the time to submit an appeal and received an email that funds had been exhausted, which is the same reason that I was given initially. It seems like the appeals process is not really an appeal as no further reason was given. I was induced into taking the time to submit an appeal when the agency had no real intention of reviewing my appeal. Please don't offer an appeal process if there isn't really an appeal review.	determination process for the applicant is to ensure procedures were followed appropriately. If no procedural errors are found in the determination process, the reason for denial remains the same.
Al Carroll	We were on the waiting list for a provider to help our son for literally years. Over two years, and one has yet to come through. We have finally given up in frustration. I'm sure there are many stories like ours.	Thank you for your comment. As these remarks are outside of the scope of the changes to the IFSP regulations, this comment will be documented for future discussion regarding the waiting list.
Cynthia White	Changing the criteria from a first come first served basis to a need based will get more individuals the supports they need to use the funding. The funding should be made available throughout the year especially for the use of respite care.	Thank you for your comment. Increases to the amount of funding in the IFSP program are decided by the General Assembly. Once the Appropriation Act (state budget) is effective, the agency works within a set timeframe to take all mandated steps and distribute the annual allotment in a timely manner.
Mary C Hendrickson	♦?It has been a challenge to find qualified Day Care Facility Programs in the Virginia Beach area. I have found only one however it's a small facility called "Indigo". They would need to hire more qualified staff to take on more young adults that fall between high functioning but do not qualify through the state to work. ♦?My son had attended 3 Facilities prior that were horribly run by individuals that want easy adults but do not have the activities that provide sensory stimulation, promote group conversations and assist in teaching them how to be productive in the community. In my opinion those generic facilities are just milking the Medicare Waver. And thus my son was very upsetting and left my son traumatized. Those experiences left a fearful impression that different races where not a positive. This is Not how I grew up from a military household, moving	Thank you for your comment. These remarks are outside of the scope of the changes to the IFSP regulations This comment will be documented for future discussion regarding the DD service system and the waiting list.

	around the US every 2-3 years. I learned that all races are uniquely different and therein lies the beauty of a diversified world. ♦?We need more Providers that have Day Care Facilities for the Autism Spectrum of young adults & other high functioning individuals especially those individuals transitioning out of High School. As we know as Patents and have been through the LONG Waiting List on the DD Waiver to get services. ♦?We need to have a more solid approach & more options of Quality Providers to choose from to help these young individuals thrive and have a sense of being productive in their communities and increases their desire to keep learning once they have finished High School and are ready to transition. ♦?A Transition Program needs to be enacted through Congress in the Virginia Beach area. ♦?Parents were promised from High School Teachers & Staff of all the options that were available once our kids have graduated HS. However the Funding & Laws have changed so much that once my son was ready to transition to a work program he was denied the "Right to Work" because of his Seizures. That it would require an assistant near by to keep him on task and or assist in the onset of a siezure. Seizures can be very common in individuals on the Autistic Spectrum Disorder ASD that can manifest at any age. ♦?My son has wanted to be a Farmer since he was 7 years old. Now at 23 How can Can We make this happen? ♦?There was in 2004 and still is Now a large population of kids, young adults and older on the ASD Spectrum. ♦?Many of them are from military families. ♦?It was my understanding back in 2010 that if a Military Service member had a Special Needs Child the military would send them to San Diego California or Virginia Beach. And the Military was to provide more Funding for their children to the State of Virginia. ♦?Congress and the State of Virginia	

	has Not provided that funding and have never been renforced to do so. ♦?Not all families in Virginia Beach are Military. ♦?We need to pressure our now Democrat Senate & House in the State of Virginia to immediately start to implement this Funding from the Military to provide financial support for their own Servicemembers children. ♦?Then the DD Waiver Services Long Waiting List would move Much Faster in getting our kids the help they deserve & need to be functioning, productive & have an overall sense that THEY can achieve their desired career and be a huge part of their Community. They are valuable Human Beings Too! ♦?WE NEED TO RESTRUCTURE THIS PROBLEM and as Most Mom & Dads with Special Needs children and adults are STILL struggling. Thank you for reading, Mary C Hendrickson email: Drsnipm@hotmail.com	
Zain Khan	Greetings, I have applied for my son in the waiver program for development and behavioral health services for over two years. As a concerned mother, I am struggling to find a suitable program for my autistic son who enjoys school and playing outside with his classmates. Since his school ended, he has been feeling down at home due to the disruption in his routine, leading to mood swings and emotional distress. I am looking to explore other options to support my son and get his routine back on track. From, Rashida Khan	Thank you for your comment. These remarks are outside of the scope of the changes to the IFSP regulations. This comment will be documented for future discussion regarding services for children with autism.
Mary Clark	I do not think that the regulations should require that the funds only be used for the specific things that are requested in the application. The process is complicated and, to my knowledge, there is no process to make changes to the application request throughout the year. Families are asked to predict needs for the future year which may or may not materialize. That does not mean that they do not need the funds to	Thank you for your comment. in accordance with the mandate for the use of funds by the General Assembly, funds for the IFSP program are targeted in accordance with the terms of the DOJ settlement agreement to ensure that funds are used to benefit individuals on the DD Waiver waiting list and fall within the allowable funding categories. If an applicant needs to change what was entered on the original application

	help the individuals with DD. For example, the family may request funds to enable the individual with DD to attend a specific recreational program in the Spring or Summer, but that program may not be available, or there may be other challenges that come up making attendance impossible. Other more important and critical needs may emerge which will better support the individual's ability to remain in the home. The program should allow for flexibility. As long as the funds are spent for items or on needs that are among those allow under the program, there should be no problem and no need for cumbersome paperwork to amend an application. There should be no need to justify a change which benefits the individual and the family when funds are spent on items or services allowed under the program.	because that item or service is no longer available, the applicant should contact IFSP. As IFSP funds are a public resource, all expenditures must be justified and documented. IFSP will approve or deny the change via email and maintain documentation of the change connected to that application.
Andrea Crockett	Our son has been on the wait-list for a few years now. He is priority but since he has us , we are told he really isn't priority. He would have been on it for over 10 yrs if it wasn't for the state's requirement for a psychologist to label him mentally retarded. Wasn't that a hurdle after the fact (several evaluations during his early school years and not one Psychologist used that term specifically). He is severe ... totally care dependent, non verbal, non ambulatory, and seizures all day, every day. He ages out of public schools in May. We both need to work to make ends meet and we don't know who or how that will happen. With so much taken in taxes by the state ...income, no tax breaks on our property nor on our adapted van to transport him still we get no real help for him nor us as aged caregivers. There has been budget surpluses and yet the slots are so very few and the wait lists getting longer and longer. I guess when caring for him disables or kills us then he may be really a priority then?! Let's think preventative and not reactive. Legislation speaks of helping families but as one can look at the stats it is all talk. Will our comments be read? Please listen to the families in need.	Thank you for your comment. These remarks are outside of the scope of the changes to the IFSP regulations. This comment will be documented for future discussion regarding the DD waiver waiting list and funding for services.
Anonymous	In the past 3 years alone, cumulative inflation is over 20%. This represents a	Thank you for your comments regarding individuals with disabilities and their

	real burden to families caring for a disabled loved one. The wait time for aid in Virginia is years -- actually more than a decade for most people on the wait list. The unfortunate reality is that most disabled individuals in-need will not receive state support, all while our economy flourishes and the Northern Virginia region ranks among the wealthiest locations in the country. More needs to be done to ensure every qualified family/disabled individual is provided some form of assistance. But, above and beyond, the most pressing matter today and for the next decade -- will be making sure that every legislator, executive, and administrator of this state works tirelessly to ensure that state funds are not diverted from disabled citizens to pay for illegal immigrants. Under no circumstances should state funds be drained to support those flooding in from around the world. Because those who will be left out will most certainly be the disabled population who cannot advocate for themselves.	families. These remarks are outside of the scope of the changes to the IFSP regulations.
Steven R Jones	In regard to changes to the IFSP funding criteria, the Commonwealth of Virginia should take a heard look at this system and say why do we have this "band aid" funding when the priority should be to get all 16,000 individuals off the waitlist and provide the services they need to have productive lives. Instead, the state created this tiny funding for severely impacted individuals to receive a sliver of the funds the Commonwealth should be providing. Should the IFSP funding method be changed? Yes. Ideally it should be completely eliminated with the Commonwealth providing the needed and necessary funding for every individual in need. My daughter has been on the wait list for a DD waiver (currently on CCC+ waiver) well into the second decade. Is the IFSP funding better than nothing, marginally yes. However, it does nothing to solve our assist my daughter (27) to improve her quality of life or her interactions with the outside world. Instead as a result, my wife (63) and myself (64) and the primary	Thank you for your comments. These remarks are outside of the scope of the changes to the IFSP regulations. This comment will be documented for future discussion regarding funding the DD Waiver wait list. Please note that Governor Youngkin proposed, as part of the Right Help Right Now initiative, to eliminate the Priority 1 Waitlist; that is in the pending budget.

	caregivers. We have a modest income and are currently in good health for our age. However, how long does the Commonwealth expect us to fulfill the role of untrained and aging care providers? All at the expense of services that could enrich our daughter's life. At the rate the Commonwealth is making progress (despite being found guilty of underfunding services for its most vulnerable population and now operating under a federal court order – that should not be removed) either one or both of us will die caring for our daughter before she receives services. This is shameful for a state as wealthy as Virginia. The Governor is promoting his tax breaks, building a sports complex for a Billionaire and playing silly social agenda games. All of this instead of working to fund the services for over 16,000 citizens of the Commonwealth want and desperately need. Should the funding for the IFSP program be changed – Yes it should be eliminated as the DD and other waivers should be fully funded – So there would be no need for the IFSP. Instead of fussing with the IFSP program, when will those in the administration work on the bigger problem of eliminating the waiting list for waivers in the Commonwealth? Now that would be a move in the proper direction. Don't waste time on changing IFSP funding – Use the time to eliminate the need for this program!	
Robin Mays	How long Virginia? How long will you continue to put the most vulnerable at the bottom of the funding list? Because of federal oversight Virginia has had to change their ways but Will failing miserably. With decent budget overages there is no excuse for not funding all children and adults in need for support on the DD Waiver. The pay for people to help these individuals at home and in the community is far below a living wage. Housing is horrid for this population and with current increases in the cost of living, no doubt it will get worse.	Thank you for your comment. These remarks are outside of the scope of the changes to the IFSP regulations. This comment will be documented for future discussion regarding provider rates.

	Please step up and take care of what needs taking of now!	
Will Oldaker	As parents of a special needs child my wife and I understand and have always operated on the assumption that It is our responsibility to take care of him. That said It is a blessing to receive this type of funding and if the state is going to offer it it should be available to every family that needs it not first come first serve whoever gets their name in the hat first. I understand that there is always the concern for abuse of the system but in this instance I think it is best to help families first, make it easy to get that help and then take care of any regulatory issues. Let's default to funding everybody that needs it and fixing any broken parts that may arise later instead of making it harder on people who need it now because some legislators want to drag their feet on helping those most in need. Thank you for your time.	Thank you for your comment. The program is wholly funded by state General Fund dollars r and any increases must be approved annually by the state legislature. The funding allocation process distributes fifty percent of the funds to individuals or families on the DD Waiver waiting list with Priority 1 status, prioritizing those with the highest Critical Needs Summary scores. The remaining fifty percent of funds are awarded to applicants holding Priority 2 or 3 waitlist status through a randomization process until the funds are exhausted. In cases where demand exceeds available funds, only a portion of applicants will receive assistance. This change was made to ensure that applicants on the DD Waiver waiting list with the highest needs received funding.
Catherine Shaffer	We moved here in May 2021. We have been trying to get our son involved with the services he needs. It has been very difficult to negotiate the system. And understand what I need to do. If an advocate could be appointed to assist in the process, that would be great. I am listing Hope Enterprises in Williamsport, PA, because they, and their services were extremely helpful with parents like myself to navigate the red tape.	Thank you for your comment. These remarks are outside of the scope of the changes to the IFSP regulations. This comment will be documented for future discussion of support coordination.
Lana Ambler	Why was age of the parents removed from the criteria for the waiting lists? My husband and I are 80 years old . We have been on the waiting list for years. Our child was priority one , but was removed to priority 2. Virginia is an overly frugal state when it comes to helping people with disabilities. The legislature has never cared to spend any surplus on the disability community. The state each year seems to have generous rainy day funds that sit unused, some of which could be used for the waiver waiting list. Also, the state portions of the salaries that medicaid pays to workers in the agencies are woefully inadequate an should be raised.	Thank you for your comment. These remarks are outside of the scope of the changes to the IFSP regulations. This comment will be documented for future discussion of funding for the system.
Anonymous	VA - one of the wealthiest state, how long should people with disabilities wait to receive the basic services they need?	Thank you for your comment. These remarks are outside the scope of the changes to the IFSP regulations. This

	You understand the struggles these citizens are going through every day only if you have loved ones who live with disability or if you are the one who is living with it. Please please …this should be a priority for everyone!	comment will be documented for future discussion regarding funding for the service system.
Tamara Carter	The IFSP first come first serve rule is absolutely ridiculous. 1,000$ is a joke for parents who care for a child with disabilities. The Day Support services that my daughter needs cost $150.00 - $365.00 a day! Both my husband and I work, but nobody can afford to pay this much for summer breaks and this 1,000.00$ will pay for only 3 days of care if you can even get the funds! Last year we did not get anything. My husband and I are both basically nurses to our daughter. We are exhausted, there is no relief for caregivers unless the child has a DD waiver. It is a huge toll on our marriage, finances and mental health! Both my husband and I need to die or lose our sanity before my daughter can be awarded a DD waiver and receive the services that she desperately needs. In summer, she has nowhere to go. Regular summer camps where normal children socialize, make friends and live meaningful lives do not accept my daughter due to her extensive needs with daily activities. So she must stay at home and be depressed and isolated all summer. She aged out of regular daycare as well. So now my husband and I have to decide who will quit their job and stay home with my daughter. We have been on DD waiver waiting list for about 10 years, and I was just told by our case manager that there are homeless children and abused children who have priority and there is a very low chance that my daughter will get it. Are you serious?! Do I really need to become homeless or go insane and start abusing my child before she could get the services that she needs?! Virginia, you are a joke! Being disabled in Virginia or caring for a loved one with disability means that you don't deserve or have the right to be happy and live good, productive, and fulfilling life. Hit the rock bottom and	Thank you for your comment. These remarks are outside the scope of the changes to the IFSP regulations. This comment will be documented for future discussion regarding funding for the service system.

	even then there is no guarantee to get help! What a shame!	
Tamara Carter	Get rid of the IFSP funds for people on the DD waiver waiting list and give more DD waiver slots instead! The $500.00 - 1,000.00 per family is like a tear in the ocean! It is a very silly way of handling funds and money! The community with disabled children will benefit more from more waiver slots than these bandages that a state puts on a gushing wound! I am just absolutely disgusted by Virginia, do better for families with children with disabilities! A state this wealthy does not take care of their vulnerable citizens! Day support services for a child with disabilities cost $9,000-20,000 per summer. What am I going to do with $500.00!!! I cannot even get that much sometimes. We did not get anything last year.	Again, thank you for your taking the time to comment. These remarks are outside the scope of the changes to the IFSP regulations. This comment will be document for future discussion regarding funding for the service system.

Detail of Changes Made Since the Previous Stage

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

There are no changes since the previous stage.

Detail of All Changes Proposed in this Regulatory Action

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

Explanation: As mentioned in the proposed stage agency background document, information in the regulation was moved in the emergency regulation to a 'guidelines' document and referenced in the amended language for the emergency action. As part of the Code-mandated authority of the office, prior to publication as an emergency regulation, the Virginia Registrar acted to make a technical change of the Guidelines from a guidance document to a document incorporated by reference (DIBR). This requires that the guidelines be filed with the body of the regulation text. However, *because of the requirements for an annual review process, there is no way to annually review, and when needed update, a DIBR through regulatory action in such a tight timeframe.* Nothing about the process as adopted in the emergency regulation would change, but changes made in the proposed stage 'softening' the language to reference the award 'procedures' without naming the guidelines document allows the department to meet the

annual review requirements. The annual development process and public comment requirement is unchanged; drafts will be posted on the agency website and linked to a general notice on Town Hall with a public comment forum, and the final version will be published on the website and in a general notice when ready before the next funding cycle. **The Guidelines are now listed as a guidance document (DD07) and is unchanged from the DIBR attached to the emergency regulation. DD07 will be the vehicle moving forward and the DIBR will be removed.**

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
10		"Developmental disability" or "DD" means a severe, chronic disability of an individual that: 1. Is attributable to a mental or physical impairment or combination of mental and physical impairments; 2. Is manifested before the individual attains age 22; 3. Is likely to continue indefinitely; 4. Results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care; (ii) receptive and expressive language; (iii) learning; (iv) mobility; (v) self-direction; (vi) capacity for independent living; and (vii) economic self-sufficiency; and 5. Reflects the individual's need for a	New definitions are added for clarity: ▪ "Custodial family member" is added to make clear which family member is appropriate to apply, or assist an individual in applying, for funds. "Custodial family member" means a family member who has primary authority to make all major decisions affecting the individual and with whom the individual primarily resides. ▪ "Developmental disability" was updated in the Code of Virginia in 2015 (37.2-100). "Developmental disability" means a severe, chronic disability of an individual that : 1. Is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; 2. Is manifested before the individual reaches 22 years of age; 3. Is likely to continue indefinitely; 4. Results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction, (vi) capacity for independent living, or (vii) economic self-sufficiency; and 5. Reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may

		combination and sequence of special, interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. (42 USC § 15002)	be considered to have a developmental disability without meeting three or more of the criteria described in subdivisions 1 through 5 of this definition if the individual, without services and supports, has a high probability of meeting those criteria later in life.
		"Family member" means an immediate family member of an individual receiving services or the principal caregiver of that individual. A principal caregiver is a person who acts in the place of an immediate family member, including other relatives and foster care providers, but does not have a proprietary interest in the care of the individual receiving services. (§ 37.2-100 of the Code of Virginia)	(No change; showing for context with added term above, “custodial family member.”)
		"Individual and Family Support" means an array of individualized items and services that are intended	"Individual and Family Support Program" or "IFSP" means an array of individualized person-centered and family-centered resources, supports, items, services, and other assistance approved by the department that are intended to support the continued residence of individuals with developmental disabilities who are on the waiting list for a Medicaid Home and Community-Based Services Developmental Disability Waiver (“Medicaid HCBS DD Waiver”) in each individual's own home or the family home, which includes the home of the principal caregiver. ▪ This definition expands on the IFS definition using language from the Settlement Agreement to reflect current practice and to be in line with the Settlement Agreement: "Individual and Family Support Program State Council" or "IFSP State Council" means an advisory group of stakeholders selected by the department that shall provide consultation to the department on

		to support the continued residence of an individual with intellectual or developmental disabilities (ID/DD) in his own or the family home. "Intellectual disability" or "ID" means a disability, originating before the age of 18 years, characterized concurrently by (i) significantly subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean; and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. (§ 37.2-100 of the Code of Virginia)	creating a family support program intended to increase the resources and supports for individuals and families and promote community engagement and coordination. The IFSP State Council shall include individuals with DD and family members of individuals with DD. ▪ One definition is removed because it is not used in the regulation; the definition of 'developmental disability' was updated in the Code of Virginia in 2015 (37.2-100) (ID is a type of DD); and related, three of the existing home and community-based waivers were redesigned in 2021 combining the target populations of individuals with intellectual disabilities and other developmental disabilities. The phrase 'a Medicaid Home and Community-Based Services (HCBS) DD Waiver' is used to capture the correct waivers regardless of the specific title. ~~"Intellectual disability" or "ID" means a disability, originating before the age of 18 years, characterized concurrently by (i) significantly subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean; and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. (§ 37.2-100 of the Code of Virginia)~~
20			▪ References to intellectual disability are removed, language is streamlined and clarified to be in line with the Settlement Agreement, and the roles the

		A. The Individual and Family Support Program assists individuals with intellectual disability or developmental disabilities and their family members to access needed person-centered and family-centered resources, supports, services and other assistance as approved by the department. As such, Individual and Family Support Program funds shall be distributed directly to the requesting individual or family member or a third party designated by the individual or family member. B. The overall objective of the Individual and Family Support Program is to support the continued residence of an individual with intellectual or developmental disabilities in his own home or the family home, which include the home of a principal caregiver. C. Individual and Family Support Program funds shall not supplant or in any way limit the availability of services provided through a Medicaid Home and Community-Based Waiver, Early and Periodic Screening, Diagnosis and Treatment, or similar programs.	Council and the guidelines are inserted: A. The Individual and Family Support Program assists individuals with ~~intellectual disability or~~ developmental disabilities and their family members to access needed person-centered and family-centered resources, supports, services, and other assistance ~~as approved by the department. As such, Individual and Family Support Program funds shall be distributed directly to the requesting individual or family member or a third party designated by the individual or family member. B~~. The overall objective of the Individual and Family Support Program is to support the continued residence ~~an~~ individuals with ~~intellectual or~~ developmental disabilities in ~~his~~ each individual's own home or the family home, which ~~include~~ includes the home of a principal caregiver. B. The department shall administer the IFSP funding awards directly or through a third party designated by the department to administer all or part of the IFSP, based on annual funding priorities and program criteria developed by the department in consultation with the department's IFSP State Council. C. ~~Individual and Family Support Program~~ IFSP funds shall be distributed directly to the requesting individual or custodial family member or a third party designated by the individual or custodial family member. IFSP funds shall not supplant or in any way limit the availability of services provided through ~~a~~ Medicaid ~~Home and Community-Based Waiver, Early and Periodic Screening, Diagnosis and Treatment, or similar~~ programs.
30		(Repealed; replaced with Section 35.) ~~**Program eligibility requirements**~~ ~~Eligibility for Individual and Family Support Program funds shall be limited to individuals who are living in~~	

		~~their own or a family home and are on the statewide waiting list for the Intellectual Disability (ID) Medicaid Waiver or the Individual and Family Developmental Disabilities Support (IFDDS) Medicaid Waiver and family members who are assisting those individuals.~~	
31 (new)			▪ These new changes clarify the overall structure for the work of the department: **Community coordination.** The department shall: 1. Ensure an annual public input process that encourages the continued residence of individuals on the waiting list for a Medicaid HCBS DD Waiver in community settings and includes a survey of needs and satisfaction. 2. Establish the IFSP State Council. 3. Develop, in coordination with the IFSP State Council, a strategic plan that is consistent with these regulations and the purpose of the IFSP and that is updated as necessary as determined by the department. 4. Provide technical assistance to individuals or family members to facilitate their access to covered services and supports listed in 12VAC35-230-55, that are intended to enhance or improve the individuals' or family members' quality of life and promote the independence and continued residence of an individual with DD in that individual's own home or the family home, which includes the home of a principal caregiver.
35 (new)		(Previously Section 30.)	▪ Replaces Section 30. Language moved from 30 now 35 A; new clarifying language regarding public input and the generic reference to Waivers (see above); puts the regulation in line with the Settlement Agreement; the roles of the Council and the annual review process are inserted. (Note in the project, all language shows as entirely new due to formatting requirements; existing language is shown in this table.)

			Program eligibility requirements and policies. A. Eligibility for IFSP funds shall be limited to individuals who are living in their own home or a family home and are on the statewide waiting list for a Medicaid HCBS DD Waiver and their custodial family members who are assisting those individuals. B. The department, based on information gathered through public input and in consultation with the IFSP State Council, shall annually establish eligibility criteria, the award process, the appeals process, and any other protocols necessary for ensuring the effective use of state funds. All procedures used by the department for determining funding awards shall be published annually in draft form for public comment and in final form prior to opening the funding opportunity. C. For each funding period, the department shall base funding awards on the following published information: 1. Criteria for prioritized funding categories; 2. A summary of allowable expenditures; 3. Application deadlines; and 4. Award notification schedules. D. All procedures used by the department for funding awards shall be reviewed annually.
40		(Repealed; replaced with Section 45.) ~~**Program implementation.**~~ ~~A. Individual and Family Support Program funds shall be limited by the amount of funds allocated to the program by the General Assembly. Department approval of funding requests shall not exceed the funding available for the fiscal year.~~ ~~B. Based on funding availability, the department shall establish an annual individual financial support limit, which is the maximum annual amount of funding that can be provided to support an eligible~~	

		~~individual during the applicable fiscal year.~~ ~~C. Individual and Family Support Program funds may be provided to individuals or family members in varying amounts, as requested and approved by the department, up to the established annual individual financial support limit.~~ ~~D. On an annual basis, the department shall announce Individual and Family Support Program total funding availability and the annual individual financial support limit for the applicable fiscal year. This announcement shall include a summary of covered services, the application, and the application review criteria.~~ ~~E. Individuals and family members may submit applications for Individual and Family Support Program funding as needs arise throughout the year. Applications shall be considered by the department on a first-come, first-served basis until the annual allocation appropriated to the program by the General Assembly for the applicable fiscal year has been expended.~~ ~~F. Individuals and their family members may apply for Individual and Family Support Program funding each year and may submit more than one application in a single year; however, the total amount approved during the year shall not exceed the annual individual financial support limit.~~	
45 (new)		(Previously Section 40.)	▪ *Replaces from Section 40. Changes emphasize the public input process, remove the funding

			limit and 'first come first served' structure, insert the focus on prioritized funding categories as established in the annual awards procedures, and move any other information in deleted text to be addressed elsewhere in the revised regulation or shall be addressed in the procedures. (Note in the project, all language shows as entirely new due to formatting requirements; existing language is shown in this table.) A. ~~Individual and Family Support Program~~ IFSP funds shall be limited by the amount of funds allocated to the IFSP by the General Assembly. The ~~D~~department approval of funding requests shall not exceed the funding available for the fiscal year. Based on information gathered through relevant data and public input, and in collaboration with the IFSP State Council, the department shall establish annual funding categories. B. ~~Based on funding availability, the department shall establish an annual individual financial support limit, which is the maximum annual amount of funding that can be provided to support an eligible individual during the applicable fiscal year.~~ ~~C~~. ~~Individual and Family Support Program~~ IFSP funds may be provided to individuals or custodial family members in varying amounts, as ~~requested and approved~~ determined by the department's annually prioritized funding categories~~, up to the established annual individual financial support limit~~. ~~D. On an annual basis, the department shall announce Individual and Family Support Program total funding availability and the annual individual financial support limit for the applicable fiscal year. This announcement shall include a summary of covered services, the application, and the application review criteria.~~ ~~E. Individuals and family members may submit applications for Individual and Family Support Program funding as needs arise throughout the year. Applications shall be considered by the department on a first-come, first-served~~

			~~basis until the annual allocation appropriated to the program by the General Assembly for the applicable fiscal year has been expended.~~ ~~F. Individuals and their family members may apply for Individual and Family Support Program funding each year and may submit more than one application in a single year; however, the total amount approved during the year shall not exceed the annual individual financial support limit.~~
50		(Repealed; replaced with Section 55.) ~~**Covered services and supports.**~~ ~~Services and items funded through the Individual and Family Support Program are intended to support the continued residence of an individual in his own or the family home and may include:~~ ~~1. Professionally provided services and supports, such as respite, transportation services, behavioral consultation, and behavior management;~~ ~~2. Assistive technology and home modifications, goods, or products that directly support the individual;~~ ~~3. Temporary rental assistance or deposits;~~ ~~4. Fees for summer camp and other recreation services;~~ ~~5. Temporary assistance with utilities or deposits;~~ ~~6. Dental or medical expenses of the individual;~~ ~~7. Family education, information, and training;~~ ~~8. Peer mentoring and family-to-family supports;~~ ~~9. Emergency assistance and crisis support; or~~ ~~10. Other direct support services as approved by the department.~~	
55 (new)		(Previously Section 50.)	▪ Replaces Section 50; removes language and instead focuses on the three categories of covered services and points to the annual

			awards process and procedures for any list of fundable services and items. Services and items funded through the ~~Individual and Family Support Program~~ IFSP as published annually in accordance with this chapter, are intended to support the continued residence of an individual in ~~his~~ that individual's own or the family home and may ~~include~~ be approved in the following three main categories: (i) safe community living, (ii) improved health outcomes, and (iii) community integration~~:~~ ~~1. Professionally provided services and supports, such as respite, transportation services, behavioral consultation, and behavior management;~~ ~~2. Assistive technology and home modifications, goods, or products that directly support the individual;~~ ~~3. Temporary rental assistance or deposits;~~ ~~4. Fees for summer camp and other recreation services;~~ ~~5. Temporary assistance with utilities or deposits;~~ ~~6. Dental or medical expenses of the individual;~~ ~~7. Family education, information, and training;~~ ~~8. Peer mentoring and family-to-family supports;~~ ~~9. Emergency assistance and crisis support; or~~ ~~10. Other direct support services as approved by the department~~. No services or items shall be funded by the IFSP if not listed in the department's procedures or if covered by another entity.
60		(Repealed; replaced with Section 65.) ~~**Application for funding.**~~ ~~A. Eligible individuals or family members who choose to apply for Individual and Family Support Program funds shall submit a completed application to the department.~~	

		~~B. Completed applications shall include the following information:~~ ~~1. A detailed description of the services or items for which funding is requested;~~ ~~2. Documentation that the requested services or items are needed to support the continued residence of the individual with ID/DD in his own or the family home and no other public funding sources are available;~~ ~~3. The requested funding amount and frequency of payment; and~~ ~~4. A statement in which the individual or family member:~~ ~~a. Agrees to provide the department with documentation to establish that the requested funds were used to purchase only approved services or items; and~~ ~~b. Acknowledges that failure to provide documentation that the requested funds were used to purchase only approved services or items may result in recovery of such funds and denial of subsequent funding requests.~~ ~~C. The application shall be signed by the individual or family member requesting the funding.~~	
65 (new)		(Previously Section 60.)	▪ Replaces Section 60; removes the requirement to submit receipts but requires that any such documentation be available on request; changes the information about need to an attestation rather than more formal documentation (the only requirement is if the individual is on the waiting list); adds “custodial” where appropriate before “family member.” (Note in the project, all language shows as entirely new due to formatting requirements; existing language is shown in this table.) A. Eligible individuals or <u>custodial</u> family members who choose to apply

			for ~~Individual and Family Support Program~~ IFSP funds shall submit a completed application to the department. B. Completed applications shall include the following information: 1. A ~~detailed~~ description of the services or items for which funding is requested; 2. ~~Documentation~~ Acknowledgment that the requested services or items are needed to support the continued residence of the individual with ~~ID/~~DD in ~~his~~ that individual's own home or the family home and no other public funding sources are available; 3. The requested funding amount ~~and frequency of payment~~; and 4. A statement in which the individual or custodial family member: a. Agrees to provide to the department, if requested, ~~with~~ documentation ~~to establish~~ that the requested funds were used to purchase only ~~approved~~ services or items described in the application and approved by the department; and b. Acknowledges that failure to provide documentation, when requested, that the ~~requested~~ funds applied for were used to purchase only ~~approved~~ services or items described in the application and approved by the department may result in recovery of such funds and denial of subsequent funding requests. C. The application shall be signed by the individual or custodial family member requesting the funding.
70		(Repealed; replace with Section 75.) ~~**Application review criteria.**~~ ~~Upon receipt of a completed application, the department shall:~~ ~~1. Verify that the individual is on the statewide ID or IFDDS Medicaid Waiver waiting list;~~ ~~2. Confirm that the services or items for which funding is requested are eligible for funding in accordance with 12VAC35-230-50;.~~	

		~~3. Determine that the services or items for which funding is requested are needed to support the continued residence of the individual with ID/DD in his own or the family home;~~ ~~4. Determine that other public funding sources have been fully explored and utilized and are not available to purchase or provide the requested services or items;~~ ~~5. Evaluate the cost of the requested services or items; and~~ ~~6. Consider past performance of the individual and family members regarding compliance with this chapter.~~	
75 (new)		(Previously Section 70.)	▪ Replaces Section 70; removes unnecessary language regarding the application process and review as such detail will be included in the annual funding process, and updated for the new process; requires the department to produce two reports, one of basic data and information post-funding season, and one on a summary of accomplishments towards meeting stated goals. (Note in the project, all language shows as entirely new due to formatting requirements; existing language is shown in this table.) ~~Application Review Criteria~~ Reporting. ~~Upon receipt of a completed application, the department shall:~~ ~~1. Verify that the individual is on the statewide ID or IFDDS Medicaid Waiver waiting list;~~

			~~2. Confirm that the services or items for which funding is requested are eligible for funding in accordance with 12VAC35-230-50;~~ ~~3. Determine that the services or items for which funding is requested are needed to support the continued residence of the individual with ID/DD in his own or the family home;~~ ~~4. Determine that other public funding sources have been fully explored and utilized and are not available to purchase or provide the requested services or items;~~ ~~5. Evaluate the cost of the requested services or items; and~~ ~~6. Consider past performance of the individual and family members regarding compliance with this chapter.~~ A. For each funding period, the department shall develop and publish a summary that details the total dollar amount of funded awards, a summary of expenditure requests, the number of applications received, and the number of applications and individuals approved for receipt of IFSP funds. B. The department, with input from the IFSP State Council, shall develop an annual summary of accomplishments toward meeting the goals of the Virginia State Plan to Increase Individual and Family Supports.
80		(Repealed; replaced with Section 85.) **~~Funding decision-making process.~~** ~~A. Applications may be approved at a reduced amount when the amount requested exceeds a reasonable amount as determined by department staff as being necessary to purchase the services or items.~~ ~~B. Applications shall be denied if the department determines that:~~ ~~1. The service or item for which funding is requested is not eligible for funding in accordance with 12VAC35-230-50;~~	

		~~2. The request exceeds the maximum annual individual financial support limit for the applicable fiscal year;~~ ~~3. Other viable public funding sources have not been fully explored or utilized;~~ ~~4. The requesting individual or family member has not used previously received Individual and Family Support Program funds in accordance with the department's written notice approving the request or has failed to comply with these regulations; or~~ ~~5. The total annual Individual and Family Support Program funding appropriated by the General Assembly has been expended for the applicable fiscal year.~~ ~~C. The department shall provide a written notice to the individual or family member who submitted the application indicating the funding decision.~~ ~~1. Approval notices shall include:~~ ~~a. The services, supports, or other items for which funding is approved;~~ ~~b. The amount and time frame of the financial allocation;~~ ~~c. The expected date that the funds should be released; and~~ ~~d. Financial expenditure documentation requirements, and the date or dates by which this documentation shall be provided to the department.~~ ~~2. For applications where funding is denied or approved at a reduced amount, the department's notice shall state the reason or reasons why the requested services, supports, or other items~~	

		~~were denied or were approved at a reduced amount and the process for requesting the department to reconsider its funding decision.~~	
85 (new)		(Previously Section 80.)	▪ Replaces Section 80; streamlined language. (Note in the project, all language shows as entirely new due to formatting requirements; existing language is shown in this table.) A. ~~Applications may be approved at a reduced amount when the amount requested exceeds a reasonable amount as determined by department staff as being necessary to purchase the services or items.~~ ~~B.~~ Applications shall be denied if the department determines that~~:~~ ~~1. The~~ the service or item for which funding is requested is not eligible for funding in accordance with 12VAC35-230-~~50~~ 65, other public funding sources are available, or the total annual IFSP funding appropriated by the General Assembly has been expended for the applicable fiscal year~~;~~. ~~2. The request exceeds the maximum annual individual financial support limit for the applicable fiscal year;~~ ~~3. Other viable public funding sources have not been fully explored or utilized;~~ ~~4. The~~ B. Additionally, applications for IFSP funds may be denied if the requesting individual or custodial family member has not used previously received ~~Individual and Family Support~~ Program funds in accordance with the department's written notice approving the request or has failed to comply with these regulations~~; or~~. ~~5.~~ B. ~~The total annual Individual and Family Support Program~~ IFSP ~~funding appropriated by the General Assembly has been expended for the applicable fiscal year.~~ C. The department shall provide a written notice to the individual or custodial family member who submitted the application indicating the funding decision, including the reason for denial of funding, if applicable. ~~1. Approval notices shall include:~~

			~~a. The services, supports, or other items for which funding is approved;~~ ~~b. The amount and time frame of the financial allocation;~~ ~~c. The expected date that the funds should be released; and~~ ~~d. Financial expenditure documentation requirements, and the date or dates by which this documentation shall be provided to the department.~~ ~~2. For applications where funding is denied or approved at a reduced amount, the department's notice shall state the reason or reasons why the requested services, supports, or other items were denied or were approved at a reduced amount and the process for requesting the department to reconsider its funding decision.~~
90			▪ One word addition to specify "custodial" family members as those to be involved with the application process. Other clarifying use of the term 'commissioner.' A. Individuals or custodial family members who disagree with the determination of the department may submit a written request for reconsideration to the commissioner, or his the commissioner's designee, within 30 days of the date of the written notice of denial or approval at a reduced amount. B. The commissioner, or ~~his~~ the commissioner's designee, shall provide an opportunity for the person requesting reconsideration to submit for review any additional information or reasons why the funding should be approved as originally requested. C. The commissioner, or his the commissioner's designee, after reviewing all submitted materials shall render a written decision on the request for reconsideration within 30 calendar days of the receipt of the request and shall notify all involved parties in writing. The ~~commissioner's~~ decision shall be binding.
100			▪ Amendments point to the annual funding procedures for specification on how funds may be spent; changes documentation to 'if requested' as in another section;

		D. Failure to use funds in accordance with the department's written notice or provide documentation that the funds were used to purchase only approved services or items may result in recovery of such by the department.	and also, points to the applicant's description of services in order to simplify the review process. D. Failure to use funds in accordance with the department's ~~written notice IFSP~~ procedures for funding awards or provide documentation, if requested, that the funds were used to purchase only ~~approved~~ services or items as described in the application and approved by the department may result in recovery of such by the department.
110		Funding through the Individual and Family Support Program shall be terminated when the individual is enrolled in the ID or IFDDS Medicaid Waiver or if approved funds are used for purposes not approved by the department in its written notice. Any funds approved, but not released, will be forfeited in such circumstances.	▪ Clarifying edits. Funding through the ~~Individual and Family Support Program~~ IFSP shall be terminated when the individual is enrolled in ~~the~~ a ~~ID or IFDDS~~ Medicaid HCBS DD Waiver, if the individual is found to be no longer eligible to be on a waiting list for a Medicaid HCBS DD Waiver in accordance with 12VAC30-122-90 and any appeal has been exhausted, or if approved funds are used for purposes not approved by the department in its written notice. In such circumstance, ~~Any~~ any funds approved, but not yet released~~, will be forfeited in such circumstances~~ shall not be disbursed .

I. Initiation of Final Stage.

Department of Behavioral Health And Developmental Services
:Amendments to establish criteria and annual funding priorities and ensure public input

Operation of the Individual and Family Support Program
Chapter 230

12VAC35-230-10 Definitions

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

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

"Custodial family member" means a family member who has primary authority to make all major decisions affecting the individual and with whom the individual primarily resides.

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

"Developmental disability" or "DD" means a severe, chronic disability of an individual that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments, other than a sole diagnosis of mental illness;

2. Is manifested before the individual ~~attains age~~ reaches 22 years of age;

3. Is likely to continue indefinitely;

4. Results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care; (ii) receptive and expressive language; (iii) learning; (iv) mobility; (v) self-direction; (vi) capacity for independent living; ~~and~~ or (vii) economic self-sufficiency; and

5. Reflects the individual's need for a combination and sequence of special, interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. ~~(42 USC § 15002)~~

An individual from birth to age nine years, 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 subdivisions 1 through 5 of this definition if the individual, without services and supports, has a high probability of meeting those criteria later in life.

"Family member" means an immediate family member of an individual receiving services or the principal caregiver of that individual. A principal caregiver is a person who acts in the place of an immediate family member, including other relatives and

foster care providers, but does not have a proprietary interest in the care of the individual receiving services. (§ 37.2-100 of the Code of Virginia)

~~"Individual and Family Support" means an array of individualized items and services that are intended to support the continued residence of an individual with intellectual or developmental disabilities (ID/DD) in his own or the family home.~~

~~"Intellectual disability" or "ID" means a disability, originating before the age of 18 years, characterized concurrently by (i) significantly subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean; and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. (§ 37.2-100 of the Code of Virginia)~~

"Individual and Family Support Program" or "IFSP" means an array of individualized person-centered and family-centered resources, supports, items, services, and other assistance approved by the department that are intended to support the continued residence of individuals with developmental disabilities who are on the waiting list for a Medicaid Home and Community-Based Services Developmental Disability Waiver in each individual's own home or the family home, which includes the home of the principal caregiver.

"Individual and Family Support Program State Council" or "IFSP State Council" means an advisory group of stakeholders selected by the department that shall provide consultation to the department on creating a family support program intended to increase the resources and supports for individuals and families and promote community engagement and coordination. The IFSP State Council shall include individuals with DD and family members of individuals with DD.

"Medicaid HCBS DD Waiver" means a Medicaid Home and Community-Based Services Developmental Disability Waiver.

12VAC35-230-20 Program description

A. The Individual and Family Support Program assists individuals with ~~intellectual disability or~~ developmental disabilities and their family members to access needed person-centered and family-centered resources, supports, services, and other assistance ~~as approved by the department. As such, Individual and Family Support Program funds shall be distributed directly to the requesting individual or family member or a third party designated by the individual or family member~~. ~~B.~~ The overall objective of the Individual and Family Support Program is to support the continued residence of ~~an individual~~ individuals with ~~intellectual or~~ developmental disabilities in ~~his~~ each individual's own home or the family home, which ~~include~~ includes the home of a principal caregiver.

B. The department shall administer the IFSP funding awards directly or through a third party designated by the department to administer all or part of the IFSP, based on annual funding priorities and program criteria developed by the department in consultation with the department's IFSP State Council.

C. ~~Individual and Family Support Program~~ IFSP funds shall be distributed directly to the requesting individual or custodial family member or a third party designated by the individual or custodial family member. IFSP funds shall not supplant or in any way limit the availability of services provided through ~~a~~ Medicaid ~~Home and Community-Based Waiver; Early and Periodic Screening, Diagnosis, and Treatment; or similar~~ programs.

12VAC35-230-30 ~~Program eligibility requirements.~~ (Repealed.)

~~Eligibility for Individual and Family Support Program funds shall be limited to individuals who are living in their own or a family home and are on the statewide waiting list for the Intellectual Disability (ID) Medicaid Waiver or the Individual and Family Developmental Disabilities Support (IFDDS) Medicaid Waiver and family members who are assisting those individuals.~~

12VAC35-230-31 Community coordination

The department shall:

1. Ensure an annual public input process that encourages the continued residence of individuals on the waiting list for a Medicaid HCBS DD Waiver in community settings and includes a survey of needs and satisfaction.

2. Establish the IFSP State Council.

3. Develop, in coordination with the IFSP State Council, a strategic plan that is consistent with this chapter and the purpose of the IFSP and that is updated as necessary as determined by the department.

4. Provide technical assistance to individuals or family members to facilitate an individual's or a family member's access to covered services and supports listed in 12VAC35-230-55 that are intended to enhance or improve the individual's or family member's quality of life and promote the independence and continued residence of an individual with DD in the individual's own home or the family home, which includes the home of a principal caregiver.

12VAC35-230-35 Program eligibility requirements and policies

A. Eligibility for IFSP funds shall be limited to individuals who are living in their own home or a family home and are on the statewide waiting list for a Medicaid HCBS DD Waiver and their custodial family members who are assisting those individuals.

B. The department, based on information gathered through public input and in consultation with the IFSP State Council, shall annually establish eligibility criteria, the award process, the appeals process, and any other protocols necessary for ensuring the effective use of state funds. All procedures used by the department for determining funding awards shall be published annually in draft form for public comment and in final form prior to opening the funding opportunity using the Virginia Regulatory Town Hall and the Virginia Register of Regulations.

C. For each funding period, the department shall base funding awards on the following published information:

1. Criteria for prioritized funding categories;

2. A summary of allowable expenditures;

3. Application deadlines; and

4. Award notification schedules.

D. All procedures used by the department for funding awards shall be reviewed annually.

12VAC35-230-40 ~~Program implementation.~~ (Repealed.)

~~A. Individual and Family Support Program funds shall be limited by the amount of funds allocated to the program by the General Assembly. Department approval of funding requests shall not exceed the funding available for the fiscal year.~~

~~B. Based on funding availability, the department shall establish an annual individual financial support limit, which is the maximum annual amount of funding that can be provided to support an eligible individual during the applicable fiscal year.~~

~~C. Individual and Family Support Program funds may be provided to individuals or family members in varying amounts, as requested and approved by the department, up to the established annual individual financial support limit.~~

~~D. On an annual basis, the department shall announce Individual and Family Support Program total funding availability and the annual individual financial support limit for the applicable fiscal year. This announcement shall include a summary of covered services, the application, and the application review criteria.~~

~~E. Individuals and family members may submit applications for Individual and Family Support Program funding as needs arise throughout the year. Applications shall be considered by the department on a first-come, first-served basis until the annual allocation appropriated to the program by the General Assembly for the applicable fiscal year has been expended.~~

~~F. Individuals and their family members may apply for Individual and Family Support Program funding each year and may submit more than one application in a single year; however, the total amount approved during the year shall not exceed the annual individual financial support limit.~~

12VAC35-230-45 Program implementation

A. IFSP funds shall be limited by the amount of funds allocated to the IFSP by the General Assembly. The department approval of funding requests shall not exceed the funding available for the fiscal year. Based on information gathered through relevant data and public input, and in collaboration with the IFSP State Council, the department shall establish annual funding categories.

B. IFSP funds may be provided to individuals or custodial family members in varying amounts, as determined by the department's annually prioritized funding categories.

12VAC35-230-50 ~~Covered services and supports.~~ (Repealed.)

~~Services and items funded through the Individual and Family Support Program are intended to support the continued residence of an individual in his own or the family home and may include:~~

~~1. Professionally provided services and supports, such as respite, transportation services, behavioral consultation, and behavior management;~~

~~2. Assistive technology and home modifications, goods, or products that directly support the individual;~~

~~3. Temporary rental assistance or deposits;~~

~~4. Fees for summer camp and other recreation services;~~

~~5. Temporary assistance with utilities or deposits;~~

~~6. Dental or medical expenses of the individual;~~

~~7. Family education, information, and training;~~

~~8. Peer mentoring and family-to-family supports;~~

~~9. Emergency assistance and crisis support; or~~

~~10. Other direct support services as approved by the department.~~

12VAC35-230-55 Covered services and supports

Services and items funded through the IFSP, as published annually, using the Virginia Regulatory Town Hall and the Virginia Register of Regulations, in accordance with this chapter, are intended to support the continued residence of an individual in that individual's own home or the family home and may be approved in the following three main categories: (i) safe community living, (ii) improved health outcomes, and (iii) community integration. No services or items shall be funded by the IFSP if not listed in the department's procedures or if covered by another entity.

12VAC35-230-60 ~~Application for funding.~~ (Repealed.)

~~A. Eligible individuals or family members who choose to apply for Individual and Family Support Program funds shall submit a completed application to the department.~~

~~B. Completed applications shall include the following information:~~

~~1. A detailed description of the services or items for which funding is requested;~~

~~2. Documentation that the requested services or items are needed to support the continued residence of the individual with ID/DD in his own or the family home and no other public funding sources are available;~~

~~3. The requested funding amount and frequency of payment; and~~

~~4. A statement in which the individual or family member:~~

~~a. Agrees to provide the department with documentation to establish that the requested funds were used to purchase only approved services or items; and~~

~~b. Acknowledges that failure to provide documentation that the requested funds were used to purchase only approved services or items may result in recovery of such funds and denial of subsequent funding requests.~~

~~C. The application shall be signed by the individual or family member requesting the funding.~~

12VAC35-230-65 Application for funding

A. Eligible individuals or custodial family members who choose to apply for IFSP funds shall submit a completed application to the department.

B. Completed applications shall include the following information:

1. A description of the services or items for which funding is requested;

2. Acknowledgment that the requested services or items are needed to support the continued residence of the individual with DD in that individual's own home or the family home and no other public funding sources are available;

3. The requested funding amount; and

4. A statement in which the individual or custodial family member:

a. Agrees to provide to the department, if requested, documentation that the requested funds were used to purchase only services or items described in the application and approved by the department; and

b. Acknowledges that failure to provide documentation, when requested, that the funds applied for were used to purchase only services or items described in the application and approved by the department may result in recovery of such funds and denial of subsequent funding requests.

C. The application shall be signed by the individual or custodial family member requesting the funding.

12VAC35-230-70 ~~Application review criteria.~~ (Repealed.)

~~Upon receipt of a completed application, the department shall:~~

~~1. Verify that the individual is on the statewide ID or IFDDS Medicaid Waiver waiting list;~~

~~2. Confirm that the services or items for which funding is requested are eligible for funding in accordance with 12VAC35-230-50;~~

~~3. Determine that the services or items for which funding is requested are needed to support the continued residence of the individual with ID/DD in his own or the family home;~~

~~4. Determine that other public funding sources have been fully explored and utilized and are not available to purchase or provide the requested services or items;~~

~~5. Evaluate the cost of the requested services or items; and~~

~~6. Consider past performance of the individual and family members regarding compliance with this chapter.~~

12VAC35-230-75 Reporting

A. For each funding period, the department shall develop and publish a summary, using the Virginia Regulatory Town Hall and the Virginia Register of Regulations, that details the total dollar amount of funded awards, a summary of expenditure requests, the number of applications received, and the number of applications and individuals approved for receipt of IFSP funds.

B. The department, with input from the IFSP State Council, shall develop an annual summary of accomplishments toward meeting the goals of the Virginia State Plan to Increase Individual and Family Supports.

12VAC35-230-80 ~~Funding decision-making process.~~ (Repealed.)

~~A. Applications may be approved at a reduced amount when the amount requested exceeds a reasonable amount as determined by department staff as being necessary to purchase the services or items.~~

~~B. Applications shall be denied if the department determines that:~~

~~1. The service or item for which funding is requested is not eligible for funding in accordance with 12VAC35-230-50;~~

~~2. The request exceeds the maximum annual individual financial support limit for the applicable fiscal year;~~

~~3. Other viable public funding sources have not been fully explored or utilized;~~

~~4. The requesting individual or family member has not used previously received Individual and Family Support Program funds in accordance with the department's written notice approving the request or has failed to comply with these regulations; or~~

~~5. The total annual Individual and Family Support Program funding appropriated by the General Assembly has been expended for the applicable fiscal year.~~

~~C. The department shall provide a written notice to the individual or family member who submitted the application indicating the funding decision.~~

~~1. Approval notices shall include:~~

~~a. The services, supports, or other items for which funding is approved;~~

~~b. The amount and time frame of the financial allocation;~~

~~c. The expected date that the funds should be released; and~~

~~d. Financial expenditure documentation requirements, and the date or dates by which this documentation shall be provided to the department.~~

~~2. For applications where funding is denied or approved at a reduced amount, the department's notice shall state the reason or reasons why the requested services, supports, or other items were denied or were approved at a reduced amount and the process for requesting the department to reconsider its funding decision.~~

12VAC35-230-85 Funding decision-making process

A. Applications shall be denied if the department determines that the service or item for which funding is requested is not eligible for funding in accordance with 12VAC35-230-55, other public funding sources are available, or the total annual IFSP funding appropriated by the General Assembly has been expended for the applicable fiscal year.

B. Additionally, applications for IFSP funds may be denied if the requesting individual or custodial family member has not used previously received IFSP funds in accordance with the department's written notice approving the request or has failed to comply with this chapter.

C. The department shall provide a written notice to the individual or custodial family member who submitted the application indicating the funding decision, including the reason for denial of funding, if applicable.

12VAC35-230-90 Requests for reconsideration

A. Individuals or custodial family members who disagree with the determination of the department may submit a written request for reconsideration to the commissioner~~,~~ or ~~his~~ the commissioner's designee~~,~~ within 30 days of the date of the written notice of denial or approval at a reduced amount.

B. The commissioner~~,~~ or ~~his~~ the commissioner's designee~~,~~ shall provide an opportunity for the person requesting reconsideration to submit for review any additional information or reasons why the funding should be approved as originally requested.

C. The commissioner~~,~~ or ~~his~~ the commissioner's designee, after reviewing all submitted materials shall render a written decision on the request for reconsideration within 30 calendar days of the receipt of the request and shall notify all involved parties in writing. The ~~commissioner's~~ decision shall be binding.

D. Applicants may obtain further review of the decision in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

12VAC35-230-100 Post-funding review

A. Utilization review of documentation or verification of funds expended may be undertaken by department staff. Reviews may include home visits to view items purchased or services delivered.

B. Individuals and family members receiving ~~Individual and Family Support Program~~ IFSP funds shall permit the department representatives to conduct utilization reviews, including home visits.

C. Individuals and family members receiving ~~Individual and Family Support Program~~ IFSP funds shall fully cooperate with such reviews and provide all information requested by the department.

D. Failure to use funds in accordance with the ~~department's written notice~~ procedures for funding awards or provide documentation, if requested, that the funds were used to purchase only approved services or items as described in the application and approved by the department may result in recovery of such by the department.

12VAC35-230-110 Termination of funding for services, supports, or other assistance

Funding through the ~~Individual and Family Support Program~~ IFSP shall be terminated when the individual is enrolled in ~~the ID or IFDDS~~ a Medicaid HCBS DD Waiver if the individual is found to be no longer eligible to be on a waiting list for a Medicaid HCBS DD Waiver in accordance with 12VAC30-122-90 and any appeal has been exhausted, or if approved funds are used for purposes not approved by the department in its written notice. ~~Any~~ In such circumstance, any funds approved~~,~~ but not yet released~~, will be forfeited in such circumstances~~ shall not be disbursed .

12VAC35-230-9998 FORMS (12VAC35-230)

Individual and Family Support Program Funding Application online application available at the Virginia Waiver Management System (WaMS) Portal at https://www.dbhds.virginia.gov/waitlistforms

townhall.virginia.gov

Exempt Action: Final Regulation
Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services
Virginia Administrative Code (VAC) Chapter citation(s)	▪ 12 VAC35-105 ▪ 12 VAC35-115
VAC Chapter title(s)	▪ Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services ▪ Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services
Action title	Amendments to ensure that licensing and human rights regulations support high-quality mental health services.
Final agency action date	May 14, 2024
Date this document prepared	May 10, 2024

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.

The 2024 Session of the General Assembly directed the State Board of Behavioral Health and Developmental Services to amend its regulations to ensure they support high-quality crisis services. Crisis services are unique among the services that Department of Behavioral Health and Developmental Services (DBHDS) licenses due to their acute nature. The current Licensing Regulations do not make the necessary distinctions to best serve individuals experiencing crisis or ensure providers have the tools

they need to best implement their crisis services. These amendments create a new section VIII of the Licensing Regulations named Crisis Services tailored to crisis receiving centers, community-based crisis stabilization, crisis stabilizations units, and REACH providers ("REACH" is an acronym for (regional/education/assessment/crisis services/habitation). Most of the provisions included in the action were developed over the course of a year in a part of DBHDS' overall regulatory overhaul efforts and were carefully vetted by both internal subject matter experts as well as providers as part of a regulatory advisory panel convened for that larger effort. Regulatory advisory panel meetings were held in the summer of 2023 on June 20th, June 27th, and July 11th, and draft language was included in a general notice with a public comment forum that ended on March 14, 2024. Additional clarifying provisions were developed to specifically address the most recent General Assembly mandate.

This exempt action amends regulations two regulatory chapters to ensure regulatory support of high-quality mental health services and that the regulations align with the changes being made to the Medicaid behavioral health regulations for services funded in this Act in support of the Governor's Right Help, Right Now Behavioral Health Transformation Plan. See the attached addendum explanatory table by section.

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 2024 Session of the General Assembly passed SB569, which requires the State Board of Behavioral health and Developmental Services to amend its licensing and human rights regulations to support high-quality crisis services in crisis receiving centers and crisis stabilization units. The legislation specifically authorizes the appropriate and safe use of seclusion in crisis receiving centers and crisis stabilizations units. The legislation further states that the initial adoption of these regulatory amendments shall be exempt from the Administrative Process Act (APA) to allow for a faster adoption process.

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.

Section 37.2-203 of the Code of Virginia authorizes the State Board of Behavioral Health and Developmental Services to adopt regulations that may be necessary to carry out the provisions of Title 37.2 and other laws of the Commonwealth administered by the commissioner and the department. At its meeting on May 14, 2024, the State Board voted to initiate this exempt action to amend two chapters:

1. Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services ("Licensing Regulations") [12VAC35-105]; and
2. Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services ("Human Rights Regulations") [12VAC35-115].

NOTE: An explanatory chart of changes is included following the draft amendments on page 122. A copy of SB569 is on page 130.

II. Crisis Final Exempt.

Department of Behavioral Health And Developmental Services

Amendments to ensure that licensing and human rights regulations support high-quality mental health services.

Chapter 105

Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services

Part II

Licensing Process

Article 2

Definitions

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 , as defined by § 37.2-100 of the Code of Virginia, any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Virginia Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse. Examples of abuse include acts such as:

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

2. Assault or battery;

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

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

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

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

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

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

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

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

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

"ASAM" means the American Society of Addiction Medicine.

"Assertive community treatment service" or "ACT" means a self-contained interdisciplinary community-based team of medical, behavioral health, and rehabilitation professionals who use a team approach to meet the needs of an individual with severe and persistent mental illness. ACT teams:

1. Provide person-centered services addressing the breadth of an individual's needs, helping him achieve his personal goals;

2. Serve as the primary provider of all the services that an individual receiving ACT services needs;

3. Maintain a high frequency and intensity of community-based contacts;

4. Maintain a very low individual-to-staff ratio;

5. Offer varying levels of care for all individuals receiving ACT services and appropriately adjust service levels according to each individual's needs over time;

6. Assist individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles, such as worker, family member, resident, spouse, tenant, or friend;

7. Carry out planned assertive engagement techniques, including rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques;

8. Monitor the individual's mental status and provide needed supports in a manner consistent with the individual's level of need and functioning;

9. Deliver all services according to a recovery-based philosophy of care; and

10. Promote self-determination, respect for the individual receiving ACT as an individual in such individual's own right, and engage peers in promoting recovery and regaining meaningful roles and relationships in the community.

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

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

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

1. Improved behavioral functioning and effectiveness;

2. Alleviation of symptoms of psychopathology; or

3. Reduction of challenging behaviors.

"Board" or "State Board" means, as defined by § 37.2-100 of the Code of Virginia, 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.

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

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

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

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

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

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

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

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

"Community-based crisis stabilization" means services that are short-term and designed to support an individual and his natural support system following contact with an initial crisis response service or as a diversion to a higher level of care. Providers deliver community-based crisis stabilization services in an individual’s natural environment and provide referrals and linkage to other community-based services at the appropriate level of care. Interventions may include brief therapeutic and skill-building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services. Coordination of specialized services to address the needs of co-occurring developmental disabilities and substance use disorders are also available through this service. Services include advocacy and networking to provide linkages and referrals to appropriate community-based services and assist the individual and his family or caregiver in accessing other benefits or assistance programs for which he may be

eligible. Community-based crisis stabilization is a non-center community-based service. The goal of community-based crisis stabilization services is to stabilize the individual within the community and support the individual or the individual's support system during the periods: (1) between an initial mobile crisis response and entry into an established follow-up service at the appropriate level of care; (2) as a transitional step-down from a higher level of care if the next level of care service is identified but not immediately available for access; or (3) as a diversion to a higher level of care.

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

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

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

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

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

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

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

who is under the supervision of a licensed clinical social worker and is registered with the Virginia Board of Social Work (18VAC140-20-10).

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

"Crisis education and prevention plan (CEPP)" means a DBHDS approved, individualized, client-specific document that provides a concise, clear, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist an individual who may be experiencing a behavioral loss of control. The goal of the CEPP is to identify problems that have arisen in the past or are emergent in order to map out strategies that offer tools for the natural support system to assist the individual in addressing and deescalating problems in a healthy way and provide teaching skills that the individual can apply independently.

"Crisis planning team" means the team that is consulted to plan the individual's safety plan or crisis ISP. The crisis planning team shall at a minimum consist of the individual receiving services, the individual's legal guardian or authorized representative, and a member of the provider's crisis staff. The crisis planning team may include the individual's support coordinator, case manager, the individual's family, or other identified persons, as desired by the individual, such as the individual's family of choice.

"Crisis receiving center" or "CRC," also referred to as "23-hour crisis stabilization," means a community-based, non-hospital facility providing short-term assessment, observation, and crisis stabilization services for up to 23 hours. This service must be accessible 24 hours per day, seven days per week, 365 days per year, and is indicated when an individual requires a safe environment for initial assessment and intervention. This service includes a thorough assessment of an individual's behavioral health crisis, psychosocial needs, and supports in order to determine the least restrictive environment most appropriate for stabilization. Key service functions include rapid assessment, crisis intervention, de-escalation, short-term stabilization, and appropriate referrals for ongoing care. This distinct service may be co-located with other services such as crisis stabilization units.

"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.

"Crisis stabilization unit" or "CSU," also referred to as "residential crisis stabilization unit," is a community-based, short-term residential treatment unit. CSUs serve as primary alternatives to inpatient hospitalization for individuals who are in need of a safe, secure environment for assessment and crisis treatment. CSUs also serve as a step-down option from psychiatric inpatient hospitalization and function to stabilize and reintegrate individuals who meet medical necessity criteria back into their communities.

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

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

"Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or a combination of mental and physical impairments other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to nine years of age, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual without services and supports has a high probability of meeting those criteria later in life.

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

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

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

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

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

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

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

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

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

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

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

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

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

"Informed consent" means the voluntary written agreement of an individual, or that individual's authorized representative, to surgery, electroconvulsive treatment, use of psychotropic medications, or any other treatment or service that poses a risk of harm

greater than that ordinarily encountered in daily life or for participation in human research. To be voluntary, informed consent must be given freely and without undue inducement; any element of force, fraud, deceit, or duress; or any form of constraint or coercion.

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

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

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

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

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

"Intensive 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.

"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 the presence of alcohol or other drugs in the individual's body.

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

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

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

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

"Medication administration" means the legally permitted direct application of medications , as enumerated by § 54.1-3408 of the Code of Virginia, by injection, inhalation, ingestion, or any other means to an individual receiving services by (i) persons legally permitted to administer medications or (ii) the individual at the direction and in the presence of persons legally permitted to administer medications.

"Medication assisted opioid treatment" or "opioid treatment service" means an intervention of administering or dispensing of medications, such as methadone, buprenorphine, or naltrexone approved by the federal Food and Drug Administration for the purpose of treating opioid use disorder.

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

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

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

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

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

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

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

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

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

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

"Mental illness" means , as defined by § 37.2-100 of the Code of Virginia, 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 crisis response" means a service that is available 24 hours per day, seven days a week, 365 days per year to provide rapid response, assessment, and early intervention to individuals experiencing a behavioral health crisis. Services are deployed in real-time to the location of the individual experiencing a behavioral health crisis. The purpose of this service is to: (i) de-escalate the behavioral health crisis and prevent harm to the individual or others; (ii) assist in the prevention of an individual's acute exacerbation of symptoms; (iii) development of an immediate plan to maintain safety; and (iv) coordination of care and linking to appropriate treatment services to meet the needs of the individual.

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

"Neglect" means , as defined by § 37.2-100 of the Code of Virginia, 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.

"Office of Human Rights" means the Department of Behavioral Health and Developmental Services Office of Human Rights.

"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.

"Provider" means , as defined by § 37.2-403 of the Code of Virginia, 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"~~ "Qualified mental health professional-trainee" or "QMHP-T" 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.

“Regional education assessment crisis services habilitation” or “REACH” means the statewide crisis system of care that is designed to meet the crisis support needs of individuals who have a developmental disability and are experiencing mental health or behavior crisis events which put them at risk for homelessness, incarceration, hospitalization, or danger to self or others.

"REACH crisis therapeutic home" or "REACH CTH" means a residential home with crisis stabilization REACH service for individuals with a developmental disability and who are experiencing a mental health or behavior crisis.

"REACH mobile crisis response" means a REACH service that provides mobile crisis response for individuals with a developmental disability and who are experiencing a mental health or behavior crisis.

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

"Residential treatment service" means providing an intensive and highly structured clinically-based 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~~ initial assessment .

"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~~ an individual's ~~Wellness Recovery Action Plan~~ wellness 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 , as defined by § 37.2-403 of the Code of Virginia, (i) planned individualized interventions intended to reduce or ameliorate mental illness, developmental disabilities, or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders). Services include outpatient services, intensive in-home services, medication assisted opioid treatment services, inpatient psychiatric hospitalization, community gero-psychiatric residential services, assertive community treatment and other clinical services; day support, day treatment, partial hospitalization, psychosocial rehabilitation, and habilitation services; case management services; and supportive residential, special school, halfway house, in-home services, crisis stabilization, and other residential services; and (ii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports provided in residential services for persons with brain injury.

"Shall" means an obligation to act is imposed.

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

"Signed" or “signature” means a handwritten signature, an electronic signature, or a digital signature, as long as the signer showed clear intent to sign.

"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.

"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 , as defined by § 37.2-100 of the Code of Virginia, the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of

continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

"Substance abuse intensive outpatient service" or "Level of care 2.1" means structured treatment provided to individuals who require more intensive services than is normally provided in an outpatient service but do not require inpatient services. Treatment consists primarily of counseling and education about addiction-related and mental health challenges delivered a minimum of nine to 19 hours of services per week for adults or six to 19 hours of services per week for children and adolescents. Within this level of care an individual's needs for psychiatric and medical services are generally addressed through consultation and referrals.

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

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

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

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

"Substance abuse partial hospitalization services" or "Level of care 2.5" means a short-term, nonresidential substance use treatment program provided for a minimum of 20 hours a week that uses multidisciplinary staff and is provided for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment. This level of care is designed to offer highly structured intensive treatment to those individuals whose condition is sufficiently stable so as not to require 24-hour-per-day monitoring and care, but whose illness has progressed so as to require consistent near-daily treatment intervention.

"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.

"Telehealth" shall have the same meaning as "telehealth services" in § 32.1-122.03:1 of the Code of Virginia.

“Telemedicine” shall have the same meaning as "telemedicine services" in § 38.2-3418.16 of the Code of Virginia.

"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.

"Written," "writing," and "in writing" include any representation of words, letters, symbols, numbers, or figures, whether (i) printed or inscribed on a tangible medium or (ii) stored in an electronic or other medium and retrievable in a perceivable form and whether an electronic signature authorized by Chapter 42.1 (§ 59.1-479 et seq.) of Title 59.1 of the Code of Virginia is or is not affixed.

12VAC35-105-30. Licenses.

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

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

1. Assertive community treatment (ACT);

2. Case management;

3. Clinically managed high-intensity residential care or Level of care 3.5;

4. Clinically managed low-intensity residential care or Level of care 3.1;

5. Clinically managed population specific high-intensity residential or Level of care 3.3;

6. Community gero-psychiatric residential;

7. ~~ICF/IID~~ Community-based crisis stabilization ;

8. ~~Residential crisis stabilization~~ Crisis receiving center ;

9. ~~Nonresidential crisis stabilization~~ Crisis stabilization unit ;

10. Day support;

11. Day treatment, includes therapeutic day treatment for children and adolescents;

~~12. Emergency ;~~

~~13~~ 12. Group home and community residential;

13. ICF/IID ;

14. Inpatient psychiatric;

15. Intensive in-home;

16. Medically managed intensive inpatient service or Level of care 4.0;

17. Medically monitored intensive inpatient treatment or Level of care 3.7;

18. Medication assisted opioid treatment;

19. Mental health community support;

20. Mental health intensive outpatient;

21. Mental health outpatient;

22. Mental health partial hospitalization;

23. Psychosocial rehabilitation;

24. ~~Residential treatment~~ REACH CTH ;

25. ~~Respite care~~ REACH Mobile Crisis Response ;

26. ~~Sponsored residential home~~ Residential treatment ;

27. ~~Substance abuse intensive outpatient~~ Respite care ;

28. ~~Substance abuse outpatient~~ Sponsored residential home ;

29. ~~Substance abuse partial hospitalization~~ Substance abuse intensive outpatient ;

30. ~~Supervised living residential~~ Substance abuse outpatient ; ~~and~~

31. ~~Supportive in-home.~~ Substance abuse partial hospitalization ;

32. Supervised living residential; and

33. Supportive in-home.

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

Part III
Administrative Services

Article 2

Physical Environment

12VAC35-105-280. Physical environment.

A. The physical environment, design, structure, furnishings, and lighting shall be appropriate to the individuals served and the services provided.

B. The physical environment shall be accessible to individuals with physical and sensory disabilities, if applicable.

C. The physical environment and furnishings shall be clean, dry, free of foul odors, safe, and well-maintained.

D. Floor surfaces and floor coverings shall promote mobility in areas used by individuals and shall promote maintenance of sanitary conditions.

E. The physical environment shall be well ventilated. Temperatures shall be maintained between 65°F and 80°F in all areas used by individuals.

F. Adequate hot and cold running water of a safe and appropriate temperature shall be available. Hot water accessible to individuals being served shall be maintained within a range of 100-110°F. If temperatures cannot be maintained within the specified range, the provider shall make provisions for protecting individuals from injury due to scalding.

G. Lighting shall be sufficient for the activities being performed and all areas within buildings and outside entrances and parking areas shall be lighted for safety.

H. Recycling, composting, and garbage disposal shall not create a nuisance, permit transmission of disease, or create a breeding place for insects or rodents.

I. If smoking is permitted, the provider shall make provisions for alternate smoking areas that are separate from the service environment. This subsection does not apply to home-based services.

J. For all program areas added after September 19, 2002, minimum room height shall be 7-1/2 feet.

K. This section does not apply to home and noncenter-based or crisis services. Sponsored residential services shall certify compliance of sponsored residential homes with this section.

Article 3

Physical Environment of Residential and Inpatient Service Locations

12VAC35-105-330. Beds.

Article 3

Physical Environment of Residential and Inpatient Service Locations

A. The provider shall not operate more beds than the number for which its service location is licensed.

B. An ICF/IID may not have more than 12 beds at any one location. This applies to new applications for services and not to existing services or locations licensed prior to December 7, 2011.

C. This section does not apply to crisis services as crisis services shall comply with Part VIII of these regulations.

12VAC35-105-340. Bedrooms.

A. Bedrooms shall meet the following square footage requirements:

1. Single occupancy bedrooms shall have no less than 80 square feet of floor space.

2. Multiple occupancy bedrooms shall have no less than 60 square feet of floor space per individual.

3. This subsection does not apply to community gero-psychiatric residential services.

B. No more than four individuals shall share a bedroom, except in group homes where no more than two individuals shall share a room. This does not apply to group home locations licensed prior to December 7, 2011.

C. Each individual shall have adequate private storage space accessible to the bedroom for clothing and personal belongings.

D. This section does not apply to correctional facilities and jails or crisis services . Providers of sponsored residential home services shall certify that their sponsored residential homes comply with this section.

12VAC35-105-350. Condition of beds.

A. Beds shall be clean, comfortable, and equipped with a mattress, pillow, blankets, and bed linens. When a bed is soiled, providers shall assist individuals with bathing as needed, and provide clean clothing and bed linen. Providers of sponsored residential home services shall certify that their sponsored residential homes comply with this section.

B. This section does not apply to crisis services as crisis services shall comply with Part VIII of these regulations.

12VAC35-105-360. Privacy.

A. Bedroom and bathroom windows and doors shall provide privacy.

B. Bathrooms intended for use by more than one individual at the same time shall provide privacy for showers and toilets.

C. No required path of travel to the bathroom shall be through another bedroom.

D. This section does not apply to correctional facilities and jails or crisis services . Providers of sponsored residential home services shall certify that their sponsored residential homes comply with this section.

12VAC35-105-370. Ratios of toilets, basins, and showers or baths.

For all residential and inpatient locations established, constructed, or reconstructed after January 13, 1995, there shall be at least one toilet, one hand basin, and shower or bath for every four individuals. This section does not apply to correctional facilities or jails or crisis services . Providers of sponsored residential home services shall certify that their sponsored residential homes comply with this section .

12VAC35-105-380. Lighting.

Each service location shall have adequate lighting in halls and bathrooms at night. This section does not apply to crisis services as crisis services shall comply with Part VIII of these regulations. Providers of sponsored residential home services shall certify that their sponsored residential homes comply with this section.

Part IV
Services and Supports

Article 2

Screening, Admission, Assessment, Service Planning, and Orientation

12VAC35-105-650. Assessment policy.

A. The provider shall implement a written assessment policy. The policy shall define how assessments will be conducted and documented.

B. The provider shall actively involve the individual and authorized representative, if applicable, in the preparation of initial and comprehensive assessments and in subsequent reassessments. In these assessments and reassessments, the provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

C. The assessment policy shall designate employees or contractors who are responsible for conducting assessments. These employees or contractors shall have experience in working with the needs of individuals who are being assessed, the assessment tools being utilized, and the provision of services that the individuals may require.

D. Assessment is an ongoing activity. The provider shall make reasonable attempts to obtain previous assessments or relevant history.

E. An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall complete an initial assessment detailed enough to determine whether the individual qualifies for admission and to initiate an ISP for those individuals who are admitted to the service. This assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's:

1. Diagnosis;

2. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems;

3. Current medical problems;

4. Current medications;

5. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and

6. At-risk behavior to self and others.

F. A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days, after admission for

providers of mental health and substance abuse services and 60 days after admission for providers of developmental services. It shall address:

1. Onset and duration of problems;

2. Social, behavioral, developmental, and family history and supports;

3. Cognitive functioning including strengths and weaknesses;

4. Employment, vocational, and educational background;

5. Previous interventions and outcomes;

6. Financial resources and benefits;

7. Health history and current medical care needs, to include:

a. Allergies;

b. Recent physical complaints and medical conditions;

c. Nutritional needs;

d. Chronic conditions;

e. Communicable diseases;

f. Restrictions on physical activities if any;

g. Restrictive protocols or special supervision requirements;

h. Past serious illnesses, serious injuries, and hospitalizations;

i. Serious illnesses and chronic conditions of the individual's parents, siblings, and significant others in the same household; and

j. Current and past substance use including alcohol, prescription and nonprescription medications, and illicit drugs.

8. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues;

9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma;

10. Legal status including authorized representative, commitment, and representative payee status;

11. Relevant criminal charges or convictions and probation or parole status;

12. Daily living skills;

13. Housing arrangements;

14. Ability to access services including transportation needs; and

15. As applicable, and in all residential services, fall risk, communication methods or needs, and mobility and adaptive equipment needs.

G. Providers of short-term intensive services including inpatient and crisis stabilization services shall develop policies for completing comprehensive assessments within the time frames appropriate for those services.

H. Providers of nonintensive or short-term services shall meet the requirements for the initial assessment at a minimum. Nonintensive services are services provided in jails, nursing homes, or other locations when access to records and information is limited by the location and nature of the services. Short-term services typically are provided for less than 60 days.

I. Providers may utilize standardized state or federally sanctioned assessment tools that do not meet all the criteria of 12VAC35-105-650 as the initial or comprehensive assessment tools as long as the tools assess the individual's health and safety issues and substantially meet the requirements of this section.

J. Individuals who receive medication-only services shall be reassessed at least annually to determine whether there is a change in the need for additional services and the effectiveness of the medication.

K. This section does not apply to crisis services as crisis services shall comply with Part VIII of these regulations.

12VAC35-105-660. Individualized services plan (ISP).

A. The provider shall actively involve the individual and authorized representative, as appropriate, in the development, review, and revision of a person-centered ISP. The individualized services planning process shall be consistent with laws protecting confidentiality, privacy, human rights of individuals receiving services, and rights of minors.

B. The provider shall develop and implement an initial person-centered ISP for the first 60 days for developmental services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall

continue in effect until the ISP is developed or the individual is discharged, whichever comes first.

C. The provider shall implement a person-centered comprehensive ISP as soon as possible after admission based upon the nature and scope of services but no later than 30 days after admission for providers of mental health and substance abuse services and 60 days after admission for providers of developmental services.

D. The initial ISP and the comprehensive ISP shall be developed based on the respective assessment with the participation and informed choice of the individual receiving services.

1. To ensure the individual's participation and informed choice, the following shall be explained to the individual or the individual's authorized representative, as applicable, in a reasonable and comprehensible manner:

a. The proposed services to be delivered;

b. Any alternative services that might be advantageous for the individual; and

c. Any accompanying risks or benefits of the proposed and alternative services.

2. If no alternative services are available to the individual, it shall be clearly documented within the ISP, or within documentation attached to the ISP, that alternative services were not available as well as any steps taken to identify if alternative services were available.

3. Whenever there is a change to an individual's ISP, it shall be clearly documented within the ISP, or within documentation attached to the ISP that:

a. The individual participated in the development of or revision to the ISP;

b. The proposed and alternative services and their respective risks and benefits were explained to the individual or the individual's authorized representative; and

c. The reasons the individual or the individual's authorized representative chose the option included in the ISP.

<u>E. This section does not apply to crisis services as crisis services shall comply with Part VIII of these regulations.</u>

12VAC35-105-665. ISP requirements.

A. The comprehensive ISP shall be based on the individual's needs, strengths, abilities, personal preferences, goals, and natural supports identified in the assessment. The ISP shall include:

1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing each need;

2. Services and supports and frequency of services required to accomplish the goals including relevant psychological, mental health, substance abuse, behavioral, medical, rehabilitation, training, and nursing needs and supports;

3. The role of the individual and others in implementing the service plan;

4. A communication plan for individuals with communication barriers, including language barriers;

5. A behavioral support or treatment plan, if applicable;

6. A safety plan that addresses identified risks to the individual or to others, including a fall risk plan;

7. A crisis or relapse plan, if applicable;

8. Target dates for accomplishment of goals and objectives;

9. Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies;

10. Recovery plans, if applicable; and

11. Services the individual elects to self direct, if applicable.

B. The ISP shall be signed and dated at a minimum by the person responsible for implementing the plan and the individual receiving services or the authorized representative in order to document agreement. If the signature of the individual receiving services or the authorized representative cannot be obtained, the provider shall document attempts to obtain the necessary signature and the reason why he was unable to obtain it. The ISP shall be distributed to the individual and others authorized to receive it.

C. The provider shall designate a person who shall be responsible for developing, implementing, reviewing, and revising each individual's ISP in collaboration with the individual or authorized representative, as appropriate.

D. Employees or contractors who are responsible for implementing the ISP shall demonstrate a working knowledge of the objectives and strategies contained in the individual's current ISP, including an individual's detailed health and safety protocols.

E. Providers of short-term intensive services such as inpatient and crisis services that are typically provided for less than 30 days shall implement a policy to develop an ISP within a timeframe consistent with the length of stay of individuals.

F. When a provider provides more than one service to an individual the provider may maintain a single ISP document that contains individualized objectives and strategies for each service provided.

G. Whenever possible the identified goals in the ISP shall be written in the words of the individual receiving services.

H. This section does not apply to crisis services as crisis services shall comply with Part VIII of these regulations.

12VAC35-105-693. Discharge.

A. The provider shall have written policies and procedures regarding the discharge or termination of individuals from the service. These policies and procedures shall include medical and clinical criteria for discharge.

B. Discharge instructions shall be provided in writing to the individual, his authorized representative, and the successor provider, as applicable. Discharge instructions shall include at a minimum medications and dosages; names, phone numbers, and addresses of any providers to whom the individual is referred; current medical issues or conditions; and the identity of the treating health care providers.

C. The provider shall make appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the individual's scheduled discharge date.

D. The content of the discharge plan and the determination to discharge the individual shall be consistent with the ISP and the criteria for discharge.

E. The provider shall document in the individual's service record that the individual, his authorized representative, and his family members, as appropriate, have been involved in the discharge planning process.

F. A written discharge summary shall be completed within 30 days of discharge and shall include at a minimum the following:

1. Reason for the individual's admission to and discharge from the service;

2. Description of the individual's or authorized representative's participation in discharge planning;

3. The individual's current level of functioning or functioning limitations, if applicable;

4. Recommended procedures, activities, or referrals to assist the individual in maintaining or improving functioning and increased independence;

5. The status, location, and arrangements that have been made for future services;

6. Progress made by the individual in achieving goals and objectives identified in the ISP and summary of critical events during service provision;

7. Discharge date;

8. Discharge medications prescribed by the provider, if applicable;

9. Date the discharge summary was actually written or documented; and

10. Signature of the person who prepared the summary.

G. This section does not apply to crisis services as crisis services shall comply with Part VIII of these regulations.

Article 3

Crisis Intervention and Emergencies

Article 4

Medical Management

12VAC35-105-740. Physical examination for residential and inpatient services.

A. Providers of residential or inpatient services shall administer or obtain results of physical exams within 30 days of an individual's admission. The examination must have been conducted within one year of admission to the service. Providers of inpatient services shall administer physical exams within 24 hours of an individual's admission.

B. A physical examination shall include, at a minimum:

1. General physical condition (history and physical);

2. Evaluation for communicable diseases;

3. Recommendations for further diagnostic tests and treatment, if appropriate;

4. Other examinations that may be indicated; and

5. The date of examination and signature of a qualified practitioner.

C. Locations designated for physical examinations shall ensure individual privacy.

D. The provider shall review and follow-up with the results of the physical examination and of any follow-up diagnostic tests, treatments, or examinations in the individual's record.

E. This section does not apply to crisis services as crisis services shall comply with Part VIII of these regulations.

Part VI

Additional Requirements for Selected Services

12VAC35-105-1120. Vital signs.

A. Unless the individual refuses, the provider shall take vital signs:

1. At admission and discharge;

2. Every four hours for the first 24 hours and every eight hours thereafter; and

3. As frequently as necessary, until signs and symptoms stabilize for individuals with a high-risk profile.

B. The provider shall have procedures to address situations when an individual refuses to have vital signs taken.

C. The provider shall document vital signs, all refusals and follow-up actions taken.

D. This section does not apply to crisis services as crisis services shall comply with Part VIII of these regulations.

Part VIII
Crisis Services

12VAC35-105-1830. Applicability of part.

All crisis receiving centers, community-based crisis stabilization, crisis stabilization units, and REACH providers shall comply with the provisions of this Part.

12VAC35-105-1840. Staffing.

A. Crisis receiving centers shall meet the following staffing requirements:

1. A licensed psychiatrist or nurse practitioner shall be available to the program, either in person or via telemedicine, 24 hours per day, seven days a week;

2. An LMHP, LMHP-R, LMHP-RP or LMHP-S shall be available for conducting assessments;

3. Nursing services shall be provided by a registered nurse (RN) or a licensed practical nurse (LPN). Nursing staff shall be available 24 hours per day, in person. LPNs shall work directly under the supervision of a physician, nurse practitioner, or RN; and

4. Medical, psychological, psychiatric, laboratory, and toxicology services shall be available by consult or referral.

B. Community based crisis stabilization shall meet the following staffing requirements:

1. An LMHP, LMHP-R, LMHP-RP, or LMHP-S shall conduct assessments and for any CEPP not authored by an LMHP review and, if they agree, sign the CEPP;

2. All staff are required to utilize a working GPS enabled smart phone or GPS enabled tablet;

3. Any time staff are dispatched for the provision of mobile crisis response the provider shall dispatch a team that meets at least one of the below staffing composition requirements:

a. If a single person is dispatched for mobile crisis response:

(1) One licensed staff member; or

(2) One certified pre-screener.

b. If the provider dispatches a team for mobile crisis, the team shall include:

(1) One licensed staff member and one peer recovery specialist (PRS);

(2) One licensed staff member and one certified substance abuse counselor (CSAC), CSAC-supervisee, or certified substance abuse counselor assistant (CSAC-A);

(3) One licensed staff member and one QMHP (QMHP-A, QMHP-C, or QMHP-T);

(4) One QMHP (QMHP-A or QMHP-C) CSAC (or CSAC-supervisee) and one PRS. A licensed staff member shall be required to be available via telemedicine for the assessment;

(5) One QMHP (QMHP-A or QMHP-C), or CSAC (or CSAC-supervisee) and one CSAC-A. A licensed staff member shall be required to be available via telemedicine for the assessment;

(6) Two QMHPs (QMHP-A, QMHP-C or QMHP-T; however, the team shall not be two QMHP-Ts). A licensed staff member shall be required to be available via telemedicine for the assessment;

(7) Two CSACs. A licensed staff member shall be required to be available via telemedicine for the assessment; or

(8) One QMHP (QMHP-A or QMHP-C), and one CSAC or one CSAC-supervisee. A licensed staff member shall be required to be available via telemedicine for the assessment.

C. Crisis stabilization units shall meet the following staffing requirements:

1. A licensed psychiatrist or psychiatric nurse practitioner shall be available 24 hours per day, seven days per week either in-person or via telemedicine;

2. An LMHP, LMHP-R, LMHP-RP, or LMHP-S shall be available to conduct an assessment;

3. Nursing services shall be provided by either an RN or an LPN. Nursing staff shall be available in-person 24 hours per day, seven days per week. LPNs shall work directly under the supervision of a physician, nurse practitioner, or an RN ;and

4. Medical, psychological, psychiatric, laboratory, and toxicology services shall be available by consult or referral.

D. REACH shall meet the staffing standards specific to its licensed services. The service shall also meet the REACH standards. A REACH crisis therapeutic home shall meet both the crisis stabilization unit standards and the REACH standards.

12VAC35-105-1850. Crisis assessment.

A. The provider shall implement a written crisis assessment policy. The policy shall define how crisis assessments will be conducted and documented.

B. The provider shall actively involve the individual and authorized representative, if applicable, in the preparation of crisis assessment. In the crisis assessment, the provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

C. The crisis assessment policy shall designate appropriately qualified employees or contractors who are responsible for conducting, obtaining, or updating assessments and medical screenings. These employees or contractors shall have experience working with the needs of individuals who are being assessed, with the crisis assessment tool or tools being utilized, and with the provision of services that the individuals may require. The crisis assessment policy shall include methods the provider will utilize to identify other appropriate services to assist individuals who are not admitted to the provider’s service.

D. Assessment is an ongoing activity. The provider shall make reasonable attempts to obtain previous assessments or history relevant to the crisis. The provider shall use the individual's previous assessments or other relevant history within the course of treatment, if applicable, as noted within subsection F.

E. Providers shall utilize standardized state- or federally- sanctioned crisis assessment tools as approved by the department, or utilize their own crisis assessment tools that shall meet the requirements in subsection F.

F. A crisis assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall complete, or obtain information from other qualified providers in order to complete, a crisis assessment detailed enough to: (i) determine whether the individual qualifies for admission; and (ii) initiate a safety plan or crisis ISP as required by these regulations for those individuals who are admitted to the service.

1. The crisis assessment shall assess the individual's service, health, and safety needs, and at a minimum include:

a. For community-based crisis stabilization providers providing the mobile crisis component of the service and crisis receiving centers:

(1) Diagnosis, including current and past substance use or dependence and risk for intoxication or substance withdrawal, and co-occurring mental illness or developmental disability;

(2) Risk of harm, including elements that may make an individual a danger to himself or others;

(3) Cognitive functional status, including the individual's ability to protect himself from harm and provide for his basic human needs;

(4) Precipitating issues, including recent stressors or events;

(5) Presenting needs, including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of needs. The assessor shall record:

(a) Any physical reaction to the presenting crisis, if these issues are mentioned by the individual or observed during the assessment. Examples include issues with sleep, appetite, or daily activities;

(b) The individual's housing arrangements and living situation, if mentioned by the individual; and

(c) Any trauma, such as sexual abuse, physical abuse, natural disaster, etc., if appropriate, including if it is related to the current crisis or mentioned by the individual.

(6) Additional current medical issues and symptoms, if applicable;

(7) Current medications, including recent changes to medications. The assessor shall review current medications to the best of the individual's ability.

(8) Barriers that will impact the individual's ability to seek treatment or continue to participate in services, including the individual's mood, ability and willingness to engage in treatment, and access to transportation.

(9) The individual's recovery environment and circle of support; and

(10) Communication modality and language preference.

b. For crisis stabilization units and community-based crisis stabilization providing services other than mobile crisis, the assessment shall also include:

(1) Relevant treatment history and health history, to include as applicable:

(a) Past medications prescribed;

(b) Hospitalizations for challenging behaviors, mental illness, or substance use;

(c) Other treatments for challenging behaviors, mental illness, or substance use;

(d) Allergies, including allergies to food and medications;

(e) Recent physical complaints and medical conditions;

(f) Nutritional needs;

(g) Chronic conditions;

(h) Communicable diseases;

(i) Restrictions on physical activities, if any;

(j) Restrictive protocols or special supervision requirements;

(k) Preferred interventions in the event behaviors or symptoms become a danger to self or others;

(l) All known contraindications to the use of seclusion, time out, or any form of physical or mechanical restraint, including medical contraindications and a history of trauma;

(m) Past serious illnesses, serious injuries, and hospitalizations;

(n) Serious illnesses and chronic conditions of the individual's parents, siblings, and significant others in the same household; and

(o) Other interventions and outcomes including interventions and outcomes that were unsuccessful. The provider should ensure previous assessments are utilized to note these interventions.

(2) The individual's housing arrangements or living situation;

(3) Trauma, such as sexual abuse, physical abuse, natural disaster, etc.; and

(4) Current or previous involvement in systems such as legal, adult protective services, or child protective services.

c. If applicable to the individual's crisis the assessment shall include:

(1) The individual's social, behavioral, developmental, family history, and supports;

(2) Employment, vocational, and educational background;

(3) Cultural and heritage considerations; and

(4) Financial stressors, if applicable.

G. The timing for completion of the crisis assessment shall be as soon as possible after admission but no later than 24 hours after admission.

H. The provider shall retain documentation of the assessments in the individual's record for a minimum of six years following the last patient encounter, in accordance with § 54.1-2910.4 of the Code of Virginia.

12VAC35-105-1860. Safety plans and crisis individualized services plans (crisis ISP).

A. The provider shall actively involve the individual and authorized representative, as appropriate, in the development, review, and revision of a person-centered safety plan and if appropriate crisis individualized services plan (crisis ISP). The individualized safety and services planning process shall be consistent with laws protecting confidentiality, privacy, human rights of individuals receiving services, and rights of minors. To the extent possible the provider shall collaborate with the individual's crisis planning team to develop, review, revise, and implement, as appropriate, the individual's safety plan or crisis ISP.

B. Providers of developmental services shall collaborate with the individual's support coordinator to develop or review and revise, and implement, as appropriate a person-centered crisis education and prevention plan (CEPP). A provisional CEPP shall be completed within 15 days of admission. An updated CEPP shall be completed within 45 days of admission. Developmental services providers may utilize a CEPP as an

individual’s safety plan, if appropriate. If a CEPP is to be used as a safety plan, the provider shall meet the deadline listed in subpart C of this section.

C. Providers of mental health and substance abuse services shall develop or review and revise, and implement, as appropriate, a person-centered safety plan immediately after admission that shall continue in effect until discharge from the provider’s crisis service.

D. Providers of crisis services shall develop, or review and revise, and implement a crisis ISP as soon as possible after admission but no later than 48 hours after admission and prior to discharge from the provider's crisis service. This provision does not apply to the initial mobile crisis contact or to crisis receiving centers.

E. The safety plan and crisis ISP shall be developed based on the crisis assessment with the participation and informed choice of the individual receiving services.

1. To ensure the individual's participation and informed choice, the following shall be explained to the individual or his authorized representative, as applicable, in a reasonable and comprehensible manner:

a. The proposed services to be delivered;

b. Any alternative services that might be advantageous for the individual; and

c. Any accompanying risks or benefits of the proposed alternative services.

2. If no alternative services are available to the individual, it shall be documented within the individual’s service record that alternative services were not available and any steps taken to identify if alternative services were available.

3. Whenever there is a change to an individual’s safety plan or crisis ISP, it shall be documented within the safety plan, crisis ISP or within documentation attached to the safety plan or crisis ISP that:

a. The individual participated in the development of or revision to the safety plan or crisis ISP;

b. The proposed and alternative services and their respective risks and benefits were explained to the individual or the individual’s authorized representative, and;

c. The reasons the individual or the individual’s authorized representative chose the option included in the safety plan or crisis ISP.

12VAC35-105-1870. Safety plan and crisis ISP requirements.

A. All individuals receiving crisis services shall have a safety plan.

1. The safety plan shall be based on the individual's immediate service, health, and safety needs identified in the crisis assessment. The safety planning process shall be an ongoing activity. The safety plan shall include:

a. Warning signs that a crisis may be developing, such as thoughts, images, mood, situation, and behavior, or stressors that may trigger the individual;

b. Internal coping strategies and things the individual can do without contacting another person, such as relaxation techniques or physical activities;

c. People and social settings that the individual may turn to for distraction or support;

d. People the individual may ask for help;

e. Professionals or agencies the individual can contact during a crisis; and

f. Things the individual can do to make his environment safe.

2. The safety plan may include:

a. A description of how to support the individual when pre-crisis behaviors are observed;

b. Specific instructions for the systems supporting the individual during pre-crisis;

c. A description of how to support the individual when crisis behaviors are observed; and

d. Specific instructions for the systems supporting the individual during crisis.

3. In the event an individual receiving services requires medication management or seclusion the need shall be clearly documented in an attachment to the individual's safety plan.

B. Community-based crisis stabilization and crisis stabilization unit providers shall also develop a crisis ISP. A crisis ISP shall be based on the individual's immediate service, health, and safety needs identified in the crisis assessment. The crisis ISP shall include:

1. Relevant and attainable goals, measurable objectives to inform current and future treatment, and specific strategies for addressing each need documented within the individual's crisis assessment;

2. Services, supports, and frequency of services required to accomplish the goals including relevant psychological, mental health, substance use, behavioral, medical, rehabilitation, training, and nursing needs and supports;

3. Any use of seclusion if allowed in the service per 12VAC35-110;

4.The role of the individual and others, including the individual's family, if appropriate, in implementing the crisis ISP;

5. Identification of employees or contractors responsible for the coordination and integration of services, including employees of other agencies;

6. A behavioral support or treatment plan, if applicable; and

7. Projected discharge plan and estimated length of stay within the service.

C. In order to document agreement, both the safety plan and the crisis ISP shall be signed and dated at a minimum by the person responsible for implementing the safety plan or crisis ISP and the individual receiving services or the authorized representative, if appropriate.

1. If the signature of the individual receiving services or the authorized representative cannot be obtained, the provider shall document attempts to obtain the necessary signature and the reason why obtaining it was not possible. The provider shall continue to make attempts to obtain the necessary signature for the length of time the safety plan or crisis ISP is in effect. An attempt to obtain the necessary signature shall occur at a minimum each time the provider reviews the safety plan or crisis ISP.

2. The safety plan and crisis ISP shall be distributed to the individual and others authorized to receive it. The provider shall document that the safety plan and crisis ISP were distributed within the individual's services record. If the safety plan or crisis ISP cannot be distributed, the provider shall document attempts to distribute the safety plan and crisis ISP to the individual and the reason why distribution was not possible. The provider shall continue to make attempts to distribute the safety plan and crisis ISP for the length of time the safety plan and crisis ISP are in effect. An attempt to distribute the safety plan and crisis ISP shall occur at a minimum each time the provider reviews the safety plan or crisis ISP.

D. The provider shall have a safety plan and crisis ISP policy that designates a staff person responsible for developing, implementing, reviewing, and revising each individual's safety plan and crisis ISP, in collaboration with the individual or authorized representative, as appropriate.

E. Employees or contractors who are responsible for implementing the safety plan or crisis ISP shall: (i) have access to the individual's safety plan or crisis ISP, including an individual's detailed health and safety protocols; and (ii) be competent to implement the safety plan or crisis ISP as written.

F. Whenever possible the identified goals in the safety plan or crisis ISP shall be written in the words of the individual receiving services.

G. The provider shall use signed and dated progress notes to document the provider's efforts towards the implementation of the goals and objectives contained within the safety plan or crisis ISP.

12VAC35-105-1880. Crisis discharge planning.

A. Crisis providers are not subject to the provisions of 12VAC35-105-693.

B. Community-based crisis stabilization providers that are supplying mobile crisis response and crisis receiving center providers are not required to provide discharge planning to individuals receiving services and, therefore, are not subject to subsections B-F of this section. Community-based crisis stabilization providers of mobile crisis response and crisis receiving centers shall make referrals to all follow up service providers, if determined appropriate, and document in accordance with the provider's crisis assessment policy. The provider shall document such arrangements, referrals, or reasons why follow up care was not indicated within the individual’s record.

C. Community-based crisis stabilization providers, crisis stabilization units, and REACH providers shall have written policies and procedures regarding the discharge or termination of individuals from the service. These policies and procedures shall include medical and clinical criteria for discharge.

D. Discharge instructions shall be provided in writing to the individual, his authorized representative, and any successor provider, as applicable. Discharge instructions shall include at a minimum medications and dosages; names, phone numbers, and addresses of any providers to whom the individual is referred; current medical issues or conditions; and the identity of the treating health care providers. The provider shall make appropriate referrals to all service providers identified within the individual’s discharge instructions prior to the individual’s scheduled discharge date.

E. The provider shall document in the individual's service record whether the individual, his authorized representative, and his family members, as appropriate, were involved in the discharge planning process.

F. A written discharge summary shall be completed within 30 days of discharge and shall include at a minimum the following:

1. The reason for the individual's admission to and discharge from the service;

2. A description of the individual's, and authorized representative's, participation in discharge planning and documentation of informed choice by the individual, authorized representative, or legal guardian, as applicable, in the decision to and planning for discharge;

3. The individual's current level of functioning or functioning limitations, if applicable;

4. Recommended procedures, activities, or referrals to assist the individual in maintaining or improving functioning and increased independence;

5. The status, location, and arrangements that were made for future services;

6. Progress made by the individual in achieving goals and objectives identified in the crisis ISP and summary of critical events during service provision;

7. Discharge date;

8. Any discharge medications prescribed by the provider, if applicable;

9. Dates the discharge plan was written and documented; and

10. The signature of the person who prepared the discharge plan.

G. The content of the discharge summary and the determination to discharge the individual shall be consistent with the crisis ISP and the criteria for discharge.

12VAC35-105-1890. Nursing assessment.

A. Crisis receiving centers, crisis stabilization units, and REACH CTH providers shall administer a nursing assessment within 24 hours of admission of an individual.

B. Prior to admission, each individual shall have a screening for communicable diseases, including tuberculosis, as evidenced by the completion of a screening form containing, at a minimum, the elements found on the Report of Tuberculosis Screening form published by the Virginia Department of Health. The screening may be no older than 30 days. A screening shall not be required for a new individual separated from a service with another licensed provider with a break in service of six months or less or who is transferred from another DBHDS licensed provider.

C. A staff member shall conduct a nursing assessment. The nursing assessment shall collect information about the non-psychiatric medical or surgical condition of an individual to determine whether there is a need for a medical assessment before a decision is made regarding continued treatment within the provider's service or transfer to a more intensive level of care. The nursing assessment should determine if there is a current medical crisis or underlying medical condition for the individual's psychological crisis, such as any medical condition that affects the individual's psychological state, presenting behavior, or ability to receive the provider's service. The nursing assessment shall note the date of examination and have the signature of a qualified practitioner.

D. Locations designated for nursing assessments shall ensure individual privacy.

E. The provider shall review and follow-up with: (i) the results of the nursing assessment including any follow-up diagnostic tests, treatments, or examinations; and (ii) documentation of the arrangements for follow-up care in the individual's record.

F. Each individual's health record shall include notations of any health or dental complaints mentioned by the individual or any injuries, and shall summarize symptoms and treatment given.

G. Each individual's health record shall include or document the facility's efforts to obtain treatment summaries of ongoing psychiatric or other mental health treatment and reports.

H. The provider shall develop and implement written policies and procedures that include the use of standard precautions and address communicable and contagious medical conditions.

I. Community-based crisis stabilization providers are not required to administer nursing assessments. The provider may administer a nursing assessment if the provider has the resources to do so or may obtain a medical history, or relevant information which would be a part of a medical history, if the individual receiving services provides it.

12VAC35-105-1900. Vital signs for crisis services.

A. This section applies to all crisis receiving centers, crisis stabilization units, and REACH CTH providers.

B. Unless the individual refuses, the provider shall take vital signs upon admission, during the provision of services as per the medical provider's orders, and at discharge.

C. The provider shall implement written procedures regarding the collection of vital signs including documentation of vital signs, all refusals, and follow-up actions taken.

12VAC35-105-1910. Beds or recliners for crisis services.

A. For the purpose of this section, "clean" means freshly laundered, sanitized, and not soiled or stained.

B. Crisis receiving center providers shall arrange for each individual to have a recliner or bed. Crisis stabilization unit and REACH CTH providers shall arrange for each individual to have a bed.

C. Upon admission, the provider shall offer to launder the individual's clothes.

D. The provider shall not operate more recliners or beds at each service location than the number for which its service is licensed at that location.

E. Recliners, beds, and linens shall be clean, comfortable, and well-maintained.

F. Beds shall be equipped with a clean mattress and recliners shall be equipped with clean cushions. Beds and recliners shall be equipped with a clean pillow, clean blankets, and clean linens. When a bed or recliner is soiled, providers shall assist individuals with bathing, as needed, and provide clean clothing and clean linens, including a clean waterproof mattress cover for a bed.

G. Providers shall change linens at least every seven days and with each new admission.

H. Providers shall provide mattresses that are fire retardant as evidenced by documentation from the manufacturer, except in buildings equipped with an automated sprinkler system as required by the Virginia Statewide Building Code (13VAC5-63).

I. Providers shall inspect each individual's recliner or bed upon discharge to: (i) ensure the individual has all personal belongings; and (ii) prepare the recliner or bed for cleaning.

12VAC35-105-1920. Bedrooms for crisis services.

A. This section only applies to crisis stabilization units and REACH CTH providers.

B. Bedrooms shall meet the following square footage requirements:

1. Single occupancy bedrooms shall have no less than 80 square feet of floor space.

2. Multiple occupancy bedrooms shall have no less than 60 square feet of floor space per individual.

C. No more than four individuals shall share a bedroom.

D. Bedrooms shall be free of all protrusions, sharp corners, hardware, fixtures, or other devices that may cause injury to the individual.

E. Windows in the bedrooms shall be so constructed as to minimize breakage and otherwise prevent the individual from harming himself.

F. Each individual shall have adequate private storage space accessible to the bedroom for clothing and personal belongings.

G. Every sleeping area shall have a door that: (i) may be closed for privacy or quiet; and (ii) shall be readily opened in case of fire or other emergency.

H. The environment of sleeping areas shall be conducive to sleep and rest.

I. Providers of children's residential services shall provide separate sleeping areas for boys and girls four years of age or older.

J. Providers of children's residential services shall ensure beds are at least three feet apart at the head, foot, and sides; and double-decker beds shall be at least five feet apart at the head, foot, and sides.

12VAC35-105-1930. Physical environment for crisis services.

A. The physical environment, design, structure, furnishings, and lighting shall be appropriate to the individuals receiving services and the services provided.

B. The physical environment shall be accessible to individuals with physical and sensory disabilities.

C. The physical environment and furnishings shall be clean, dry, free of foul odors, safe, and well-maintained.

D. Floor surfaces and floor coverings shall promote mobility in areas used by individuals and shall promote maintenance of sanitary conditions. There shall be clear pathways through the setting, free of tripping hazards, to ensure that all individuals can move about the setting safely.

1. Any electrical cords, extension cords, or power strips utilized by the provider shall be properly secured and not be placed anywhere that the cord or strip can cause trips or falls.

E. Heat shall be evenly distributed in all rooms occupied by individuals such that a temperature no less than 68 degrees Fahrenheit is maintained, unless otherwise mandated by state or federal authorities. Natural or mechanical ventilation to the outside shall be provided in all rooms used by residents. Individual or mechanical ventilating systems shall be provided in all rooms occupied by individuals when the temperature in those rooms exceeds 80 degrees Fahrenheit.

F. Plumbing shall be maintained in good operational condition. Adequate hot and cold running water of a safe and appropriate temperature shall be available. Hot water accessible to individuals receiving services shall be maintained within a range of 100-120° Fahrenheit. Precautions shall be taken to prevent scalding from running water.

G. Adequate provision shall be made for the collection and legal disposal of garbage and waste materials.

H. The physical environment, structure, furnishings, and lighting shall be kept free of vermin, rodents, insects, and other pests.

I. If smoking is permitted, the provider shall make provisions for alternate smoking areas that are separate from the service environment.

J. For all program areas added after September 19, 2002, minimum room height shall be 7-1/2 feet.

K. Bedroom, bathroom, and dressing area windows and doors shall provide privacy.

L. Bathrooms intended for use by more than one individual at the same time shall provide privacy for showers and toilets.

M. The right of privacy within bathrooms includes the right to be free of cameras or audio monitors within the bathroom or angled toward a bathroom.

N. Bedrooms and bathrooms shall be free of all protrusions, sharp corners, hardware, fixtures or other devices which may cause injury to the individual. Windows in the bathrooms shall be so constructed as to minimize breakage and otherwise prevent the individual from harming himself.

O. No required path of travel to the bathroom shall be through another bedroom. Each individual’s room shall have direct access to a corridor, living area, dining area, or other common area.

P. Each provider shall make available at least one toilet, one hand basin, and a shower or bath for every four individuals. Providers of children’s residential services shall:

1. Make available at least one toilet, one hand basin, and one shower or bathtub in each living unit;

2. Make available at least one bathroom equipped with a bathtub in each facility;

3. Make available at least one toilet, one hand basin, and one shower or tub for every eight individuals for facilities licensed before July 1, 1981;

4. Make available one toilet, one hand basin, and one shower or tub for every four individuals in any building constructed or structurally modified after July 1, 1981. Facilities licensed after December 28, 2007, shall comply with the one-to-four ratio; and

5. The maximum number of staff members on duty in the living unit shall be counted in determining the required number of toilets and hand basins when a separate bathroom is not provided for staff.

Q. If a provider utilizes cameras or audio monitors the provider shall have written policies and procedures regarding audio or audio-video recordings of individuals receiving services approved by the Office of Licensing and the Office of Human Rights. The policies and procedures shall ensure and provide that:

1. The provider has obtained written consent of individuals before the individual is recorded;

2. No recording by the provider shall take place without the individual being informed;

3. The provider has postings informing individuals receiving services and others that recording is taking place; and

4. All recordings shall be used in a manner that respects the dignity and confidentiality of the individuals receiving services.

R. A provider shall develop and implement written policies and procedures approved by the Office of Licensing governing searches that shall provide that:

1. Searches shall be limited in instances where they are necessary to prohibit contraband;

2. Searches shall be conducted only by personnel who are specifically authorized to conduct searches by the written policies and procedures;

3. Searches shall be conducted in such a way to protect the individual’s dignity and in the presence of one or more witnesses; and

4. The policy and procedures shall note the actions to be taken by a provider if contraband is found by a search including methods to manage and dispose of contraband.

S. Providers who serve temporary detention orders or emergency custody orders shall ensure the program is provided in a secure facility or a secure program space.

T. Providers shall provide privacy from routine sight supervision by staff members while bathing, dressing, or conducting toileting activities. This subsection does not apply to medical personnel performing medical procedures or staff providing assistance to individuals whose physical, mental, or safety needs dictate the need for assistance with these activities as justified in the individual's record.

12VAC35-105-1940. Seclusion.

Seclusion is only allowed as permitted by 12VAC35-115 and other applicable state regulations.

12VAC35-105-1950. Seclusion room requirements.

The room used for seclusion shall meet the following design requirements for rooms used for seclusion of persons:

1. The seclusion room shall be at least six feet wide and six feet long with a minimum ceiling height of eight feet.

2. The seclusion room shall be free of all protrusions, sharp corners, hardware, fixtures, or other devices, that may cause injury to the occupant.

3. Windows in the seclusion room shall be constructed to minimize breakage and otherwise prevent the occupant from harming himself.

4. Light fixtures and other electrical receptacles in the seclusion room shall be recessed or so constructed as to prevent the occupant from harming himself. Light controls shall be located outside the seclusion room.

5. Doors to the seclusion room shall be at least 32 inches wide, open outward, and contain observation view panels of transparent wire glass or its approved equivalent, not exceeding 120 square inches but of sufficient size for someone outside the door to see into all corners of the room.

6. The seclusion room shall contain only a mattress with a washable mattress covering designed to avoid damage by tearing.

7. The seclusion room shall maintain temperatures appropriate for the season.

8. All space in the seclusion room shall be visible through the locked door, either directly or by mirrors.

Chapter 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

Part III

Explanation of Individual Rights and Provider Duties

12VAC35-115-110. Use of seclusion, restraint, and time out.

A. Each individual is entitled to be completely free from any unnecessary use of seclusion, restraint, or time out.

B. The voluntary use of mechanical supports to achieve proper body position, balance, or alignment so as to allow greater freedom of movement or to improve normal body functioning in a way that would not be possible without the use of such a mechanical support, and the voluntary use of protective equipment are not considered restraints.

C. The provider's duties.

1. Providers shall meet with the individual or his authorized representative upon admission to the service to discuss and document in the individual's services record his preferred interventions in the event his behaviors or symptoms become a danger to himself or others and under what circumstances, if any, the intervention may include seclusion, restraint, or time out.

2. Providers shall document in the individual's services record all known contraindications to the use of seclusion, time out, or any form of physical or mechanical restraint, including medical contraindications and a history of trauma, and shall flag the record to alert and communicate this information to staff.

3. Seclusion may be used only in an emergency and ~~Only~~ only in: facilities operated by the department; residential facilities for children that are licensed under the Regulations for Children's Residential Facilities (12VAC35-46) ; ~~and~~ inpatient hospitals; and crisis receiving centers or crisis stabilization units that are licensed under Part VIII of 12VAC35-105 ~~may use seclusion and only in an emergency~~.

4. Providers shall not use seclusion, restraint, or time out as a punishment or reprisal or for the convenience of staff.

5. Providers shall not use seclusion or restraint solely because criminal charges are pending against the individual.

6. Providers shall not use a restraint that places the individual's body in a prone (face down) position.

7. Providers shall not use seclusion or restraint for any behavioral, medical, or protective purpose unless other less restrictive techniques have been considered and documentation is placed in the individual's safety plan, the crisis ISP, or the ISP that these less restrictive techniques did not or would not succeed in reducing or eliminating behaviors that are self-injurious or dangerous to other people or that no less restrictive measure was possible in the event of a sudden emergency.

8. Providers that use seclusion, restraint, or time out shall develop written policies and procedures that comply with applicable federal and state laws and regulations, accreditation and certification standards, third party payer requirements, and sound therapeutic practice. These policies and procedures shall include at least the following requirements:

a. Individuals shall be given the opportunity for motion and exercise, to eat at normal meal times and take fluids, to use the restroom, and to bathe as needed.

b. Trained, qualified staff shall monitor the individual's medical and mental condition continuously while the restriction is being used.

c. Each use of seclusion, restraint, or time out shall end immediately when criteria for removal are met.

d. Incidents of seclusion and restraint, including the rationale for and the type and duration of the restraint, shall be reported to the department as provided in 12VAC35-115-230 C.

9. Providers shall comply with all applicable state and federal laws and regulations, certification and accreditation standards, and third party requirements as they relate to seclusion and restraint.

a. Whenever an inconsistency exists between this chapter and federal laws or regulations, accreditation or certification standards, or the requirements of third party payers, the provider shall comply with the higher standard.

b. Providers shall notify the department whenever a regulatory, accreditation, or certification agency or third party payer identifies problems in the provider's compliance with any applicable seclusion and restraint standard.

10. Providers shall ensure that only staff who have been trained in the proper and safe use of seclusion, restraint, and time out techniques may initiate, monitor, and discontinue their use.

11. Providers shall ensure that a qualified professional who is involved in providing services to the individual reviews every use of physical restraint as soon as possible after it is carried out and documents the results of his review in the individual's services record.

12. Providers shall ensure that review and approval by a qualified professional for the use or continuation of restraint for medical or protective purposes is documented in the individual's services record. Documentation includes:

a. Justification for any restraint;

b. Time-limited approval for the use or continuation of restraint; and

c. Any physical or psychological conditions that would place the individual at greater risk during restraint.

13. Providers may use seclusion or mechanical restraint for behavioral purposes in an emergency only if a qualified professional involved in providing services to the individual has, within one hour of the initiation of the procedure:

a. Conducted a face-to-face assessment of the individual placed in seclusion or mechanical restraint and documented that alternatives to the proposed use of seclusion

or mechanical restraint have not been successful in changing the behavior or were not attempted, taking into account the individual's medical and mental condition, behavior, preferences, nursing and medication needs, and ability to function independently;

b. Determined that the proposed seclusion or mechanical restraint is necessary to protect the individual or others from harm, injury, or death;

c. Documented in the individual's services record the specific reason for the seclusion or mechanical restraint;

d. Documented in the individual's services record the behavioral criteria that the individual must meet for release from seclusion or mechanical restraint; and

e. Explained to the individual, in a way that he can understand, the reason for using mechanical restraint or seclusion, the criteria for its removal, and the individual's right to a fair review of whether the mechanical restraint or seclusion was permissible.

14. Providers shall limit each approval for restraint for behavioral purposes or seclusion to four hours for individuals age 18 and older, two hours for children and adolescents ages nine through 17, and one hour for children under age nine.

15. Providers shall not issue standing orders for the use of seclusion or restraint for behavioral purposes.

16. Providers shall ensure that no individual is in time out for more than 30 minutes per episode.

17. Providers shall monitor the use of restraint for behavioral purposes or seclusion through continuous face-to-face observation, rather than by an electronic surveillance device.

D. For purposes of this section, "safety plan" or a "crisis individualized services plan" (or "crisis ISP") shall mean as described in 12VAC35-105-1860 and 12VAC35-105-1870.

Crisis Final Exempt (Ch. 105 and 115): 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
12VAC35-105-20 Definitions		Definitions for the licensing regulations	Addition of the following new terms: • Community-based crisis stabilization. • Crisis education and prevention plan (CEPP). • Crisis planning team. • Crisis receiving center (CRC). • Crisis stabilization unit (CSU). • Mobile crisis response. • Office of Human Rights. • Regional education assessment crisis services habilitation (REACH). • REACH crisis therapeutic home (CTH). • REACH mobile crisis response. • Signed. • Telehealth. • Telemedicine. • Written. Clear and concise definitions created for the emerging crisis service continuum, that were drafted with assistance from other agencies.
12VAC35-105-30 Licenses		Lists the current license types and describes license addendums	Addition of the following new crisis licenses: • Community-based crisis stabilization. • Crisis receiving center. • Crisis stabilization unit. • REACH CTH. • REACH mobile crisis response.

These sections are included in the action due to the need for the same exemption for crisis services:			
Current chapter-section number	**New chapter-section number, if applicable**	**Current requirements in VAC**	**Change, intent, rationale, and likely impact of new requirements**
12VAC35-105-280-Physical environment		Provides physical environment requirements for all licensed providers	Exempts crisis providers from these requirements as crisis providers will be required to fulfill crisis specific physical environment requirements.
12VAC35-105-330 – Beds		Provides requirements for beds operating within residential and inpatient locations	Exempts crisis providers from these requirements as crisis providers will be required to fulfill crisis specific requirements related to beds
12VAC35-105-350-Condition of beds		Provides requirements for the condition of beds within residential and inpatient locations	Exempts crisis providers from these requirements as crisis providers will be required to fulfill crisis specific requirements related to the condition of beds
12VAC35-105-360-Privacy		Provides requirements for privacy	Exempts crisis providers from these requirements as crisis providers will be required to fulfill crisis specific privacy requirements
12VAC35-105-370-Ratios of toilets, basins, and showers or baths		Provides requirements regarding the ratios of toilets, basins and showers or baths in residential and inpatient locations	Exempts crisis providers from these requirements as crisis providers will be required to fulfill crisis specific requirements related to toilets, showers etc.
12VAC35-105-380-Lighting		Provides requirements regarding lighting	Exempts crisis providers from these requirements as crisis providers will have crisis specific requirements related to lighting
12VAC35-105-650 – Assessment policy		Provides requirements regarding the provider's assessment policy	Exempts crisis providers from these requirements as the regulatory action creates a new crisis assessment process more uniquely tailored to crisis providers
12VAC35-105-660 – Individualized		Provides requirements regarding individualized services plans	Exempts crisis providers from these requirements as the regulatory action creates a new safety plan and crisis ISP process more uniquely tailored to crisis providers

services plan (ISP)			
12VAC35-105-665- ISP requirements		Provides the required elements of ISPs	Exempts crisis providers from these requirements as the regulatory action creates a new safety plan and crisis ISP process more uniquely tailored to crisis providers
12VAC35-105-693 – Discharge		Provides the required elements of discharge policies and procedures	Exempts crisis providers from these requirements as the regulatory action creates a new discharge process more uniquely tailored to crisis providers
12VAC35-105-740- Physicial examination for residential and inpatient services		Requires that providers of residential or inpatient services to administer physical exams and lays out the requirements for those physical exams	Exempts crisis providers from these requirements as the regulatory action creates a new nursing assessment process that is more uniquely tailored to crisis providers
12VAC35-105-1120 – Vital signs		Requires providers to take vital signs	Exempts crisis providers from these requirements as the regulatory action creates crisis specific vital signs requirements
	Part VIII – Crisis Services		New part that creates provisions specifically tailored to crisis services and only applies to crisis providers.
	12VAC35-105-1830- Applicability of part		New section that clarifies that Part VIII only applies to crisis receiving centers, community-based crisis stabilization, crisis stabilization units, and REACH providers.
	12VAC35-105-1840- Staffing		New section that lays out the requirements for staffing of crisis receiving centers and community-based crisis stabilization, including those that provide mobile crisis response, crisis stabilization units, and REACH providers.
	12VAC35-105-1850		New section that lays out the requirements for a provider's crisis assessment policy. A crisis assessment is more tailored to crisis services, and therefore, is intended to be less administratively burdensome. The assessment has different elements based upon the crisis service being provided. More acute services have less elements. Mobile crisis response and CRC assessments include:

			• Diagnosis. • Risk of harm. • Cognitive functional status. • Precipitating issues. • Presenting needs. • Medical issues. • Medications. • Barriers to treatment. • Recovery environment and circle of support. • Communication needs. CSUs and community-based crisis stabilization providers need to collect these additional elements within their assessments: • Relevant treatment history. • Housing arrangements. • Trauma. • Involvement in systems, such as the legal system. If applicable to the individual's crisis, the assessment should also include: • The individual's social, behavioral, developmental, family history, and supports. • Employment, vocational, and educational background. • Cultural and heritage considerations. • Financial stressors. Crisis providers need only complete one assessment rather than an initial and comprehensive assessment as other providers are required to complete. Crisis assessments must be created as soon as possible after admission but no later than 24 hours after admission.
	12VAC35-105-1860-Safety plans and crisis		New section that lays out the timeframes for safety plans and crisis ISPs to be drafted and implemented. Both a safety plan and crisis ISP are more tailored to crisis services, and therefore, are intended to be less administratively burdensome than the ISP process.

	individualized services plans		Providers of crisis services for individuals with developmental disability are required to develop and implement a crisis education and prevention plan (CEPP), which can be used in lieu of a safety plan, if appropriate. If used as a safety plan, it must be developed and implemented immediately after admission. Providers of mental health and substance abuse crisis services are required to develop and implement a safety plan immediately after admission. A provider must develop and implement a crisis ISP as soon as possible after admission but no later than 48 hours after admission. More acute crisis services are not required to create a crisis ISP, only a safety plan.
	12VAC35-105-1870-Safety plan and crisis ISP requirements		New section that lays out the requirements of safety plans and crisis ISPs. Both a safety plan and crisis ISP are more tailored to crisis services, and therefore, are intended to be less administratively burdensome than the ISP process. All individual's receiving crisis services shall have a safety plan. A safety plan shall include: • Warning signs that a crisis is developing. • Internal coping strategies. • People and social settings the individual may turn to for support. • People the individual may ask for help. • Professionals or agencies the individual can contact during a crisis. • Things the individual can do to make his environment safe. A safety plan may include: • How to support an individual pre-crisis. • Specific instructions for the systems supporting the individual pre-crisis. • A description of how to support the individual during a crisis.

			• Specific instructions for the systems supporting an individual during crisis. If an individual requires medication management or seclusion, then the need shall be clearly documented in an attachment to the individual's safety plan. In addition to creating a safety plan, community-based crisis stabilization and crisis stabilization unit providers shall also develop and implement a crisis ISP. A crisis ISP shall include: • Relevant and attainable goals. • Services, supports, and frequency of services to accomplish goals. • Any use of seclusion. • The role of the individual and others in implementing the crisis ISP. • Identification of employees responsible for the coordination and integration of services. • A behavioral support or treatment plan. • Projected discharge date.
	12VAC35-105-1180-Crisis discharge planning		New section that lays out discharge requirements for crisis providers. The provision clearly states that crisis providers are not subject to the provisions of 12VAC35-105-693 that specifies discharge requirements for other licensed providers. This section is tailored to crisis services, and therefore, intended to be less administratively burdensome. Providers of mobile crisis response and crisis receiving centers are not required to provide discharge planning; instead they are required to make referrals to all follow up service providers and document such referrals. This process is typically called a "warm hand off" in the crisis community. Community-based crisis stabilization providers, crisis stabilization units, and REACH providers are required to have discharge policies

			and procedures including criteria for discharge. These providers are required to provide individuals receiving services with discharge instructions and within 30 days of discharge create a written discharge summary.
	12VAC35-105-1890- Nursing assessments		New section to replace the requirement for a physical examination. This section is tailored to crisis services with the intent of being less administratively burdensome and with the consideration of the staffing limitations of crisis service providers. CRCs, CSUs, and REACH CTH providers are required to administer nursing assessments within 24 hours of admission. This includes: • A screening for communicable diseases including tuberculosis. • Information about the non-psychiatric medical or surgical conditions of an individual. • A determination if there is need for further medical assessment or transfer to a more intensive level of care. • A determination if there is a medical crisis or underlying medical condition causing the crisis. Community-based crisis stabilization providers are not required to administer nursing assessments.
	12VAC35-105-1990 – Vital signs for crisis services		New section that requires crisis receiving centers, crisis stabilization units, and REACH CTH providers to take vital signs upon admission, during the provision of services as ordered, and at discharge.
	12VAC35-105-1910- Bed or Recliners for Crisis Services		New provision that requires crisis receiving centers to arrange for each individual to have a recliner or bed, and crisis stabilization units and REACH CTH providers to arrange for each individual to have a bed. The provisions also lay out requirements for recliners and beds and maintenance of them.
	12VAC35-105-1920- Bedrooms for crisis services		New section that applies to CSUs and REACH CTH providers. The provision lays out the requirements for bedrooms maintained by these providers.

	12VAC35-105-1930-Physical environment		New section that lays out physical environment requirements for crisis providers. These provisions are specifically tailored to crisis services with the understanding that monitoring and injury may be more common in a crisis setting.
	12VAC35-105-1940-Seclusion		New section that specifies seclusion is only allowed in crisis settings as permitted by the Human Rights Regulations [12VAC35-115].
	12VAC35-105-1950-Seclusion room requirements		New section that specifies the requirements of a seclusion room should seclusion be utilized in a crisis setting.
12VAC35-115-110- Use of seclusion, restraint, and time out		Does not allow seclusion in CRCs and CSUs.	Adds the allowance that seclusion may be ins CRCs and CSUs, within other existing restrictions. Requires that provider not use seclusion unless other less restrictive techniques have been considered and documentation is placed in the individual's safety plan, crisis ISP, or ISP.

CHAPTER 795

An Act to direct the State Board of Behavioral Health and Developmental Services to amend its regulations to ensure that its licensing and human rights regulations support high-quality crisis services in crisis receiving centers and crisis stabilization units; appropriate and safe use of seclusion; work group; report.

[S 569]

Approved April 17, 2024

Be it enacted by the General Assembly of Virginia:

1. *§ 1. The State Board of Behavioral Health and Developmental Services (the Board) shall amend its regulations to ensure that its licensing and human rights regulations support high-quality crisis services, including by authorizing the appropriate and safe use of seclusion in crisis receiving centers and crisis stabilization units. Such regulations shall, to the extent practicable, permit seclusion in the same manner authorized in other public and private facilities and programs licensed or funded by the Department of Behavioral Health and Developmental Services (the Department). Such initial adoption of regulations by the Board shall be exempt from the provisions of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).*

§ 2. The Department shall convene a work group to propose additional regulations to allow for the use of (i) evidence-based and recovery-oriented seclusion and restraint practices and (ii) alternative behavior management practices that may limit or replace the use of seclusion and restraint in hospitals, residential programs, and licensed facilities. In developing such regulations, the work group shall (a) solicit input from experts in the field of behavioral health, persons with relevant lived experience with the Commonwealth's behavioral health system, and staff from both public and private providers; (b) review any data and other information made available by the Department regarding seclusion and restraint, serious incidents, and complaints and investigations regarding the misuse of seclusion and restraint; (c) review current regulations and training policies; (d) examine practices used in other states, best practice recommendations from the Substance Abuse and Mental Health Services Administration, and evidence-based and trauma-informed practices recommended by other national experts; (e) identify practices and approaches that safely de-escalate persons in crisis and reduce or replace the use of seclusion and restraint; and (f) identify staffing, training, and monitoring practices related to seclusion and restraint and that limit and ensure the appropriate use of seclusion and restraint. The work group shall include the Secretary of Health and Human Resources or his designee; the Commissioner of Behavioral Health and Developmental Services or his designee; staff from public and private facilities, including frontline workers with treatment experience; at least three mental health consumers; representatives of the disAbility Law Center of Virginia; representatives of the Institute of Law, Psychiatry, and Public Policy at the University of Virginia; staff representatives of community services boards; at least one member of the House of Delegates, to be appointed by the Speaker of the House of Delegates; and at least one member of the Senate, to be appointed by the Senate Committee on Rules. The Department may seek assistance from faculty and students of institutions of higher education in the Commonwealth and, subject to the availability of funding, may contract with a third-party expert to lead and advise the work group. The Department shall submit a report of its findings, recommendations, and proposed regulations to the General Assembly by November 1, 2025.

2. That an emergency exists and this act is in its force from its passage.

Comments for the State Board of Behavioral Health and Developmental Services, May 14, 2024
Received May 11, 2024 via email.

I observe with great concern that Virginia Commonwealth University Town Hall and IFSB sponsored website announcements, such as the May 14 upcoming Townhall, appear to be overwhelmingly devoted to advocacy and support for groups which the Virginia Department of Behavioral and Developmental Disorders (DBHDS) sponsors under its Individual and Family Support Program (IFSP) which claims to advocate for *all* individuals and families with disabilities but in practice advocates primarily for DD/Autism/IDD "special needs" populations. As a member of a national organization that advocates primarily for peers and family members of the adult seriously mentally ill, I note that this advocacy has often been to the exclusion of *other* "special needs" and "marginalized" populations worthy of such advocacy, such as those older adults with Serious/Severe Mental Illness and Post-ICU Syndrome, which comprises a large population of those with complex medical needs, including neuropsychiatric, following the COVID19 pandemic. I note also that the IFSP and Virginia Commonwealth University appear in their legal advocacy for the developmentally delayed (DD) to be dominated philosophically for the care management model known as "Supported Decision-making" as opposed to legal advocacy for alternative case management models such as "Shared Decision-making" and "Experience-Based Co-Design". Many in our organization believe that the latter care management models are more appropriate to and effective in meeting the special needs of SMI and PICS older adults (over the age of 26) and their families by VCU and the DBHDS IFSP—many of whom are disabled and home-bound.

Please consider having VCU (my graduate school alma mater) consider expanding its vision and advocacy to include advocacy and support for *all* populations with special needs and disabilities, particularly in its pursuit of VCU's sponsorship of initiative to establish often scarce resources, such as support housing, employment, and education for *all* such marginalized populations. Tragedies resulting in part from the neglect of the needs of the SMI by policy makers involving the SMI, such as Irvo Otieno and Charles Byers, recently featured in the Richmond media (Richmond Times Dispatch, TV6) bear urgent testimony to the need for more effective advocacy and support of these often-marginalized populations! Virginia's Assertive Community Treatment (ACT) program has yet to be funded in Virginia on anywhere near the level of that provided by the Commonwealth through ARTS funding for those with Substance Use Disorders (SUDs) and Co-Occurring Disorders or through federal Medicaid Waiver 1115 funding. Please consider inviting speakers, including guest speakers from outside of VCU, to address the needs of these chronically underserved populations in a more representative manner than has been the case in the past.

Lastly, my organization, the National Shattering the Silence Coalition, supports policy advocacy initiatives, such as those currently underway in Virginia and the nation, that promote full parity and non-discrimination under law to serve these underserved

populations more effectively. Note that NIMH and the National Academies of Science have recently sponsored conferences highlighting historical disparities in research undertaken with these populations, and other minority populations, on which most federal funding decisions are made. These conferences highlight the need for equity and parity in serving *all* underserved "minority" and "marginalized" populations, including those with mental health disabilities.

Edmund W. Creekmore, Jr., MS, Ph.D., Licensed Clinical Psychologist, National Shattering the Silence Coalition Policy Action Co-Chair and Virginia Legislative Advocate