COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

DRAFT MEETING AGENDA

CONCURRENT COMMITTEE MEETINGS~~S~~

Wednesday, September 25, 2024
8:30 a.m. – 9:20 a.m.
DBHDS Southern Virginia Mental Health Institute, 382 Taylor Dr., Danville, VA 24541
These meetings will be in person with a physical quorum present, but electronic or phone connection is available.

8:30	• **Policy and Evaluation Committee** ***BJ Conference Room*** **OR* ***Teams Meeting:*** **Join the meeting** Meeting ID: 228 694 907 454 Passcode: 6czc7a ***OR* call in (audio only)** *Phone:* +1 434-230-0065,,662014388# Phone conference ID: 662 014 388# • **Planning and Budget Committee** ***Large Conference Room (Main Lobby)*** OR see main meeting info below (same login↓)	Madelyn Lent *Policy Manager* Josie Mace *Legislative Manager* **Agenda p.25** Ruth Anne Walker *Board Liaison* **Agenda p.17**
9:20	**Adjourn**	

CONTINUED -

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

REGULAR MEETING

Wednesday, September 25, 2024
9:30 a.m. – 2:00 p.m.
DBHDS Southern Virginia Mental Health Institute, 382 Taylor Dr., Danville, VA 24541

***This meeting will be in person with a physical quorum present, but electronic or phone connection is available:**
Join the meeting now
Meeting ID: 212 700 268 679
Passcode: QRRNHo

OR Phone: (audio only)
+1 434-230-0065,,942446800#
Phone conference ID: 942 446 800#

1.	9:30	**Call to Order and Introductions** **Approval of September 25, 2024, Agenda** ➢ *Action Required* **Approval of Draft Minutes** **Dinner Meeting, July 16, 2024** **Nominating Committee Meeting, July 16, 2024** **Regular Meeting, July 17, 2024** ➢ *Action Required*	Moira Mazzi *Chair*	**4**
2.		**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., September 24, 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 10:00 p.m. on September 25, 2024.		
3.	9:40	**Regulatory Updates** ➢ *Action requested: Authorize four fast track actions.* **A. Valid Discharge Plans: Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services [12VAC35-105].** **B. Addition to List of Practitioners in Requirements for Virginia Early Intervention System [12VAC35-225].**	Ruth Anne Walker *Regulatory Affairs Director* Jae Benz *Licensing Director* Kyla Patterson *Part C Coordinator*	**40** **43**

		C. Regulatory Reduction: Children's Residential Facilities [12VAC35-46]. **D. Regulatory Reduction: [12VAC35-105].**		**47** **92**
4.	10:00	**Commissioner's Report**	Nelson Smith *Commissioner*	
5.	10:45	**Facility Tour**	*Board members and staff only*	
6.	11:15	**SVMHI Overview**	Robin Crews *Director*	
7.	11:35	**Legislative and Budget Update**	Nathan Miles *Budget Director* Josie Mace *Legislative Affairs Manager*	
8.	12:00	**Lunch: Break and Collect Lunch**		
9.	12:30	**Human Rights Annual Report**	Taneika Goldman *State Human Rights Director*	
11.	1:00	**Virginia Association of Community Services Boards**	Jennifer Faison *VACSB Executive Director*	
12.	1:30	**Overview: Competency Restoration Process and Data**	Elizabeth Hunt *Forensic Evaluation Manager* *Division of Forensic Services*	
13.	1:50	**Committee Reports** **A. Planning and Budget** **B. Policy and Evaluation** 1. Summary of Recommended Actions 2. Draft revised policies: a. **1007(SYS)86-2** Behavioral Health and Developmental Services for Children and Adolescents and Their Families b. **4023(CSB)**86-24 Housing Supports c. **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 3. Rescind: 1010(SYS)86-7	Ruth Anne Walker Madelyn Lent	**25** **26** **27** **29** **34** **37**
14.	2:10	**Miscellaneous** **A. SHRC Appointment** **B. Liaison Updates: Confirmation of New Assigned Areas.**	Moira Mazzi	**134**

15.	2:30	**Adjournment**		

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

MEETING SCHEDULE

DATE*	Location
2024	
December 11 (Wed)	Central Office **Richmond**
2025	
April 2 (Wed)	Western State Hospital **Staunton**
July 9 (Wed)	Southeastern Virginia Training Center **Richmond**
Late Sept/Early Oct TBA	TBA
December TBA	Central Office **Richmond**

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

BOARD DINNER MEETING
DRAFT MINUTES

Tuesday, July 16, 2024
6:00 p.m. – 7:30 p.m.
Colonial Behavioral Health, 1657 Merrimac Trail, Williamsburg VA 23185
This meeting was held entirely in person; no business was conducted.

	Members Present: Blake Andis; Varun Choudhary; Rebecca Graser; Cindy Lamb; Moira Mazzi; Jane McDonald; and Sandra Price-Stroble. **Staff Present:** Daniel Herr; Meghan McGuire; Ruth Anne Walker. **Invited Guests:** David Coe; Ed Gonzalez; Denise Kirschbaum.
Welcome and Introductions	At 6:00 p.m., member Sandra Price-Stroble, on behalf of the chair, called the meeting to order, noted a quorum was present, and welcomed everyone present. Ms. Price-Stroble indicated no business would be conducted and the purpose of the meeting was to receive information about community activities.

	On behalf of the board, Ms. Price-Stroble thanked to all who were present She noted that the location host, David Coe, Director of Colonial Behavioral Health, until the previous month was also the leader of the CSB regional consortium of CSB directors.
Dinner	At 6:10 p.m., Ms. Price-Stroble invited all to begin dinner.
Presentation – Colonial Behavioral Health	At 6:25 p.m., David Coe provided an overview of the portfolio of services provided by Colonial Behavioral Health. Ed Gonzalez, Director, Chesapeake Behavioral Health and new head of the regional consortium, and Colonial Board Member Denise Kirschbaum also provided comment.
Remarks	At 6:55 p.m., Daniel Herr, Director of the DBHDS Eastern State Hospital, provided some remarks.
Comments/Discussion	At 7:05 p.m., members asked a few clarifying questions and gave comments regarding information presented.
Closing Remarks	At 7:10 p.m., Meghan McGuire, Deputy Commissioner, Policy and Public Affairs, provided closing remarks about the topics covered.
Adjournment	Ms. Price-Stroble expressed thanks to David Coe and the Colonial staff for arranging the tours and for us to use this space. She thanked Mr. Coe for his presentation, and Mr. Gonzalez and Ms. Kirschbaum for participating. Ms. Price-Stroble adjourned the dinner meeting at 7:15 p.m.

NOMINATING COMMITTEE MEETING

(per Bylaws, Article 4.a-b.)

DRAFT MINUTES
Tuesday, July 16, 2024
Upon adjournment of the Dinner Meeting
DHBDS, Colonial CSB, 1657 Merrimac Trail, Williamsburg Va 23185

This meeting will be in person with all members physically present.	
Call to Order	Committee Chair Rebecca Graser called the meeting to order at 7:23 p.m. A quorum was present.
Approval of July 16, 2024, Agenda	*On a motion by Varun Choudhary and a second by Blake Andis, the agenda was adopted.*

Consideration of Nominees for Slate	Ms. Graser referenced that the Bylaws of the Board lay out the timeframe for the nominations and elections of officers. She reported that after communicating with all members to confirm interest of anyone interested in running for the chair and vice chair positions, that only Moira Mazzi was interested in running for chair and only Sandra Price-Stroble was interested in running for the vice chair position. *Mr. Choudhary moved to nominate as a slate, Moira Mazzi for the chair position and Sandra Price-Stroble for the vice chair position. Mr. Andis seconded the motion.* The vote was unanimous to adopt the slate as presented. Ms. Graser announced that the report of the committee would be made to the full board at the July 17, 2024, regular meeting.
Adjournment	Ms. Graser adjourned the meeting at 7:30 p.m.

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

Committee Members: Rebecca Graser, Chair; Blake Andis; Varun Choudhary.

REGULAR MEETING
DRAFT MINUTES
Wednesday, July 17, 2024
DBHDS Eastern State Hospital
4601 Ironbound Road, Williamsburg, VA 23188-2652
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 (telephonic); R. Blake Andis; Varun Choudhary; Rebecca Graser; Cindy Lamb; Moira Mazzi; Jane McDonald; Sandra Price-Stroble; and Anthony Vadella.
Members Absent	(none)
Staff Present	▪ Lauren Cunningham, Communications Director. ▪ Curt Gleeson, Assistant Commissioner, Division of Crisis Services. ▪ Taneika Goldman, Director, Office of Human Rights. ▪ Daniel Herr, Director, Eastern State Hospital. ▪ Kevin Howard, Chief Administrative Officer, Eastern State Hospital. ▪ Alethea Lambert, Director, Office of Recovery Services. ▪ Madelyn Lent, Policy Manager. ▪ Meghan McGuire, Deputy Commissioner, Policy and Public Affairs. ▪ Chaye Neal-Jones, Deputy Director, Office of Enterprise Management Services. ▪ Susan Puglisi, Regulatory Research Specialist. ▪ 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. Virtual: ▪ Cara Kaufman, DARS. ▪ Lisa Robertson, DARS. ▪ Eva Pfeiffer, GOV.
Call to Order and Introductions	At 9:38 a.m., Elizabeth Hilscher, Chair, called the meeting to order and welcomed those present. A quorum of eight members was physically present; one member participated remotely. Ms. Hilscher explained that though her term ended on June 30th, until it is filled, she could continue to serve on the board. Ms. Hilscher welcomed new board members Jane

	McDonald and Tony Vadella, and then called for introductions of all present. On behalf of the Board, Ms. Hilscher thanked first Colonial Behavioral Health Director David Coe and staff for the tour, meeting location, and presentation the day before at the dinner meeting, along with comments from Chesapeake Behavioral Health's Ed Gonzalez, and Eastern State Hospital Director Daniel Herr. She also thanked Mr. Herr and all the staff at Eastern for the hospitality, including the breakfast.
Approval of Agenda	*At 9:45 a.m. the State Board voted to adopt the July 17, 2024, agenda. On a motion by Cindy Lamb and a second by Jane McDonald, the agenda was approved.*
Approval of Draft Minutes	*At 9:47 a.m., on a motion by Varun Choudhary and a second by Blake Andis, the May 14, 2024, special called meeting minutes were approved as final, with three abstentions by members that were not present (Ms. Lamb, Ms. McDonald, and Anthony Vadella).*
Officer Elections	**Officer Elections** At 9:48 a.m., Ms. Hilscher asked Rebecca Graser, Chair of the 2024 Nominating Committee, to present the slate of candidates. **A. Presentation of the Slate of Candidates** Ms. Graser reported that the committee, which included members Mr. Andis and Dr. Choudhary, met the previous evening following the dinner meeting. The committee unanimously approved a slate of officers with Moira Mazzi for the Chair position and Sandra Price-Stroble for the Vice Chair position. **B. Nominations from the Floor** Ms. Hilscher thanked Ms. Graser and the committee for their work. In accordance with the Bylaws, Ms. Hilscher opened the floor for any additional nominations. There were no additional nominations. **C. Election** *On a motion by Ms. Lamb and a second by Sandra Price-Stroble, Moira Mazzi was unanimously elected as Board Chair.* *On a motion by Dr. Choudhary and a second by Ms. McDonald, Sandra Price-Stroble was elected unanimously as Board Vice Chair.*

	D. Passing of the Gavel Ms. Hilscher thanked member, congratulated the new officers, and 'passed the gavel' to the new chair, Ms. Mazzi.
Public Comment	At 9:52 a.m., Ms. Mazzi called for public comments. No verbal comments were received. Written comments were submitted by Ed Creekmore (see attachment).
Facility Presentation: Eastern State Hospital	At 9:54 a.m., Mr. Herr presented an overview of the hospital, beginning with its history and including the formative role of its founder in shaping the understanding of and public policy around caring for mental health disorders. More recent history includes: • 2014 to 2019 – An Acute Care Hospital: The bed of last resort legislation resulted in a 300% increase in admissions and transformed ESH from a geriatric and long-term care hospital focused on psychosocial rehabilitation and community reentry to an acute care hospital. • 2020 to 2024 – A Forensic Center Of Excellence: COVID-19, staffing shortage with concomitant reductions in operational beds, and increasing demand for care for individuals involved with the criminal justice systems transform ESH into a forensic hospital Mr. Herr spoke about the effort to shift the focus from violence management to a culture of active treatment and safety through: ▪ Elimination of mandatory overtime and achieve minimum staffing with contract staff ▪ Increasing the hiring rate; maintaining a leadership presence on all shifts; listening sessions; and action plans based upon employee engagement surveys. ▪ Unit based programming. ▪ Weekly multidisciplinary team reviews of: ▪ Seclusion and restraint events. ▪ Individuals that are high risk, clinically complex, and medically fragile. ▪ Increased inclusion and engagement in debriefing post crisis response. ▪ Investments in professional development and clarity of expectations for nurse managers and crisis prevention and response teams. ▪ Use of videos to identify opportunities in high risk interventions and worker's compensation events. Trending data was presented regarding state hospital bed use, admissions by legal status (civil, criminal temporary detention order, not guilty by reason of insanity, and restoration), acts of

physical aggression, and use by type of seclusion and restraint.

ESH's commitment to quality was recognized with the 2021 SPQA Commitment to Performance Excellence Award, part of its journey to implement the national Malcolm Baldrige Performance Excellence framework that focuses on five key performance areas: Product and process; customer; workforce; leadership and governance; and, financial and market.

Workforce challenges and successes include:

- **Total Workforce**: 855 classified positions with 178 vacancies and 21% vacancy rate
- **Critical Clinical Vacancy Rates**: Providers = 45%; Psychologists = 22%; LPNs = 70%; RNs = 38%; DSAs = 16%
- **Significant Accomplishments**:
  - Lowered overall vacancy rate by 33% in 11 months, dropping form 32.4% in July 2023 to 21% in May 2024.
  - Decreased the use of contract DSAs by 75.5% in 10 months, dropping from 54 FTEs September 2023 to17 FTEs June 2024.
  - Increased the use of part time nursing staff by 43% in 10 months, growing from 7.74% of total nursing hours in July 2023 to 11.03% in April 2024.
  - Doubled the rate of monthly new hires this calendar year when compared with last calendar year, growing from a monthly average of 25 new hires to an average of 60 new hires.

There are a number of capital outlay projects for buildings and grounds, including the completion of an exterior fence for Building ($2 - $3M). DBHDS previously received $5.93 million to address physical plant needs at ESH since its buildings were not designed to serve a forensic patient population nor comply with evolving regulatory standards. This year, DBHDS was awarded an additional $24.3 million in capital funds to continue this work, including hardening of the bathroom walls in all patient occupied buildings, removing ligature risks in Building #1, as well as mitigating other patient safety needs in Building #1; and a new access control system ($4.2M). Future projects include: a kitchen renovation ($16M) and a sewer and water line replacement ($7.8M).

Ms. Lamb asked about the attrition rate, and also about the decrease of 75% of contracts regarding how that impacted the

	budget. Mr. Herr responded that the core challenge is that the least costly contract staff (decreased by approximately 24% in costs) while contract staff increases have been in the highest paying positions (psychiatrists, doctors, nurse practitioners was approximately a 40% cost jump). Therefore, there was not a budget amount. Regarding turnover, when Mr. Herr arrived the DSA rate was about 70% and now they are about 35-40%. Overall, the rates have improved. Ms. McDonald asked about number of beds and if all were staffed beds. Mr. Herr confirmed there were 302 beds, with 22 offline during the bathroom renovations. Some geriatric beds will be shifted to adult beds, which will be an increase by 10 beds. A core challenge around incidents of violence among individuals receiving services in ESH is that approximately 14 more patients are in the hospital than the original plan, which means there is some double bunking. Ms. Graser asked what Mr. Herr thought caused the trend for such an increase of forensic admissions. The recent changes to state law made them a priority over civil admissions. State hospitals must admit within 10 days of receipt of the order. Meghan McGuire added that the two laws, bed of last resort and the requirement to accept admissions, has sandwiched the hospitals. Mr. Herr indicated that the average length of stay for competency restoration is approximately 100 days versus not guilty by reason of insanity (NGRI) length of stay is more around four years, and thus, greatly decreases the number of available beds to other categories. The region has about double the number of NGRIs as other state hospitals. Forensic TDOs are now being diverted to other hospitals outside of the region.
Facility Tours	At 10:20 a.m., Ms. Mazzi announced that the meeting would suspend while board members toured Eastern State Hospital with Mr. Herr. The meeting would resume at approximately 11:00 a.m. following the tour.
Commissioner's Report	At 10:58 a.m., Commissioner Nelson Smith provided his report covering these topics: ▪ US Department of Justice Settlement Agreement with Virginia. The Commonwealth is currently in compliance with 83% of provisions and 90% of indicators. Virginia submitted a Motion for Permanent Injunction, which outlines responsibilities for remaining non-compliant indicators and sets long-term commitments for reporting. A hearing is scheduled for August 22, 2024.

	▪ Results of a pilot regarding transportation of individuals under a temporary detention order (TDO) who need to be taken to a state facility or provider using special conservators of the peace (SCOPs). ▪ Adult Psychiatric Access Line (APAL): In partnership with the Medical Society of Virginia, a statewide consult and care navigation for adults with substance use disorders to access specialized mental health services and prepare primary care and emergency clinicians to support individuals' behavioral health needs around three components: Provider education, telephonic consultations, and care navigation assistance. This builds on the success of the Virginia Mental Health Access Program (VMAP) for children. Expansion of the program to mental health is planned. ▪ State hospital bed utilization and the impact of competency restoration. More detail was provide on forensic bed usage, specifically, that forensic admissions to state facilities increased nearly 93% from FY14 – FY23. The primary driver in forensic admission increases is restoration orders, which increased over 143% in the same time period. One consequence is that there are only 30 state civil beds in Region 5 as of 4/22/24. Mr. Smith noted that people with serious mental illness (SMI) are more likely to be: arrested and confined in jail; not granted bail or not able to pay cash bail; confined in jail or a hospital longer than misdemeanor offenders without SMI; and traumatized by incarceration or involuntary admission. Most defendants are restored to competency with an average length of stay of 106 days. Once restored, defendants are returned to jail. The impact of misdemeanor defendants is significant as over 30% of restoration admissions are for misdemeanors. These take enormous amounts of resources and costs to face very minor charges and get timed served. Mr. Smith mentioned several solutions DBHDS is engaged in to address the restoration trend. ▪ The commissioner reminded members of the agency's public dashboard as an important step in planning and accountability efforts. This includes a CSB performance dashboard. He was excited about the comprehensive change happening to the system because of the Governor's Right Help Right Now initiative and the DBHDS strategic plan. Dr. Choudhary asked about the structure of outpatient competency restoration. Mr. Smith stated that it is primarily a

	decision of the court, though forensic evaluators weigh in with their expertise on where an individual should receive restoration services. Ms. McDonald responded that the CSBs are involved but are not mandated to do it. Mr. Herr stated there are three distinct components to come together: psychiatric stability, understanding the court system, and licensed clinical psychiatrist or psychologist to write the report. They could be three different people. If an individual has a developmental disability, that requires additional specialty. Dr. Choudhary stated it would be good to be innovative and think outside the box to develop options for outpatient competency restoration. Ms. Graser seems it could be feasible to do with CSBs for the misdemeanors. Mr. Smith responded to the comments that it would be helpful to get a report on the levels of intercept. Mr. Vadella asked about coordination between mobile crisis teams and 988? Mr. Smith responded the model continuum is someone to call, someone to come, somewhere to go. Virginia Crisis Connect brings it all together. In June there were over 10,000 calls. Over 90% are resolved on the phone. Dr. Choudhary asked about changes in the budget for Right Help Right Now? Mr. Smith responded that there have been appropriations in the hundreds of millions. The General Assembly provided 58M last year for the crisis receiving centers, and this year another 30M is appropriated to sustain the buildout of the crisis system. There was additional funding for developmental disability (DD) Medicaid Waivers and pay raises for the facilities including food services. He explained that there were systems already in place doing good work and the focus has been on connecting those to new projects to improve overall. Mr. Smith thanked the members for their work that contributes to the mission of the agency.
Regulatory Actions	**A. Initiation of Fast Track: Certified Recovery Residences [12VAC35-260]** At 11:35 a.m., Ms. Mazzi welcomed Alethea Lambert, Director, DBHDS Office of Recovery Services. Ms. Walker gave a brief review of the impetus for and purpose of the action was to comply with the requirements of Chapter 30 of the 2024 Session of the General Assembly to add the requirement that

	any certified recovery residence in Virginia report any death or serious injury that occurs in the recovery residence to DBHDS. Separately from this action, a periodic review was due to be conducted. A total of 13 comments were received and are listed after the language for this action. Staff determined that none warranted additional edits to this action or a separate action. After a brief discussion, members were asked to initiate a fast track action to amend 12VAC35-260 in accordance with the legislation. Dr. Choudhary asked why these residences should not become licensed services. Ms. Walker responded that the regulations follow the peer-run model. Action by the General Assembly would be required to amend the Code of Virginia to change from that model. Ms. Graser commented that the Oxford House model has been around a long time. In recent years, the funding from the General Assembly has been very helpful for housing for individuals in crisis who seek recovery. Even though services are not provided in the residence, there is facilitation to connect to services. *On a motion by Dr. Choudhary and a second by Ms. Price-Stroble, initiation of the fast track action was approved.* **B. Action Item. Withdrawal of Exempt Final. Initiate Fast Track: Amendments per HB679 (2020) to Application Requirements: Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services ("Licensing Regulations") [12VAC35-105-40].** Ms. Walker asked for action motion to withdraw the final exempt action to amend 12VAC35-105, and to initiate it as a fast track action per direction from the Office of the Attorney General. *On a motion by Ms. McDonald and a second by Ms. Price-Stroble, the process change was approved.* **C. Regulatory Activity Status Update.** Ms. Walker directed members to the status matrix of all current actions and drafts in progress. She reminded members that the final exempt action on high quality crisis services voted on at the May meeting had become effective that day. Ms. Walker paused to acknowledge the contributions of Ms. Puglisi, in conjunction with the Crisis Division, Office of Licensing, and

	other agency experts. A chart of planned regulatory activity through April was distributed to members, with the emphasis on the unusually high number of actions planned to come to the board across the next three meetings.
Lunch: Break and Collect Lunch	*A brief lunch break was held from 12:20 p.m. to 12:30 p.m.*
Update: Board Priority 5: Bed of last resort law.	Suzanne Mayo, Assistant Commissioner for Facility Services, gave an update on one of the board's priorities for the biennium, the bed of last resort law (BOLR, Senate Bil 260 (2014)) that changed the Code of Virginia to state that if an individual who was recommended for a TDO was not accepted to an inpatient bed by the end of the emergency custody order (ECO) period, the individual "shall be detained in a state facility" (§ 37.2-809) to ensure that anyone who required emergency psychiatric treatment under a TDO had a bed identified and received treatment before being released. And, this purpose was achieved for the first few years. However, this well-intended law has extensive unintended consequences in that there are 'no guardrails,' meaning state hospitals had no legal ability to deny any admission of an individual under a TDO. Between FY2014 and FY2019, TDO admissions to state facilities rose over 400% while the percentage of TDOs accepted by private hospitals decreased. By 2019, Virginia's state hospitals were operating (and continue to operate) at 95-100%+ utilization at all times with significant increases in incidents of aggression at state hospitals, as well as worker's compensation claims. The law puts most of the responsibility related to TDOs on state hospitals and law enforcement; thus there is a lack of shared responsibility with private community hospitals, community services boards (CSBs), private providers, and other state agencies. The law unintentionally enables high levels of risk aversion and an unwillingness to care for challenging individuals from other parts of the system. Also, it unintentionally results in individuals who could be served in less restrictive levels of care being admitted to state hospitals for institutional care. The Joint Legislative Audit and Review Commission (JLARC) Report Document 584 (2023), Virginia's State Psychiatric Hospitals analyzed Virginia's system under BOLR. Ms. Mayo stated that the following questions remain on how to ensure:

	▪ Shared responsibility across the system for serving individuals exhibiting acute and challenging behaviors that are in need of mental health care. ▪ State hospitals are not forced to admit individuals with extensive or acute medical needs that the hospitals are not equipped to serve. ▪ Individuals are not placed under TDOs as a result of needs such as housing services and substance use disorder treatment. ▪ Individuals receive treatment in the least restrictive settings necessary. ▪ Individuals do not have to wait long times for care, and receive it. ▪ Law enforcement is not overburdened with providing custody for individuals under TDOs. ▪ State hospitals can resume serving individuals who truly do require longer hospitalizations for stabilization.
Update: Virginia Association of Community Services Boards	At 12:57 p.m., Jennifer Faison, Executive Director, VACSB, reported on the association's activities since adjournment of the General Assembly, including an advocacy pivot to focus from the behavioral health workforce challenges to the developmental disability service system. In particular, the new Medicaid waiver slots to be phased in over each quarter of the biennium. She noted there are some implementation issues that would carry the last distribution beyond the biennium.
Update, Board Priority 6: Temporary Detention Orders (TDOs).	At 1:30 p.m., Curt Gleeson, Assistant Commissioner for Crisis Services, presented on another priority area of interest to the board, temporary detention orders. He reviewed relevant literature; recent General Assembly workgroups, reports, and changes to state law; state initiatives; and the current civil commitment process including criteria for commitment and the assessment by the certified evaluator. Mr. Gleeson reviewed the involuntary commitment process in other states (Arizona, Pennsylvania, New Jersey, and North Carolina), the SAMSHA Policy Guidelines for Involuntary Commitment (2019), and the Mental Health America recommended best practices.
Committee Reports	**C. Planning and Budget** At 1:57 p.m., Ms. Walker reported that there was not a quorum present due to recent appointments and officer elections, therefore no business would be conducted. Ms. McGuire met with the committee about forensic admissions. Ms. Walker reviewed the existing chart of planned topics by board meeting date for the two newly appointed members. The quarterly

	budget report was distributed in the meeting; it was shared to the full board during the report out. **D. Policy and Evaluation** At 2:00 p.m., Madelyn Lent, Public Policy Manager, reported out for the committee. After reviewing the six-year review schedule and the specific workplan for FY 2025, the following policies were discussed: • 4010(CSB)83-6 Local Match Requirements for Community Services Boards (Revisions) Data from CSBs was reviewed. The committee voted to have the draft revisions will be circulated via email for a field review to CSBs, with all comments collected in table with staff responses for September. The committee had unanimous votes on the following decisions for a packet of recommendations to come to the board in September: The following policies were approved with draft revisions: ▪ 1007(SYS)86-2 Behavioral Health and Developmental Services for Children and Adolescents and Their Families (Revisions) ▪ 4023(CSB)86-24 Housing Supports (Revisions) ▪ 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 (Revisions) One policy was approved with a recommendation for rescission: ▪ 1010 (SYS) 86-7 Board Role in the Development of the Department's Comprehensive State Plan for Mental Health, Mental Retardation, and Substance Abuse Services. (§ 37.2-315 Comprehensive State Plan for Behavioral Health and Developmental Services was repealed in 2022)
Miscellaneous	C. **SHRC Appointments** Ms. Mazzi turned members' attention to the last action item, a requested appointment of Betty Crance to the State Human Rights Committee submitted by Taneika Goldman, Director of the Office of Human Rights, on behalf of the SHRC. On a motion by Tony Vadella and a second by Dr. Choudhary, Ms. Crance was unanimously appointed as a member of the SHRC. **D. Liaison Updates**

	Ms. Mazzi stated that with the appointment of new members, there would be some adjusting to assigned liaison areas that she would work with staff to have ready for the board's review in September. Ms. Price-Stroble reported her plans to attend a regional meeting that Friday. **E. Committee and Board Liaison** Ms. Mazzi stated that, with the officer elections, according to the Bylaws, the chair serves on the Planning and Budget Committee and the Vice Chair is the Chair of the Planning Committee; therefore, those changes are effective. Also, with those required changes in membership on the committees, this was another follow up on which she would work with staff, including to contact board members regarding any shifts to committee assignments. Those changes would be announced prior to the September meeting, so the work of the committees can continue uninterrupted.
Other Business	**Next Meeting:** September 25, Danville.
Adjournment	There being no other business, Ms. Mazzi expressed thanks again to all the staff at the hospital, the CSB, Nelson Smith and other DBHDS staff that presented, and to the board members for their time. The meeting was adjourned at 2:15 p.m.

MEETING SCHEDULE

DATE	Location
2024	
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**

Attachment: Written Comments Received

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

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.

PLANNING AND BUDGET COMMITTEE
DRAFT MINUTES

JULY 17, 2024
8:30-9:25 AM
DBHDS EASTERN STATE HOSPITAL - DIRECTOR'S CONFERENCE ROOM, 1282
4601 IRONBOUND ROAD, WILLIAMSBURG, VA 23188-2652

This meeting was held in person with electronic or phone connection available. A recording of the meeting is available. A physical quorum was not present.

MEMBERS PRESENT: R. BLAKE ANDIS; CINDY LAMB.
MEMBERS ABSENT: ELIZABETH HILSCHER, BOARD AND COMMITTEE CHAIR (TERM ENDED BUT CONTINUING TO SERVE).
OTHER BOARD MEMBERS PRESENT: JANE MCDONALD; ANTHONY VADELLA.
STAFF PRESENT: MEGHAN MCGUIRE; RUTH ANNE WALKER.

I. Call to Order
Ruth Anne Walker reported that there was not a quorum present due to recent appointments and officer elections, therefore no business would be conducted. However, the two members present and the two newly appointed board members (not appointed to the committee) could receive information and have general discussion.

II. Welcome and Introductions

III. Adoption of Minutes, April 4, 2024 (p.16)
The April minutes could not be adopted as no quorum was present.

IV. Adoption of Agenda, July 17, 2024
The April agenda could not be adopted as no quorum was present.

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.
Statt reviewed the chart of planned priority topics by board meeting dates.

VI. Other Business

A. State Board Budget Quarterly Report.

A handout of the quarterly budget report was provided.

B. General Updates

Meghan McGuire, Deputy Commissioner, Policy and Public Affairs met with the committee about forensic admissions.

VII. Next Steps:

A. Standing Item: Report Out

Staff would provide a report of the day's meeting to the Board in the regular meeting.

B. Next Meeting:

The next meeting is scheduled for September 28, 2024, Danville.

VIII. Adjournment

The committee meeting ended at 9:15 a.m.

POLICY AND EVALUATION COMMITTEE
DRAFT MINUTES
JULY 17, 2024
DBHDS EASTERN STATE HOSPITAL - KLINE CONFERENCE ROOM, 1201
4601 IRONBOUND ROAD, WILLIAMSBURG, VA 23188-2652
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: VARUN CHOUDHARY; REBECCA GRASER; MOIRA MAZZI; SANDRA PRICE-STROBLE
STAFF PRESENT: MADELYN LENT, POLICY MANAGER; JOSIE MACE, LEGISLATIVE DIRECTOR (VIRTUAL)
GUESTS PRESENT: KATIE BOYLE (VIRTUAL); DR. EDMUND CREEKMORE (VIRTUAL).

I. Call to Order
Sandra Price-Stroble called the meeting to order at 8:35 AM.

II. Welcome and Introductions
Everyone in attendance provided a brief introduction.

III. Adoption of Minutes, April 4, 2024
Varun Choudhary moved to adopt the minutes. Rebecca Graser seconded. The minutes were adopted unanimously.

IV. Adoption of Agenda, July 17, 2024
Dr. Choudhary moved to adopt the agenda. Ms. Graser seconded. The agenda was adopted unanimously.

V. Review of Policy Review Plan for FY2025
Madelyn Lent presented the policy review plan to the committee.

VI. Presentation of Policies for Discussion

A. 4010(CSB)83-6 Local Match Requirements for Community Services Boards (Review comments received from Community Services Boards (CSBs) and DBHDS Staff Suggested Revisions)

Members discussed comments received from CSBs, reviewed CSB local match summary statistics, and requested staff present data on local match waivers at the next meeting. Members requested a field review of proposed policy revision to the local match policy. At the suggestion of staff, members directed staff to initiate a second field review of the policy to receive comments from CSBs on DBHDS recommended revisions.

VII. Presentation of Policies for Vote to Recommend Revisions to the Board

Ms. Lent presented the Summary of Recommended Actions to the committee.

A. 1007(SYS)86-2 Behavioral Health and Developmental Services for Children and Adolescents and Their Families (Revisions)

Dr. Choudhary motioned to accept the revisions as presented; Ms. Graser seconded. Members voted unanimously to move forward with revisions.

B. 4023(CSB)86-24 Housing Supports (Revisions)

Dr. Choudhary motioned to accept the revisions as presented; Ms. Graser seconded. Members voted unanimously to move forward with revisions.

C. 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 (Revisions)

Dr. Choudhary motioned to accept the revisions as presented; Ms. Graser seconded. Members voted unanimously to move forward with revisions.

VIII. Presentation of Policy for Vote to Recommend Rescinding to the Board

A. 1010 (SYS) 86-7 Board Role in the Development of the Department's Comprehensive State Plan for Mental Health, Mental Retardation, and Substance Abuse Services. (§ 37.2-315 Comprehensive State Plan for Behavioral Health and Developmental Services was repealed in 2022)

Dr. Choudhary motioned to accept the recommendation to rescind presented by Ms. Lent; Ms. Graser seconded. Members voted unanimously to rescind.

B. Next Quarterly Meeting: September 25, 2024.

C. Adjournment

Ms. Price-Stroble adjourned the meeting at 9:13 AM.

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

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Planning and Budget Committee

DRAFT AGENDA

SEPTEMBER 25, 2024

8:30-9:25 AM

DBHDS SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE,

382 TAYLOR DR., DANVILLE, VA. 24541

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

IX. Call to Order

X. Welcome and Introductions

XI. Adoption of Minutes, April 4, 2023

XII. Adoption of Agenda, September 25, 2024

XIII. 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.*

B. 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.

XIV. Other Business

A. State Board Budget Quarterly Report. *Handout*

B. General Updates *Meghan McGuire, Deputy Commissioner, Policy and Public Affairs*

XV. Next Steps:

C. Standing Item: Report Out

Updates from committee planning activities would be reported out to the Board in the regular meeting.

D. Next Meeting:

The next meeting is scheduled for September 28, 2024, Danville.

XVI. Adjournment

Policy and Evaluation Committee

DRAFT AGENDA

SEPTEMBER 25, 2024

DBHDS SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
382 TAYLOR DRIVE, DANVILLE, VA 24541

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

I. Call to Order

II. Welcome and Introductions (5 min)

III. Adoption of Minutes, July 17, 2024

IV. Adoption of Agenda, September 25, 2024

V. Review of Policy Review Plan for FY2025 (10 min)

VI. Presentation of Background Reviews (20 min)

DBHDS Staff present background information for Policy 2010 (ADM ST BD)10-1 Review and Comment on Behavioral Health and Developmental Services Budget Priorities and Policy 5006(FAC)86-29 Demolition of Dilapidated Buildings on the Grounds of State Facilities

VII. Presentation of Policy for Vote to Recommend Revisions to the Board (15 min)

Review comments received from Community Services Boards Field Review for Policy 4010(CSB)83-6 Local Match Requirements for Community Services Boards and vote on recommended revisions

VIII. Next Quarterly Meeting: December 11, 2024.

IX. Adjournment

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

Policy and Evaluation Committee
Summary of Recommendations to the State Board
09/25/2024

This summary includes all substantive actions for each policy listed by subsection as recommended by the Policy Committee at their July 17 meeting. Additional technical and grammatical amendments are noted in the draft policies.

Revise Policy 1007(SYS) 86-2 Behavioral Health and Developmental Services for Children and Adolescents and Their Families

References

Add "Code of Virginia Chapter 39. Virginia Human Rights Act" as a reference. Language consistent with this chapter is being added to the Policy section.

Background

Add language "The developmental disabilities waiver was redesigned by the Department of Medical Assistance Services (DMAS) in collaboration with DBHDS and stakeholders in 2016 to build capacity for integrated services." This provides context for existing and new language referring to the waiver in the policy section.

Policy

Replace "Community settings are construed broadly in this policy to include public or private inpatient or residential treatment facilities, which are part of the overall continuum of care" with "across the continuum of care in public or private" community, "residential, or inpatient settings". This change will more accurately reflect the distinctions between service settings within the continuum of care.

In the anti-discrimination clause, after "Children and families receive services without regard to race," add "color". After "religion, national origin" add "pregnancy, childbirth or related medical conditions, age, marital status, sexual orientation". After "gender" add "identity, military status". Including this language will support consistency with the language used in the Virginia Human Rights Act.
Replace "support" with "provider". This language will more accurately reflect the role of DBHDS in operationalizing the Medicaid waiver for developmental disability services.

Revise Policy 4023 (CSB) 86-24 Housing Supports

References

Remove "Department of Behavioral Health and Developmental Services Comprehensive State Plan". The code section defining and requiring the state plan was repealed in 2022 (§ 37.2-315).
Add:
"Report on Investment Models and Best Practices for the Development of Affordable and Accessible Community-Based Housing for Persons with Intellectual and Related Developmental Disabilities (Item 315 Z), November 2009"

"Virginia Plan to Increase Independent Living Options; started in 2013 and updated annually, fulfills the requirements of Section III.D.3 of Virginia's Settlement Agreement with the United States Department of Justice (DOJ)".

Policy
Replace "intellectual" with "developmental" to refer to individuals with developmental disabilities to align with how this population is defined in code and regulation.
Add "CSBs shall participate in their local Continuum of Care as required in 24 CFR § 578." Adding this language will emphasize existing federal requirements. The Continuum of Care Program was created by the McKinney-Vento Homeless Assistance Act and requires local boards to be created that include "mental health agencies" as members.

Revise Policy 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

References
Add:
"Virginia Children's Services Practice Model and Practice Profiles, Virginia Department of Social Services, 2015"

Rescind Policy 1010 (SYS) 86-7 Board Role in the Development of the Department's Comprehensive State Plan for Mental Health, Mental Retardation, and Substance Abuse Services.

Code of Virginia § 37.2-315 Comprehensive State Plan for Behavioral Health and Developmental Services was repealed in 2022.

Renewed 03/23/88
Updated 02/28/90
Revised 07/28/93
Revised 12/08/09
Updated 4/2017

POLICY MANUAL

State Board of Behavioral Health and Developmental Services
Department of Behavioral Health and Developmental Services

POLICY 1007 (SYS) 86-2 Behavioral Health and Developmental Services for Children and Adolescents and Their Families

Authority

Board Minutes Dated January 22, 1986
Effective Date February 26, 1986
Approved by Board Chairman s/James C. Windsor

References

Report of Child/Adolescent Work Group, October 1985
Report of the First Lady's Forum on Child Mental Health, 1987
Survey of Community Services Board Child and Adolescent Services (2007), Report # 148-07, Office of the Inspector General for Behavioral Health and Developmental Services
Review of Community Services Board Child and Adolescent Services (2008), Report # 149-08, Office of the Inspector General for Behavioral Health and Developmental Services
An Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation, and Substance Abuse Services for Children, Adolescents and Their Families, July 1, 2007 – June 30, 2008
Report of the Joint Subcommittee on Establishing Statewide Rates for Treatment Foster Care, Report to the General Assembly, Document #224, 2007
2008 Annual Report, Virginia Children's Services System Transformation (2008) retrieved from http://www.familyconnections.com
Item 304.M. – Final Report: A Plan for Community-Based Children's Behavioral Health Services in Virginia, November 2011
~~*Comprehensive State Plan 2014-2020*, Department of Behavioral Health and Developmental Services~~
Item 308.S, Report on Funding for Child Psychiatry and Children's Crisis Response Services, October 2015
STATE BOARD POLICY 4037 (CSB) 91-2 Early Intervention Services for Infants and Toddlers with Disabilities and Their Families
STATE BOARD POLICY 4038 (CSB) 94-1 Department and CSB Roles in Providing Services to Children Under the Children's Services Act
Code of Virginia Chapter 39. Virginia Human Rights Act

Policy 1007 (SYS) 86-2 Behavioral Health and Developmental Services for Children and Adolescents and Their Families

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Supersedes STATE BOARD POLICY 4026 (CSB) 87-1 Transitional Services for Adolescents and Young Adults with Mental Disabilities

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Background Numerous studies, surveys, reports, task forces, and commissions ~~over 40 years~~ *since 1980* have considered the needs of Virginia's children and adolescents with mental illnesses, substance use disorders, or intellectual disability or with other developmental disabilities who are eligible for or are receiving Medicaid developmental disability waiver services. A small sample of these efforts is listed in the references. Many of the studies and reports contained similar findings about the services system; they noted a lack of service coordination and supports in communities for many families with children or adolescents in need of services and recommended specific strategies for the Department of Behavioral Health and Developmental Services, hereafter referred to as the Department, and community services boards and the behavioral health authority, hereafter referred to as CSBs, to address these deficiencies. Despite many studies and recommendations, lack of adequate funding and staff has resulted in inconsistent efforts and a continuing need for increased community programs to provide services to these children. While some progress has been made to coordinate and improve service availability, Virginia's service system for children remains somewhat fragmented and continues to lack necessary supports for parents who seek services to meet the needs of their children at home in their local communities.

The developmental disabilities waiver was redesigned by DMAS in collaboration with DBHDS and stakeholders in 2016 to build capacity for integrated services for individuals with developmental disabilities. Early intervention services for infants and toddlers (birth through 3 years of age) with developmental delays or disabilities, diagnosed medical conditions likely to result in developmental delays, or atypical development and their families are addressed separately in STATE BOARD POLICY 4037 (CSB) 91-2. Services for at-risk youth and their families are addressed separately in STATE BOARD POLICY 4038 (CSB) 94-1.

Purpose To articulate policy for the provision of mental health and substance use disorder services, hereafter referred to as behavioral health services and developmental services to children and their families.

Policy It is the policy of the Board that children and their families in need of services shall have access to an integrated system of child-centered and family-focused behavioral health and developmental prevention, early intervention, treatment, and habilitation services. In this policy, children mean children with serious

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emotional disturbances, mental illnesses, substance use disorders, or intellectual disability; children who are at risk of these conditions by virtue of personal vulnerability or environmental stress; or children or young adults (ages 18 through 22) with other developmental disabilities who are eligible for or are receiving Medicaid developmental disability waiver services. Children include adolescents, unless the context requires particular age-related language for clarity or emphasis. The Board recognizes the quality of life and cost saving benefits of providing services to children as early as possible to address identified needs or individual risk factors. The Board also recognizes that children and their families are valuable resources for the future development of Virginia; enhancing their health and well-being is essential to the prosperity of the Commonwealth.

It also is the policy of the Board that programs for children and their families be specialized and flexible and be delivered by specially trained staff so as to meet the individual needs of the child and family *across the continuum of care* in *public or private* community*, residential, or inpatient settings*. ~~Community settings are construed broadly in this policy to include public or private inpatient or residential treatment facilities, which are part of the overall continuum of care.~~

Further, it is the policy of the Board that these principles shall guide development and implementation of services for children and their families.

1. Children and their families who need prevention or early intervention services have access to them in a timely manner.

2. Children and their families are able to access a full complement of services that address their physical, emotional, social, educational, and economic needs and promote healthy lifestyles. Children who require continuing services are able to transition smoothly to adult services.
3. Children receive services within the context of their families, whatever their composition, and families are empowered, strengthened, and supported in caring for their children.

4. Children and their families are able to access individualized services that are tailored to build on their unique strengths and to meet their changing needs. Services are sensitive and responsive to the cultural and linguistic diversity and special requirements of children and their families.

5. Services for children and their families are coordinated among providers to ensure quality services are provided in the least restrictive and most integrated setting consistent with evidence-based practices and most appropriate to their needs.

6. Families and surrogate families are involved consistently and integrally as partners in all aspects of planning, delivering, and evaluating services for their children. All participants in the services system are responsible and accountable to each other.

7. Children and families receive services without regard to race, *color,* religion, national origin, *sex*, *pregnancy, childbirth or related medical conditions, age, marital status, sexual orientation,* gender *identity*, *military status,* spoken language, disability, location, or socioeconomic status.

8. Services to children and their families effectively use natural and community resources, including schools, work places, community social and recreational organizations, and the home.

9. Adequate stable funding is required to develop and maintain community services and supports for children and their families.

It also is the policy of the Board that the Department shall support community services for children and their families through training, technical assistance, funding, and evaluation, and that the Department and CSBs shall encourage:

- Development and expanded use of nonresidential community services,
- Interagency service delivery and community responsibility, and
- Transition back to the home or community as soon as appropriate for children placed outside of their homes or communities.

Further, it is the policy of the Board that CSBs shall provide whenever possible care coordination to ensure consistent access to services and to increase community-based service alternatives to prevent out-of-home placements. Finally, it is the policy of the Board that the Department, in collaboration with CSBs, shall have the following responsibilities:

- Designate children as a priority for services and develop a structure translating this designation into action with responsibility and accountability for serving individual children and their families located at the local level;
- Seek increased funding to support the availability of an array of behavioral health and developmental prevention, early intervention, treatment, and habilitation services for children in every locality;

- Support the role of CSBs as the single points of entry for Medicaid developmental disability;
- Expand Medicaid waiver ~~support~~ *provider* options for families of children (ages birth through 17) and young adults (ages 18 through 21) with developmental disability to increase integrated, inclusive community options to serve children in their homes or, if that is not possible, in their communities close to the family;
- Develop a children's services plan with the active involvement of the families to be served, including detailed strategies and timetables for meeting the needs for services identified in the plan;
- Increase employment opportunities for children (ages 16 and 17) and young adults (ages 18 through 22) with intellectual disability or with other developmental disabilities who are eligible for or are receiving Medicaid developmental disability waiver services;
- Support efforts to bring about coordination between the public and private sectors for services to children and their families;
- Develop a clear and comprehensive model service delivery system that will define and establish a statewide array of services to meet the needs of children and their families;
- Emphasize interagency programmatic and fiscal coordination and cooperation in the provision of services to children and their families among the Department and the Departments of Education, Social Services, Health, Medical Assistance Services, Juvenile Justice, and Aging and Rehabilitative Services, the Departments for the Blind and Vision Impaired and Deaf and Hard of Hearing, the Office of Children's Services, and other related agencies;
- Advocate with and provide consultation to the Department of Education and local school divisions about the behavioral health and developmental service needs of children;
- Expand interagency program coordination and cooperation and the provision of case management services to enhance continuity in the transition of children and young adults from school to employment and independent living;
- Collect and use accurate data through the Department's automated reporting systems and data warehouse on services, revenues, expenditures, costs, individuals receiving services, and service utilization and to document needs and requirements for additional services for children and their families; and
- Collaborate with and support advocacy groups concerned with the needs of children and their families.

Updated 8/8/1988
Updated 9/28/1994
Updated 9/14/2010
Updated 7/12/2017

POLICY MANUAL

State Board of Behavioral Health and Developmental Services
Department of Behavioral Health and Developmental Services

POLICY 4023 (CSB) 86-24 Housing Supports

Authority

Board Minutes Date~~d:~~ October 22, 1986
Effective Date: November 19, 1986
Approved by Board Chairman: /s/James C. Windsor

References

§15.2-2223, § 36-96.1, § 37.2-504, and § 37.2-505 of the *Code of Virginia* (1950), as amended
House Joint Resolution 287, Housing Action Plan, 1987 and updates
Report of the Committee on Housing for the Disabled, July 1985
~~Department of Behavioral Health and Developmental Services Comprehensive State Plan~~
Report on Investment Models and Best Practices for the Development of Affordable and Accessible Community-Based Housing for Persons with Intellectual and Related Developmental Disabilities (Item 315 Z), November 2009
Virginia Plan to Increase Independent Living Options; started in 2013 and updated annually, fulfills the requirements of Section III.D.3 of Virginia's Settlement Agreement with the United States Department of Justice (DOJ)

Background

Since the 1970s, Virginia, like other states, ~~has been increasing~~ increased resources for community behavioral health (mental health and substance abuse) and developmental services so that individuals with mental ~~health~~ *illness* or substance use disorders, developmental disabilities, or co-occurring disorders can return to or remain in their communities. Traditionally, community services boards and the behavioral health authority, hereafter referred to as CSBs, have provided residential services to individuals with mental ~~health~~ *illness* or substance use disorders, developmental disabilities, or co-occurring disorders. ~~Many of these residential services provide treatment or training and housing at the same site, and some individuals need this combination.~~ *Some individuals benefit from the provision of treatment or training and housing services at the same site as provided by residential services.* However, many ~~other~~ individuals do not need this combination; they need stable, affordable, appropriate, and accessible housing, and ~~they~~ *to* obtain treatment or training services separately.

Many studies have identified housing as a major barrier to discharging individuals from state hospitals or training centers, hereafter referred to as state facilities, or to individuals remaining in their communities. ~~While §~~ *Section* 37.2-505 of *the Code of Virginia* requires discharge plans developed by CSBs to identify the housing services individuals will need upon discharge from a state facility and the public or private agencies that will provide them, otherwise the role and responsibilities of CSBs regarding housing supports have been ambiguous or unclear.

This policy reflects the Americans with Disabilities Act, the decision of the Supreme Court of the United States in *Olmstead v. L.C.*, 527 U.S. 581 (1999), and federal policy such as the New Freedom Initiative, a nationwide effort by the federal Substance Abuse and Mental Health Services Administration to remove barriers to community living for individuals with disabilities or long-term illnesses.

Purpose

To articulate policy about housing supports for individuals with mental health or substance use disorders, developmental disabilities, or co-occurring disorders and to clarify the role and responsibilities of CSBs regarding housing supports.

Policy

It is the policy of the Board that the provision of housing supports to individuals with mental health or substance use disorders, developmental disabilities, or co-occurring disorders shall be guided by the following principles:

- Individuals should be afforded to opportunity to live in stable, decent, and affordable housing of their own choice, based on income.
- Individuals should be able to choose from an array of housing options that is available to the general public throughout their communities.
- Appropriate, flexible, accessible, and effective support services should be available to assist individuals to obtain and maintain their housing.
- Housing should be available in integrated settings throughout the community and without restrictions based on disability in accordance with the Virginia Fair Housing Law, § 36-96.1 et seq. of the *Code of Virginia*.
- To ensure choice, the behavioral health and developmental services system has the responsibility to facilitate access to existing housing and to stimulate the preservation and development of housing.

It also is the policy of the Board that CSBs shall assist individuals whom they serve to obtain or retain housing in their home communities within

resources available. CSBs are expected to explore every available resource to provide access to needed housing for the individuals they serve.

~~Policy~~
~~(continued)~~

Further, it is the policy of the Board that CSBs shall develop, implement, and annually review joint written agreements with public housing agencies, where they exist, in accordance with subdivision 12 of subsection A of § 37.2-504 of the Code of Virginia. CSBs shall assist their local planning district commissions to prepare the comprehensive plans described in § 15.2-2223 of the Code of Virginia for the development of housing, including appropriate services as needed, available to individuals with mental health or substance use disorders, ~~intellectual~~ *developmental* disability, or co-occurring disorders. CSBs shall collaborate with individuals receiving services, local advocates, service providers, public housing agencies where they exist, and private developers to ensure that the housing developed is consistent with local needs and the preferences of individuals receiving services.

It also is the policy of the Board that the Department shall work collaboratively with the Virginia Housing Development Authority and the Virginia Department of Housing and Community Development to incentivize the development affordable and accessible housing options for individuals with mental health or substance use disorders, developmental disabilities, or co-occurring disorders.

Further, it is the policy of the Board that the Department shall provide, as resources permit, technical assistance to CSBs about housing.

Finally, it is the policy of the Board that CSBs and state facilities shall work with
public housing agencies where they exist, local governments, private developers,
and other stakeholders to maximize federal, state, and local resources for the
development of affordable housing and appropriate supports. *CSBs shall participate in their local Continuum of Care as required in 24 CFR § 578.*

POLICY MANUAL

State Board of Behavioral Health and Developmental Services
Department of Behavioral Health and Developmental Services

POLICY 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

Authority

Board Minutes Date~~d~~: April 27, 1991
Effective Date: April 27, 1991
Approved by Board Chairman: /s/ Lindsay B. West

References

Children's Services Act for At-Risk Youth and Families, § 2.2-5200 through § 5214, Code of Virginia (1950), as amended
~~*CSA Policy Manual*, July 2016~~
Policy Manual for the Children's Services Act, Office of Children's Services, Issued July 2015; Revised Annually
Virginia Children's Services Practice Model and Practice Profiles, Virginia Department of Social Services, 2015
Report of the Joint Subcommittee Studying the Comprehensive Services Act and Comprehensive Services for At-Risk Youth and Families Programs, SENATE DOCUMENT NO. 14, 2007
Report to the Governor and Chairmen of the Senate Committees on Finance, Rehabilitation, and Social Services and the House Committees on Appropriations and Health, Welfare, and Institutions. *Role of the State Executive Council for Children's Services-December 7, 2015.* Document No. 493, 2015.

Background

In March 1993, the Governor signed the Comprehensive Services Act for At-Risk Youth and Families (Comprehensive Services Act*, or CSA*), which creates a collaborative system of services and funding that is child-centered, family-focused, and community-based when addressing the strengths and needs of *"*troubled and at-risk youth and their families*"* across the Commonwealth. This legislation grew out of the extensive work of the Council on Community Services for Youth and Families established by the Secretaries of Health and Human Resources, Education, and Public Safety in 1990 with the charge of improving community service delivery systems for children and families and controlling the costs of residential care. The 2015 General Assembly passed legislation to change the name of the Comprehensive Services Act. Effective July 1, 2015, the Comprehensive Services Act for At-Risk Youth and Families became the Children's Services Act.

It is important to note that the Children's Services Act was preceded by a long history and active development of a system of care in Virginia. The Act

represents formalization of the interagency approach that has been promoted by the Department of Behavioral Health and Developmental Services *(DBHDS, or department),* hereafter referred to as the ~~D~~department, since 1985. Because many children with behavioral health service needs require coordinated services from more than one agency, the Department remains committed to the successful implementation of the Children's Services Act.

Purpose

To articulate policy for participation of the Department and community services boards and the behavioral health authority, hereafter referred to as CSBs, in full implementation of the Children's Services Act.

Policy

It is the policy of the Board that the Department shall:

- Participate in the full implementation of the Children's Services *Act*, working collaboratively with other child-serving agencies to achieve positive outcomes for children and their families;
- Participate on the State Executive Council and the State and Local Advisory Team, ensuring that the duties in the Children's Services Act, § 2.2-2648 and in §§ 2.2-5202 and 2.2-5203 of the Code of Virginia, are accomplished;
- Seek the resources necessary to support the involvement and participation required by CSB staff in the activities required by the Children's Services Act; and
- Support the coordinated effort of the Office of Children's Services to help develop partnerships among CSBs and private providers for services to children and their families.

It is also the policy of the Board that CSBs shall:

- Be represented on the State and Local Advisory Team, ensuring that the duties in the Children's Services Act, § 2.2-5202 of the Code of Virginia, are accomplished;
- Be full and active partners on community policy and management teams and family assessment and planning teams, ensuring that the duties in the Children's Services Act, §§ 2.2-5205, 2.2-5206, 2.2-5207, and 2.2-5208 of the Code of Virginia, are accomplished;
- Continue to be responsible for providing services identified in the individual family service plans that are within the agency's scope of responsibility and that are funded separately from the state pool, pursuant to the Children's Services Act, subsection E of § 2.2-5211 of the Code of Virginia;
- Ensure their local plans and proposed service initiatives for the current ~~Department Comprehensive State Plan~~ *department strategic plan* related to

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the development of local child behavioral health (mental health and substance abuse) services are coordinated and integrated with the long-range, community-wide planning of community policy and management teams, pursuant to the Children's Services Act, § 2.2-5206 of the Code of Virginia;

- Focus on children with behavioral health service needs who require coordinated services from more than one agency; and
- Play an active role in collaborative initiatives to increase the availability of and access to community services and reduce the need for group care placements.
- Recognize the rights of youth with disabilities to receive services and supports in the most integrated setting appropriate to their needs and preferences consistent with the Americans with Disabilities Act as interpreted by the Supreme Court in *Olmstead*.

Further, it is the policy of the Board that the Department and CSBs shall:

- Be guided by ~~the statewide~~ Virginia's Children's Services ~~Act~~ ~~p~~*P*ractice ~~m~~*M*odel *and Practice Profiles*, valuing child and community safety, believing that children do best when raised in families, and striving to achieve permanent family connections for all children, and;
- Engage families in meaningful participation in all aspects of Children's Services Act operations, including the development of policies and programs.

Agenda Item 3

MEMORANDUM

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

Fr: Ruth Anne Walker, Director of Regulatory Affairs

Date: September 13, 2024

Re: Four Regulatory Action Items

A. Action Item. Initiation of Fast Track: Valid Discharge Plans [12VAC35-105].

Background: DBHDS licensing regulations, Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services [12VAC35-105], require providers to have policies and procedures regarding the discharge or termination of individuals from their service. Discharge instructions must be provided to the individual, including medications and providers to whom the individual has been referred. The provider shall make arrangements or referrals to all providers identified in the discharge plan.

Purpose: The goal of this regulatory action is to comply with the requirements of Chapter 808 of the 2024 Acts of Assembly that mandated DBHDS to amend its regulations to require inpatient and residential substance abuse treatment providers "prepare and record a valid discharge plan" with certain minimum provisions.

Action Requested: Initiate the fast track process as these amendments are expected to be noncontroversial because it is a nondiscretionary alignment with the legislative mandate that passed the General Assembly unanimously.

VAC Citation	Title	Last Activity	Date
12 VAC 35-105	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services	Final Exempt	07/17/2024

Next Steps: If approved, staff initiates the fast track.

CHAPTER 808

An Act to direct the Department of Behavioral Health and Developmental Services to require certain facilities to prepare and record valid discharge plans.

[H 434]

Approved April 17, 2024

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That the Department of Behavioral Health and Developmental Services (the Department) shall amend its regulations to require that any facility licensed by the Department to provide inpatient or residential substance use disorder treatment be required to prepare and record a valid discharge plan upon the discharge or withdrawal of any individual from the facility who has received substance use disorder treatment while admitted to such facility. Such discharge plan shall include the provisions that the facility (i) identify and coordinate with public and private agencies or persons identified as able to deliver any needed services to such individuals and (ii) provide care coordination with such individual's payor to assist such individual in the execution of such discharge plan. The regulations shall provide that failure by a facility to prepare and record valid discharge plans may result in issuance of a licensing report, reduction in license status, or sanctions enumerated in § **37.2-419** of the Code of Virginia, as deemed appropriate by the Department.*

Fast-Track: Valid Discharge Plans

Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services [12VAC35-105]

Part IV. Services and Supports

Article 2. Screening, Admission, Assessment, Service Planning, and Orientation

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, the individual's authorized representative, and the successor provider, as applicable. Discharge instructions shall include, at a minimum, medications and dosages; names, telephone 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. A provider of an inpatient or residential substance abuse (substance use disorder) treatment program shall prepare and record a valid discharge plan prior to discharge or withdrawal of any individual who has received substance use disorder treatment from the service. The discharge plan shall (i) identify, and describe the coordination by the provider with, public and private agencies or persons able to deliver any needed

services; and (ii) provide care coordination with the individual’s payor to assist the individual in executing the discharge plan. Failure to prepare and record valid discharge plans in accordance with this section may result in issuance of a licensing report, reduction in license status, or sanctions enumerated in § 37.2-419 of the Code of Virginia, as deemed appropriate by the department.

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

~~F.~~ G. 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 the individual's 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.~~ H. This section does not apply to crisis services as crisis services shall comply with Part VIII of this chapter.

B. Action Item. Initiation of Fast Track: Addition to List of Practitioners in Requirements for Virginia Early Intervention System [12VAC35-225].

Background: As with other sectors of Virginia's behavioral health and developmental services workforce, personnel shortages are prevalent in Virginia's birth-three early intervention system and have the potential to negatively impact outcomes for eligible infants, toddlers and families. Based on data and input from local early intervention programs, providers and families, DBHDS has determined it is necessary to expand the early intervention workforce in order to meet the needs of all eligible infants, toddlers, and families and improve child and family outcomes resulting from participation in early intervention. This requires adding new disciplines to the list of qualified personnel who can apply for early intervention certification under 12VAC35-225-430.

Purpose: This action is part of the periodic review cycle and will help to ensure effective intervention improves the lives of Virginia's children and families. DBHDS has the authority to promulgate these regulations under Virginia Code § 2.2-5304. Under 12VAC30-50-131, the Department of Medical Assistance Services (DMAS) also defers to DBHDS to certify individual disciplines for provision of early intervention services that are reimbursed by Medicaid.

In addition, these regulations implement Part C of the Individuals with Disabilities Education Act at 20 U.S.C. §1435(a) and at 34 C.F.R. Part 303 in Virginia.

Action Requested: Initiate the fast track process as these amendments are expected to be noncontroversial because these changes would allow, but not require, individuals in these professional disciplines to apply for early intervention certification and provide early intervention services. Similarly, the language would allow, but not require, local early intervention programs to employ individuals from these disciplines who obtain early intervention certification.

VAC Citation	Title	Last Activity	Date
12 VAC 35-225	Requirements for Virginia's Early Intervention System	Periodic Review	12/20/2023

Next Steps: If approved, staff initiates the fast track.

Fast Track: Addition to List of Practitioners

Requirements for Virginia Early Intervention System [12VAC35-225]
Part IX
Early Intervention Practitioner Certification Requirements

12VAC35-225-430. Certification required for early intervention professionals and early intervention specialists.

A. Individual practitioners of early intervention services, with the exception of physicians, audiologists, and registered dietitians, shall be certified by the department as early intervention professionals or early intervention specialists.

B. Certified early intervention professionals shall have expertise in a discipline trained to enhance the development of children with a disability, as evidenced by state licensure, including application for state licensure if the discipline authorizes practice in Virginia while the application is pending and the individual practitioner meets all applicable requirements for such practice; state endorsement; or certification by a national professional organization. Qualified personnel in the following disciplines may seek certification from the department as early intervention professionals:

1. Child life specialists certified by the Association of Child Life Professionals, Child Life Certification Commission.

2. Counselors.

a. Licensed professional counselors licensed by the Virginia Board of Counseling; and

b. School counselors (Pre K - 12) endorsed by the Virginia Board of Education;

~~2~~ 3. Behavior analysts licensed by the Virginia Board of Medicine;

~~3~~ 4. Educators.

a. Educators licensed by the Virginia Board of Education with endorsement in Special Education - Early Childhood (Birth - 5);

b. Educators licensed by the Virginia Board of Education with endorsement in Early/Primary Education (Pre K - 3 or NK - 4);

c. Educators licensed by the Virginia Board of Education with endorsement in Elementary Education (Pre K - 6);

d. Educators licensed by the Virginia Board of Education with endorsement in Career and Technical Education - Family and Consumer Services;

e. Educators licensed by the Virginia Board of Education with endorsement in Special Education - Hearing Impairments (Pre K - 12);

f. Educators licensed by the Virginia Board of Education with endorsement in Special Education - Visual Impairments (Pre K - 12);

g. Educators with a technical professional license issued by the Virginia Board of Education in Career and Technical Education - Family and Consumer Sciences;

h. Educators licensed by the Virginia Board of Education with Endorsement in adapted curriculum K - 12; ~~and~~

i. Educators licensed by the Virginia Board of education with Endorsement in general curriculum K - 12; and

j. Educators licensed by the Virginia Board of Education with endorsement in English as a Second Language.

~~4~~ 5. Family and consumer science professionals certified through the American Association of Family and Consumer Sciences (AAFCS). Individuals certified by the AAFCS after June 30, 2009, shall meet certification requirements in family and consumer sciences - human development and family studies;

~~5~~ 6. Marriage and family therapists licensed by the Virginia Board of Counseling;

~~6~~ 7. Music therapists certified by the Certification Board for Music Therapists (CBMT);

~~7~~ 8. Nurses.

a. Nurse practitioners licensed by the Virginia Board of Nursing; and

b. Registered nurses licensed by the Virginia Board of Nursing;

~~8~~ 9. Occupational therapists licensed by the Virginia Board of Medicine;

~~9~~ 10. Orientation and mobility specialists certified by the National Blindness Professional Certification Board as a National Orientation and Mobility Certificant (NOMC) or certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) as a Certified Orientation and Mobility Specialist (COMS);

~~10~~ 11. Physical therapists licensed by the Virginia Board of Physical Therapy;

~~11~~ 12. Physicians licensed in medicine or osteopathic medicine by the Virginia Board of Medicine;

13. Psychologists.

a. Applied psychologists licensed by the Virginia Board of Psychology;

b. Clinical psychologists licensed by the Virginia Board of Psychology; and

c. School psychologists licensed by the Virginia State Board of Education with an endorsement in school psychology;

~~12~~ 14. Social workers.

a. Licensed clinical social workers licensed by the Virginia Board of Social Work; and

b. School social workers licensed by the Virginia State Board of Education with an endorsement as a school social worker;

~~13~~ 15. Speech-language pathologists licensed by the Virginia Board of Audiology and Speech-Language Pathology; and

~~14~~ 16. Therapeutic recreation specialists certified by the National Council on Therapeutic Recreation.

C. Certified early intervention specialists shall hold a minimum of a high school diploma or general equivalency diploma. Qualified personnel in the following disciplines may seek certification from the department as early intervention specialists:

1. Assistant behavior analysts licensed by the Virginia Board of Medicine.

2. Early intervention assistants whose qualifications have been approved by the Department of Behavioral Health and Developmental Services.

3. Residents in counseling with temporary licensure as a resident in counseling by Virginia Board of Counseling; residents in psychology with registration of residency in clinical or school psychology by the Virginia Board of Psychology; and supervisees in social work with registration of supervised experience by the Virginia Board of Social Work.

~~3~~ 4. Licensed social workers licensed by the Virginia Board of Social Work.

~~4~~ 5. Nurses.

a. Certified nurse aides certified by the Virginia Board of Nursing; and

b. Licensed practical nurses licensed by the Virginia Board of Nursing.

~~5~~ 6. Occupational therapy assistants licensed by the Virginia Board of Medicine.

~~6~~ 7. Physical therapy assistants licensed by the Virginia Board of Physical Therapy.

8. Qualified mental health professional ("QMHP") or qualified mental health professional-trainee (“QMHP-T”) approved and registered by the Virginia Board of Counseling,

9. Speech-language pathology assistant meeting the qualifications of, and supervised in accordance with, 18VAC30-21-140.

D. Certified early intervention professionals and certified early intervention specialists shall demonstrate knowledge of early intervention principles and practices, including infant and toddler development, family-centered practice and multidisciplinary team practice, by successful completion of the early intervention principles and practices online training modules administered by the department. A score of at least 80% accuracy on each module's competency test shall be required for successful completion.

C. Action Item. Initiation of Fast Track: Regulatory Reduction [12VAC35-46].

Background: DBHDS Regulations for Children's Residential Facilities [12VAC35-46] were reviewed by the DBHDS Office of Licensing to identify **noncontroversial** amendments and developed drafts for consideration as fast track actions. A 30-day public comment forum was conducted (notice was sent to all providers), closing on September 6, 2024; two commenters responded.

Purpose: In accordance with Executive Directive 1, this action reduces the administrative burden and compliance costs on licensed providers by repealing or simplifying regulatory provisions that are obsolete, overly prescriptive, duplicative, or confusing.

Action Requested: Initiate the fast track process as these amendments are expected to be noncontroversial after receiving only two commenters. Of those, staff updated language in 190 and instead inserted language currently in the draft 'overhaul' regulatory project, and included a cross reference to § 37.2-405.2.A.1. This will remove the annual reporting requirement which is burdensome to providers and the department but touches on many of the issues the commenters noted in both regulatory reduction drafts.

VAC Citation	Title	Last Activity	Date
12 VAC 35-46	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services	Final Stage	12/07/2023

Next Steps: If approved, staff initiates the fast track.

Section	Reasoning
12VAC35-46-20. Service description and applications; required elements. A. In order to determine whether an applicant is subject to these regulations, the applicant must submit a service description initially. B. Each provider shall have a written service description that accurately describes its structured program of care and treatment consistent with the treatment, habilitation, or training needs of the residential population it serves. Service description elements shall include: 1. The mental health, substance abuse, mental retardation, or brain injury population it intends to serve; 2. The mental health, substance abuse, mental retardation, or brain injury interventions it will provide; 3. Provider goals; 4. Services provided; and 5. Contract services, if any. C. The provider shall develop, implement, review, and revise its services according to the provider's mission and shall have that information available for public review. D. Initial applications. 1. A completed application includes ~~, but is not limited to,~~ an initial application form; proposed working budget for the year showing projected revenue and expenses for the first year of operation and a balance sheet showing assets and liabilities; evidence of financial resources or a line of credit sufficient to cover estimated operating expenses for 90 days unless the facility is operated by a state or local government agency, board, or commission; a service description; a proposed staffing/supervision plan including the staff information sheet; copies of all job descriptions; evidence of the applicant's authority to	Stricken language in subdivision D.1 to comply with Registrar's Style Guide The stricken language in subsection D 1 is a confusing requirement to providers as they are unsure of what type of information to submit: business references or personal references. There is confusion who the references are for when the provider is a larger provider and the department does not have the resources to check these references.

Section	Reasoning
conduct business in Virginia; a copy of the floor plan with dimensions of rooms; a certificate of occupancy; current health inspection; evidence of consultation with state or local fire prevention authorities; and a list of board members, if applicable~~; three references for the applicant; and, if required by the department, references for three officers of the board if applicable~~. This information shall be submitted to and approved by the department in order for the application to be considered complete. 2. All initial applications that are not complete within 12 months shall be closed. 3. Facilities operated by state or local government agencies, boards, and commissions shall submit ~~evidence of sufficient funds to operate including~~ a working budget showing appropriated revenue and projected expenses for the coming year. 4. Currently licensed providers shall demonstrate that they are operating in substantial compliance with applicable regulations before new facilities operated by the same provider will be licensed. E. Renewal applications. A completed application for renewal of a facility's license shall be submitted within 30 days after being notified to submit a renewal application.	Striking this language reduces administrative burden on providers operated by state or local governments as the funding for those entities is already public. The remaining language still requires the provider to handle funds responsibly and allow DBHDS to cite when necessary.
12VAC35-46-80. Written corrective action plans. A. If there is noncompliance with applicable regulations during an initial or ongoing review or investigation, the department shall issue a licensing report describing the noncompliance and requesting the provider to submit a corrective action plan. B. The provider shall submit to the department and implement a written corrective action plan for each regulation for which the provider is found to be in noncompliance. C. The corrective action plan shall include a:	

Section	Reasoning
1. Description of each corrective action to be taken to correct the noncompliance and to prevent reoccurrence in the future and the person responsible for implementation; and 2. Date of completion for each action~~; and~~ ~~3. Signature of the person responsible for oversight of the implementation of the pledged corrective action~~. D. The provider shall submit the corrective action plan to the department within 15 business days of the issuance of the licensing report. Extensions may be granted by the department when requested prior to the due date, but extensions shall not exceed an additional 10 business days. An immediate corrective action plan shall be required if the department determines that the violations pose a threat to the health, safety, or welfare of residents. E. ~~A corrective action plan shall be approved by the department.~~ Upon receipt of the corrective action plan, the department shall review the plan and determine whether the plan is approved or not approved. The provider shall have an additional 10 business days to submit a revised corrective action plan after receiving a notice that the plan submitted has not been approved.	Subsection C 3 edits are made as the electronic CONNECT process makes this requirement for a signature unnecessary. It is only necessary to know who is responsible. This allows someone else to enter the information in the system. Subsection E edits for clarity. Existing language stricken because it suggests the department is required to approve the plan as submitted. Inserted language from analogous section in Chapter 105.
12VAC35-46-110. Modification. A. The conditions of a license may be modified during the term of the license with respect to the capacity, residents' age range, facility location, residents' gender, or changes in the services. Limited modifications may be approved during the conditional licensure period. B. ~~The provider shall submit a written report of any contemplated changes in operation that would affect the terms of the license or the continuing eligibility for licensure to the department.~~ ~~C.~~ A change shall not be implemented prior to approval by the department. The provider shall be notified in writing within 60 days	The requirement in subsection B is arbitrary and not directly related to a decision to approve or disapprove a service modification.

Section	Reasoning
following receipt of the request as to whether the modification is approved or a new license is required.	
12VAC35-46-170. ~~Governing body.~~ (Repealed.) ~~A. The provider shall clearly identify the corporation, association, partnership, individual, or public agency that is the licensee.~~ ~~B. The provider shall clearly identify any governing board, body, entity, or person to whom it delegates the legal responsibilities and duties of the provider.~~	Providers are required to submit such information to the State Corporation Commission. (With the exception of sole proprietors doing business under their own names. Only sole proprietors operating under an assumed or fictitious DBA name are required to register with the SCC.)
12VAC35-46-180. Responsibilities of the provider. ~~A. The provider shall appoint a qualified chief administrative officer to whom it delegates, in writing, the authority and responsibility for administrative direction of the facility.~~ ~~B. The provider shall develop and implement a written decision-making plan that shall provide for a staff person with the qualifications of the chief administrative officer or program director to be designated to assume the temporary responsibility for the operation of the facility. Each plan shall include an organizational chart.~~ ~~C. The provider shall develop a written statement of the objectives of the facility including a description of the target population and the programs to be offered.~~ ~~D.~~ The provider shall develop and implement written policies and procedures to monitor and evaluate service quality and effectiveness on a systematic and on-going basis. The provider shall implement improvements when indicated.	It is the provider's responsibility to ensure appropriate administrative organization. Target populations and programs are in the service description section (20); therefore, this is redundant.
12VAC35-46-190. Fiscal accountability. A. ~~Facilities operated by corporations, unincorporated organizations or associations, individuals, or partnerships shall prepare at the end of each fiscal year:~~	Removes annual reporting requirement which is burdensome to providers and the department as DBHDS does not have the staff resources to analyze the information in a meaningful way. The remaining language still requires the provider to handle funds responsibly,

Section	Reasoning
~~1. An operating statement showing revenue and expenses for the fiscal year just ended;~~ ~~2. A working budget showing projected revenue and expenses for the next fiscal year that gives evidence that there are sufficient funds to operate; and~~ ~~3. A balance sheet showing assets and liabilities for the fiscal year just ended.~~ ~~B. There shall be~~ The provider shall maintain a system of financial recordkeeping that shows a separation of the ~~facility's~~ provider's accounts from all other ~~records~~ accounts. ~~C. The provider shall develop and implement written policies and procedures that address the day-to-day handling of facility funds to include:~~ ~~1. Handling of deposits;~~ ~~2. Writing of checks; and~~ ~~3. Handling of petty cash~~. B. The provider shall keep individual accounts separate. Providers shall not comingle funds of multiple individuals receiving services. C. The provider shall identify in writing the title and qualifications of the person with designated authority and responsibility for the fiscal management of its services. D. The provider shall notify the department in writing if its line of credit or other funds required by § 37.2-405.2 of the Code of Virginia has been cancelled or significantly reduced at any time during the licensing period.	responds to issues from commenters, and allows DBHDS to cite when necessary for public protection.
12VAC35-46-200. Insurance. A. The provider shall maintain liability insurance covering the premises and the facility's operations.	

Section	Reasoning
B. The provider shall provide documentation that all vehicles used to transport residents are insured, including vehicles owned by staff. C. ~~The members of the governing body and staff who have been authorized to handle the facility's or residents' funds shall be bonded or otherwise indemnified against employee dishonesty.~~ At a minimum, the person who has the authority and responsibility for fiscal management shall be bonded.	Reduces burden.
12VAC35-46-220. Weapons. The provider shall develop and implement a written ~~policies and procedures governing the possession and use of firearms, pellet guns, air guns, and other weapons on the facility's premises and during facility-related activities. The~~ policy ~~shall provide that~~ prohibiting firearms, pellet guns, air guns, or other weapons ~~shall be permitted~~ on the premises or at facility-sponsored activities unless the weapons are: 1. In the possession of licensed security personnel or law-enforcement officers; 2. Kept securely under lock and key; or 3. Used by a resident with the legal guardian's permission under the supervision of a responsible adult in accord with policies and procedures developed by the facility for the weapons' lawful and safe use.	These amendments are intended to streamline language and reduce redundancy.
12VAC35-46-230. Relationship to the department. ~~A.~~ The provider shall submit or make available to the department such reports and information as the department may require to establish compliance with these regulations and other applicable regulations and statutes. ~~B. The governing body or its official representative shall notify the department within five working days of any change in administrative structure or newly hired chief administrative officer or program director.~~	This eliminates the need for an information modification that, in most cases, DBHDS does not need to determine if a provider is complying with the regulations.

Section	Reasoning
12VAC35-46-250. Health information. A. Health information required by this section shall be maintained for each staff member and for each individual who resides in a building occupied by residents, including each person who is not a staff member or resident of the facility. Health information shall be handled, maintained, and stored in a fashion that maintains confidentiality of the information at all times. B. ~~Tuberculosis evaluation.~~ ~~1.~~ At the time of hire or residency at the facility, each individual shall submit the results of a tuberculosis screening assessment documenting the absence of tuberculosis in a communicable form as evidenced by the completion of a form containing, at a minimum, the elements of a current screening form published by the Virginia Department of Health. The screening assessment shall be no older than 30 days. ~~2. Each individual shall annually submit the results of a screening assessment, documenting that the individual is free of tuberculosis in a communicable form as evidenced by the completion of a form containing, at a minimum, the elements of a current screening form published by the Virginia Department of Health.~~	This change was suggested by the Virginia Department of Health subject matter experts as it is no longer necessary due to reduction in disease prevalence.
12VAC35-46-270. Qualifications. A. Regulations establishing minimum position qualifications shall be applicable to all providers. In lieu of the minimum position qualifications contained in this chapter, providers subject to (i) the rules and regulations of the Virginia Department of Human Resource Management or (ii) the rules and regulations of a local government personnel office may develop written minimum entry-level qualifications in accord with the rules and regulations of the supervising personnel authority. B. A person who assumes or is designated to assume the responsibilities of a position or any combination of positions described in these regulations ~~after December 28, 2007,~~ shall:	The grandfathering language in subsection B from over 15 years ago seem to tie to a comprehensive regulatory revision that went into effect in December 2007. The language is obsolete.

Section	Reasoning
1. Meet the qualifications of the position or positions; 2. Fully comply with all applicable regulations for each function; and 3. Demonstrate a working knowledge of the policies and procedures that are applicable to his specific position or positions. ~~C. When services or consultations are obtained on a contractual basis they shall be provided by professionally qualified personnel.~~	The language in subsection C is not needed as subsection A is all encompassing.
12VAC35-46-280. Job descriptions. ~~A.~~ There shall be a written job description for each position that, at a minimum, includes the: 1. Job title; 2. Duties and responsibilities ~~of the incumbent~~ ; and 3. ~~Job title of the immediate supervisor; and~~ ~~4.~~ Minimum education, experience, knowledge, skills, and abilities required for entry ~~level performance of the job~~. ~~B. A copy of the job description shall be given to each person assigned to a position at the time of employment or assignment.~~	These amendments streamline language (e.g., not all positions already have an incumbent in the role) and remove unnecessary requirements.
12VAC35-46-300. Personnel records. A. Separate up-to-date ~~written or automated~~ personnel records shall be maintained for each employee, student/intern, volunteer, and contractual service provider for whom background investigations are required by Virginia statute. Content of personnel records of volunteers, students/interns, and contractual service providers may be limited to documentation of compliance with requirements of Virginia laws regarding child protective services and criminal history background investigations. B. The records of each employee shall include:	No longer necessary to differentiate between paper and electronic recordkeeping.

Section	Reasoning
1. A completed employment application form ~~or other written material~~ providing the individual's name, address, phone number, and social security number or other unique identifier; 2. Educational background and employment history , including dates of employment for each position held and separation ; 3. ~~Written references or notations of oral references~~ Professional references ; 4. Reports of required health examinations; 5. Annual performance evaluations; 6. ~~Date of employment for each position held and separation;~~ ~~7.~~ Documentation of compliance with requirements of Virginia laws regarding child protective services and criminal history background investigations; ~~8~~ 7 . Documentation of educational degrees ~~and of~~ or professional ~~certification or licensure~~ credentials, as applicable ; ~~9~~ 8 . Documentation of all training required by these regulations and any other ~~training~~ employee development received by individual staff; and ~~10~~ 9. A current job description. ~~C. Personnel records, including separate health records, shall be retained in their entirety for at least three years after separation from employment, contractual service, student/intern, or volunteer service.~~	Item B.3 edited to be less prescriptive Item B.6 incorporated into B.2 It is the provider's responsibility to handle appropriately per other laws and regulations.
12VAC35-46-310. Staff development. A. Required initial training. 1. Within seven days following their begin date, each staff member responsible for supervision of children shall receive basic orientation to	

Section	Reasoning
the facility's behavior intervention policies, procedures, and techniques regarding less restrictive interventions, timeout, and physical restraint. 2. Within 14 days following an individual's begin date, and before an individual is alone supervising children, the provider shall conduct emergency preparedness and response training that shall include: a. Alerting emergency personnel and sounding alarms; b. Implementing evacuation procedures, including evacuation of residents with special needs (i.e., deaf, blind, nonambulatory); c. Using, maintaining, and operating emergency equipment; d. Accessing emergency information for residents including medical information; and e. Utilizing community support services. 3. Within 14 days following their begin date, new employees, employees transferring from other facilities operated by the same provider, relief staff, volunteers, and students/interns shall be given orientation and training regarding: a. The objectives of the facility; b. Practices of confidentiality; c. The decision-making plan;	

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d. These regulations including the prohibited actions as outlined in this regulation; and e. Other policies and procedures that are applicable to their positions, duties, and responsibilities. 4. Within 30 days following their begin date, all staff working with residents shall be enrolled in a standard first aid class and in a cardiopulmonary resuscitation class facilitated by the American Red Cross or other recognized authority, unless the individual is currently certified in first aid and cardiopulmonary resuscitation. 5. Within 30 days following their begin date, all staff working with residents shall be trained in child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships, and interaction among staff and residents, and suicide prevention. 6. Within 30 days following their begin date, all staff shall be trained on the facility's policies and procedures regarding standard precautions. 7. Within 30 days following their begin date, all staff shall be trained on appropriate siting of children's residential facilities, and good neighbor policies and community relations. 8. Before administering medication, all staff responsible for medication administration shall have successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications. 9. ~~All staff shall be trained in~~ <u>The provider shall carry out targeted staff training in</u> any area of quality improvement as identified from the results of the quality improvement plan. B. Required annual retraining.	This change in subsection A 9 reduces burden to training as necessary by focusing on specific areas of improvement. Subsection C is arbitrary and duplicative. Removing this assists with workforce issues.

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1. All employees, contractors, students/interns, and volunteers shall complete an annual refresher emergency preparedness and response training that shall include: a. Alerting emergency personnel and sounding alarms; b. Implementing evacuation procedures, including evacuation of residents with special needs (i.e., deaf, blind, nonambulatory); c. Using, maintaining, and operating emergency equipment; d. Accessing emergency information for residents including medical information; and e. Utilizing community support services. 2. All staff who administer medication shall complete annual refresher medication training. 3. All child care staff shall receive annual retraining on the provider's behavior supports and timeout policies and procedures. 4. All staff working with residents shall receive annual retraining in child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships, and interaction among staff and residents, and suicide prevention. 5. All staff shall receive annual retraining on the provider's policies and procedures regarding standard precautions. C. ~~Each full-time staff person who works with residents shall complete an additional 15 hours of annual training applicable to their job duties.~~	Subsection D is duplicative.

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~~D. Providers shall develop and implement written policies and procedures to ensure that part-time staff receive training applicable to their positions.~~ ~~E.~~ Training provided shall be comprehensive and based on the needs of the population served to ensure that staff have the competencies to perform their jobs.	
12VAC35-46-330. The applicant. As a condition of initial licensure and, if appropriate, license renewal, each applicant shall: 1. Provide documentation ~~that they have been trained~~ of training on appropriate siting of children's residential facilities, ~~and~~ good neighbor policies , and community relations; 2. Be interviewed in person by the department to determine the qualifications of the owner or operator as set out in these regulations~~.~~ ~~Should the applicant not be qualified to perform the duties of the chief administrative officer, the applicant shall hire an individual with the qualifications, as set out in these regulations, to perform the duties of the chief administrative officer~~; and 3. Provide evidence of ~~having~~ relevant prior experience.	Clarifying edits. It is the provider's responsibility to ensure staff are qualified for job responsibilities, as applicable.
12VAC35-46-340. ~~The chief administrative officer.~~ (Repealed.) ~~A. The chief administrative officer shall have the following responsibilities:~~ ~~1. Responsibility for compliance with these regulations and other applicable regulations;~~ ~~2. Responsibility for all personnel;~~ ~~3. Responsibility for overseeing the facility operation in its entirety, including the approval of the design of the structured program of care and its implementation n; and~~	It is the provider's responsibility to ensure appropriate administrative organization.

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~~4. Responsibility for the facility's financial integrity.~~ ~~B. A chief administrative officer appointed after December 28, 2007, shall have at least:~~ ~~1. A master's degree in social work, psychology, counseling, nursing, or administration and a combination of two years professional experience working with children and in administration and supervision;~~ ~~2. A baccalaureate degree in social work, psychology, counseling, nursing, or administration and three years of combined professional experience with children, and in administration and supervision; or~~ ~~3. A baccalaureate degree and a combination of four years professional experience in a children's residential facility and in administration and supervision.~~ ~~C. Any applicant for the chief administrative officer position shall submit the following to demonstrate compliance with the qualifications required by this regulation for the chief administrative officer:~~ ~~1. Official transcripts from the accredited college or university of attendance within 30 days of hire; and~~ ~~2. Documentation of prior relevant experience.~~	
12VAC35-46-380. Child care staff. A. ~~The~~ Each child care worker shall ~~have responsibility~~ be responsible for guidance and supervision of the children to whom he is assigned ~~including:~~ ~~1. Overseeing physical care;~~ ~~2. Development of acceptable habits and attitudes;~~ ~~3. Management of resident behavior; and~~ ~~4. Helping to meet the goals and objectives of any required individualized service plan~~.	This amendment in subsection A maintains the responsibility but removes duplicative language. Amendments to subsection B for applicant clarity.

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B. ~~A~~ Each child care worker and ~~a~~ relief child care worker shall furnish evidence that one of the following experience or education standards has been attained : 1. ~~Have a~~ A baccalaureate degree in human services; 2. ~~Have an~~ An associates degree and three months experience working with children; or 3. ~~Be a~~ A high school ~~graduate~~ diploma or ~~have a~~ G.E.D. and ~~have~~ six months of experience working with children. C. ~~Child care staff~~ A person with a high school diploma or G.E.D. and less than six months ~~with no~~ of experience working with children may be hired as child care staff provided that he does not work ~~alone~~ independently. Provisional child care staff shall at all times ~~, but may be employed as long as they are working~~ work directly with the ~~chief administrative officer,~~ program director, case manager, child care supervisor, or ~~a~~ an experienced child care worker ~~with one or more years~~ who has at least one year of professional experience working with children. D. ~~Child care staff in brain injury residential services shall have two years experience working with children with disabilities.~~ ~~E. An individual~~ A person serving in ~~hired, promoted, demoted, or transferred to~~ a child care worker's position ~~after August 6, 2009,~~ shall be at least ~~21~~ 19 years old, except as provided in 12VAC35-46-270 A. F. The provider shall not be dependent on temporary contract workers to provide resident care.	Amendments to subsection C for clarity and to reflect striking of CAO in other sections. The requirement in subsection D does not need to be set out separately. Subsection E contains an amendment to support workforce challenges (and a technical amendment). Staff with no experience cannot work alone.
12VAC35-46-400. Volunteers and student/interns. A. ~~A facility that uses volunteers or students/interns shall develop and implement written policies and procedures governing their selection and use.~~	The health, welfare and safety concern of utilizing students and volunteers is the supervision aspect. Subsection B addresses this issue and the department feels it should be within the provider's discretion whether to create a policy regarding students and volunteers outside of the restriction in subsection B.

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~~B.~~ The facility shall not be dependent upon volunteers or students/interns to provide basic services. ~~C. Responsibilities of volunteers and students/interns shall be clearly defined in writing.~~ ~~D. Volunteers and students/interns shall have qualifications appropriate to the services they render.~~	The stricken language is redundant of the remaining language.
12VAC35-46-420. Buildings, inspections and building plans. A. All buildings and ~~building related~~ building-related equipment shall be inspected and approved by the local building official. Approval shall be documented by a certificate of occupancy. B. The facility shall document at the time of its original application evidence of consultation with state or local fire prevention authorities. C. The facility shall document annually after the initial application that buildings and equipment are maintained in accordance with the Virginia Statewide Fire Prevention Code (~~13VAC5-51~~ 13VAC5-52). D. At the time of the original application and at least annually thereafter ~~the buildings~~ any location where the provider is responsible for serving food shall be inspected and approved by state or local health authorities regarding food service and general sanitation in accordance with 12VAC5-421 ~~, whose inspection and approval shall include:~~ ~~1. General sanitation;~~ ~~2. The sewage disposal system;~~ ~~3. The water supply; and~~ ~~4. Food service operations~~. E. The buildings and physical environment shall provide adequate space and shall be of a design that is suitable to house the programs and services provided and meet specialized needs of the residents.	Subsection C edit corrects VAC reference. Subsection D is streamlined to cover only VDH food regulations subject to periodic inspection after original application (not building inspections, SDS generally, etc.). Subsection G provides a reduction in burden while deferring to health authorities' oversight.

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F. Building plans and specifications for new construction, change in use of existing buildings, and any structural modifications or additions to existing buildings shall be submitted to and approved by the department and by other appropriate regulatory authorities. G. Swimming pools shall be inspected ~~annually~~ by the state or local health authorities or by a swimming pool business.	
12VAC35-46-470. Personal necessities. A. An adequate supply of personal necessities shall be available to the residents at all times for purposes of personal hygiene and grooming. B. Clean, individual washcloths and towels shall be in good repair and available once each week and more often if needed. C. When residents are incontinent or not toilet trained~~:~~ ~~1. Provision shall be made for sponging, diapering, or other similar care on a nonabsorbent changing surface that shall be cleaned with warm soapy water after each use.~~ ~~2. A covered diaper pail, or its equivalent, with leakproof disposable liners shall be used to dispose of diapers. If both cloth and disposable diapers are used, there shall be a diaper pail for each.~~ ~~3. Adapter seats and toilet chairs shall be cleaned immediately after each use with appropriate cleaning materials.~~ ~~4. Staff shall thoroughly wash their hands with warm soapy water immediately after assisting a child or themselves with toileting.~~ ~~5. Appropriate privacy, confidentiality, and dignity shall be maintained for residents during toileting and diapering~~ , appropriate measures shall be taken for sanitation and to protect each individual's privacy, confidentiality, dignity, and health .	This simplified language maintains the same level of care with simplified language.
12VAC35-46-480. Sleeping areas.	

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A. When residents are four years of age or older, boys and girls shall have separate sleeping areas. B. No more than four children shall share a bedroom or sleeping area. C. Children who use wheelchairs, crutches, canes, or other mechanical devices for assistance in walking shall be provided with a planned, personalized means of effective egress for use in emergencies. D. Beds shall be 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. E. Sleeping quarters in facilities established, constructed, or structurally modified after July 1, 1981, shall have: 1. At least 80 square feet of floor area in a bedroom accommodating one person; 2. At least 60 square feet of floor area per person in rooms accommodating two or more persons; and 3. Ceilings with a primary height of at least 7-1/2 feet exclusive of protrusions, duct work, or dormers. F. Each child shall have a separate, clean, comfortable bed equipped with a clean mattress, clean pillow, clean blankets, clean bed linens, and, if needed, a clean waterproof mattress cover. G. Bed linens shall be changed at least every seven days and more often if needed. H. Mattresses shall be fire retardant as evidenced by documentation from the manufacturer except in buildings equipped with an automated sprinkler system as required by the Virginia Uniform Statewide Building Code (13VAC5-63). I. Cribs shall be provided for residents under two years of age.	The requirements of subsection K are covered by 12VAC35-115-50 C 7, and related sections of this chapter, namely item 13 of subsection 920 and B of subsection 1030.

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J. Each resident shall be assigned drawer space and closet space, or their equivalent, that is accessible to the sleeping area for storage of clothing and personal belongings except in secure custody facilities. ~~K. The environment of sleeping areas shall be conducive to sleep and rest.~~	
12VAC35-46-560. ~~Storage.~~ (Repealed.) ~~Space shall be provided for safe storage of items such as first aid equipment, household supplies, recreational equipment, luggage, out-of-season clothing, and other materials.~~	It is the provider's responsibility to arrange for appropriate storage of various items.
12VAC35-46-660. Maintenance of residents' records. A. ~~A~~ The provider shall maintain a separate ~~written or automated~~ case record ~~shall be maintained~~ for each resident in accordance with 32.1-127.1:03 of the Code of Virginia . In addition, all correspondence and documents received by the facility relating to the care of that resident shall be maintained as part of the case record. A separate health record may be kept on each resident. B. Each record shall be kept up to date and in a uniform manner. C. The provider shall develop and implement a written ~~policies and procedures for~~ records management policy that ~~of all records, written and automated, that shall describe~~ describes confidentiality, accessibility, security, and retention of paper and electronic records pertaining to residents, including: 1. Access, duplication, dissemination, and acquiring of resident information only to persons legally authorized according to federal and state laws; 2. ~~Facilities using automated records shall address procedures that include:~~ ~~a. How records are protected from unauthorized access;~~	Amendments to subsection A insert an appropriate cross-reference to the Virginia Health Records Act for clarity and remove unnecessary differentiation between paper and electronic records (aligned with Chapter 105). Amendments to subsection C simplify language and mirror Chapter 105. These requirements in subsection C 2 are unnecessary as they are covered by remaining language.

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~~b. How records are protected from unauthorized Internet access;~~ ~~c. How records are protected from loss;~~ ~~d. How records are protected from unauthorized alteration; and~~ ~~e. How records are backed up~~ Storage, processing, and handling of active and closed records ; 3. Security measures to protect records from loss, unauthorized alteration, inadvertent or unauthorized access, disclosure of information , and during transportation of records between service sites; 4. ~~Designation of person responsible for records management~~ Strategies for service continuity and record recovery from interruptions that result from disasters or emergencies including contingency plans, electronic or manual back-up systems, and data retrieval systems ; and 5. Disposition of records in the event the facility ceases to operate. D. The policy shall specify what information is available to the resident. E. Active and closed records shall be kept in areas that are accessible to authorized staff and protected from unauthorized access, fire, and flood. ~~1. When not in use written records shall be stored in a metal file cabinet or other metal compartment.~~ ~~2. Facility staff shall assure the confidentiality of the residents' records by placing them in a locked cabinet or drawer or in a locked room when the staff member is not present.~~ F. Each resident's written record shall be stored separately subsequent to the resident's discharge according to applicable statutes and regulations.	Item 4 of subsection C is not needed as it is up to the provider to ensure appropriate staffing for records management. Subdivisions E.1 and E.2 are stricken because they are duplicative of subsection C and HIPAA. If providers are following the retention requirements of state and federal laws for health records, any requirement regarding face sheets will be covered, thus making the language in subsection H unnecessary.

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G. ~~Written and automated~~ Case records shall be retained in their entirety for a minimum of three years after the date of discharge unless otherwise specified by state or federal requirements. H. ~~The face sheet shall be retained permanently unless otherwise specified by state or federal requirements.~~ ~~I.~~ Entries in a resident's record shall be current, dated, and authenticated by the person making the entry. Errors shall be corrected by striking through and initialing. ~~If records are electronic, the provider shall develop and implement a policy and procedure to identify how corrections to the record will be made.~~	
12VAC35-46-690. ~~Participation of residents in human research.~~ (Repealed.) ~~The provider shall:~~ ~~1. Implement a written policy stating that residents will not be used as subjects of human research; or~~ ~~2. Document approval, as required by the department for each research project using residents as subjects of human research, unless such research is exempt from review.~~	These requirements are covered by 12VAC35-180.
12VAC35-46-710. Application for admission. A. Admission shall be based on evaluation of ~~an~~ a screening application for admission. The requirements of this section do not apply to court-ordered placements or transfer of a resident between residential facilities located in Virginia and operated by the same sponsor. B. Providers shall develop, and fully complete prior to acceptance for care, an application for admission that is designed to compile screening information necessary to determine: 1. The educational needs of the prospective resident;	Amendments to subsections A and B reduce the intensity of the requirement to a screening and make amendments for clarity.

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2. The mental health, emotional, and psychological needs of the prospective resident; 3. The physical health needs, including the immunization needs, of the prospective resident; 4. The protection needs of the prospective resident; 5. The suitability of the prospective resident's admission; 6. The behavior support needs of the prospective resident; 7. Family history and relationships; 8. Social and development history; 9. Current behavioral functioning and social competence; 10. History of previous treatment for mental health, ~~mental retardation~~ <u>developmental disability</u> , substance abuse, brain injury, and behavior problems; and 11. Medication and drug use profile, which shall include: a. History of prescription, nonprescription, and illicit drugs ~~that were~~ taken over the six months prior to admission; b. Drug allergies, unusual and other adverse drug reactions, and ineffective medications; and c. Information necessary to develop an individualized service plan and a behavior support plan. C. The resident's record shall contain a completed assessment <u>based on information compiled from the screening application</u> at the time of a routine admission or within 30 days after an emergency admission.	

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D. Each facility shall develop and implement written policies and procedures to assess each prospective resident as part of the application process to ensure that: 1. The needs of the prospective resident can be addressed by the facility's services; 2. The facility's staff are trained to meet the prospective resident's needs; and 3. The admission of the prospective resident would not pose any significant risk to (i) the prospective resident or (ii) the facility's residents or staff.	
12VAC35-46-720. Written placement agreement. A. The facility ~~, except a facility that accepts admission only upon receipt of the order of a court of competent jurisdiction,~~ shall develop and execute a written ~~placement~~ agreement ~~that~~ authorizing the resident's placement, signed by a facility representative and the parent, legal guardian, or placing agency. The completed and signed placement agreement shall be placed in the resident's record prior to a routine admission. The requirements of this subsection do not apply to court-ordered placements.~~:~~ ~~1. Authorizes~~ the resident's placement~~;~~ ~~2. Addresses acquisition of and consent for any medical treatment needed by the resident;~~ ~~3. Addresses the rights and responsibilities of each party involved;~~ ~~4. Addresses financial responsibility for the placement;~~ ~~5. Addresses visitation with the resident; and~~ ~~6. Addresses the education plan for the resident and the responsibilities of all parties~~.	Regarding subsection A amendments, there is nothing in Chapter 11 of Title 37.2 of the Code of Virginia that requires these specifics. The language comes from juvenile justice regulatory language from 2014. The court orders specify the information needed. Further, DBHDS is not the agency involved with placement agreements. The requirements in subsection B and C are simplified with the first subsection.

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B. ~~Each resident's record shall contain, prior to a routine admission, a completed placement agreement signed by a facility representative and the parent, legal guardian, or placing agency.~~ ~~C. The record of each person admitted based on a court order shall contain a copy of the court order~~ Notwithstanding the provisions of subsection A, a facility that accepts an admission upon receipt of the order of a court of competent jurisdiction shall place a copy of the court order in the resident's record .	
12VAC35-46-730. Face sheet. A. At the time of admission, each resident's record shall include a completed face sheet that contains (i) the resident's full name, last known residence, birth date, birthplace, gender, race, social security number or other unique identifier, religious preference, and admission date; and (ii) names, addresses, and telephone numbers of the resident's legal guardians, placing agency, emergency contacts, and parents, if appropriate. B. ~~Information shall be updated~~ The provider shall update information when changes occur. C. The face sheet for pregnant teens shall also include the expected date of delivery and the name of the hospital to provide delivery services to the resident. ~~D. The face sheet of residents who are transferred to facilities operated by the same sponsor shall indicate the address and dates of placement and transfer at each location.~~ ~~E. At the time of discharge the following information shall be added to the face sheet:~~ ~~1. Date of discharge;~~ ~~2. Reason for discharge;~~	Active voice amendment to subsection B for clarity. Stricken language in subsections D and E are unnecessary.

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~~3. Names and addresses of persons to whom the resident was discharged; and~~ ~~4. Forwarding address of the resident, if known.~~	
12VAC35-46-740. Initial objectives and strategies. Within three days following admission, individualized, measurable objectives and strategies for the first 30 days shall be developed, distributed to affected staff and the resident, and placed in the resident's record. ~~The objectives and strategies shall be based on the reasons for admitting the resident.~~	The stricken language is unnecessary.
12VAC35-46-750. Individualized service plans/quarterly reports. A. An individualized service plan shall be developed and placed in the resident's record within 30 days following admission and implemented immediately thereafter. B. Individualized service plans shall describe in measurable terms the: 1. Strengths and needs of the resident; 2. Resident's current level of functioning; 3. Goals, objectives, and strategies established for the resident; 4 . Projected family involvement; 5. Projected date for accomplishing each objective; and 6. Status of the projected discharge plan and estimated length of stay, except that this requirement shall not apply to a facility that discharges only upon receipt of the order of a court of competent jurisdiction. C. ~~The initial individualized service plan shall be reviewed within 60 days of the initial plan and within each 90-day period thereafter and revised as necessary.~~ ~~D.~~ The provider shall develop and implement written policies and procedures to document progress of the resident towards meeting the	The requirements of newly ordered subsection C are covered by subsection D.

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ISP goals and objectives ~~of the individualized service plan~~ that shall include the: 1. Format; 2. Frequency; and 3. Person responsible. ~~E~~ D . There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90-day period thereafter that shall report the: 1. Resident's progress toward meeting the plan's objectives; 2. Family's involvement; ~~3~~. Continuing needs of the resident; 4. Resident's progress towards discharge; and 5. Status of discharge planning. ~~F~~ E . Each ~~plan~~ ISP revision and quarterly progress report shall include the date it was developed and the signature of the person ~~who developed it~~ responsible . ~~G~~ F . Staff responsible for daily implementation of the resident's individualized service plan shall be able to describe the resident's behavior in terms of the objectives in the current ~~plan~~ ISP . ~~H~~ G. ~~There shall be documentation showing~~ In developing and updating the ISP and in developing the quarterly progress report, the provider shall document the involvement of the following parties unless clearly inappropriate ~~, in developing and updating the individualized service plan and in developing the quarterly progress report~~ : 1. The resident; 2. The resident's family, if appropriate, and legal guardian;	

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3. The placing agency; and 4. Facility staff. ~~I~~ H . The initial individualized service plan, each update, and all quarterly progress reports shall be distributed to the resident; the resident's family, if appropriate, legal guardian, or authorized representative; the placing agency; and appropriate facility staff.	
12VAC35-46-760. Resident transfer between residential facilities located in Virginia and operated by the same sponsor. A. Except when transfer is ordered by a court of competent jurisdiction, the ~~receiving provider~~ provider's receiving service or facility shall document receipt of the following at the time of the resident's transfer: 1. ~~Preparation through sharing information with the resident, the family, if appropriate, the legal guardian, and the placing agency about the facility, the staff, the population served, activities, and criteria for admission;~~ ~~2. Notification~~ Documentation of advance notification to the family, if appropriate ~~;~~ , and to the resident, the placement agency, and the legal guardian; ~~3.~~ 2. ~~Receipt from the sending facility of a~~ A written summary of the resident's progress while at the transferring facility, justification for the transfer, and the resident's current strengths and needs; and ~~4.~~ 3. ~~Receipt~~ A copy of the resident's record. B. The ~~sending~~ transferring service or facility ~~shall retain a copy of the face sheet and a written summary of the child's progress while at the facility and~~ shall document the date of transfer and the name of the receiving service or facility to which the resident ~~has been~~ was transferred.	Language in subsection A 1 is redundant of A 2 and other parts stricken for clarity The simplification of subsection B retains the important elements of documentation.
12VAC35-46-800. Structured program of care.	

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A. There shall be evidence of a structured program of care designed to: 1. Meet the residents' physical and emotional needs; 2. Provide protection, guidance, and supervision; and 3. Meet the objectives of any required individualized service plan. B. There shall be evidence of a structured daily routine designed to ensure the delivery of program services. C. ~~A~~ The provider shall maintain a daily communication log ~~shall be maintained~~ to ~~inform staff of~~ to share information with staff about significant happenings or problems experienced by residents , with the identity of the person making each entry in the log recorded . D. Health and dental complaints and injuries shall be recorded and shall include the (i) resident's name, complaint, and affected area; and (ii) time of the complaint. E. ~~The identity of the individual making each entry in the daily communication log shall be recorded.~~ ~~F.~~ Routines shall be planned to ensure that each resident receives the amount of sleep and rest appropriate for his age and physical condition. ~~G~~ F . Staff shall promote good personal hygiene of residents by monitoring and supervising hygiene practices each day and by providing instruction when needed. ~~H. The structured daily routine shall comply with any facility and locally imposed curfews.~~	Amendments to subsection C incorporate stricken subsection E for streamlining. The edit of subsection H removes unnecessary language.
12VAC35-46-810. Health care procedures. A. The provider shall ~~have and~~ implement written procedures for promptly: 1. Providing or arranging for the provision of medical and dental services for health problems identified at admission;	

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2. Providing or arranging for the provision of routine ongoing and follow-up medical and dental services after admission; 3. Providing emergency services for each resident; and 4. Providing emergency services for any resident ~~experiencing or showing signs of suicidal or homicidal thoughts, symptoms of mood or thought disorders, or other mental health problems; and~~ ~~5. Ensuring that the required information in subsection B of this section is accessible and up to date~~ in crisis including procedures for crisis or clinical stabilization, and immediate access to appropriate internal and external resources, including a provision for obtaining physician and mental health clinical services. B. The following written information concerning each resident shall be readily accessible to staff who may have to respond to a medical or dental emergency: 1. Name, address, and telephone number of the physician and dentist to be notified; 2. Name, address, and telephone number of a relative or other person to be notified; 3. Medical insurance company name and policy number or Medicaid number; 4. Information concerning: a. Use of medication; b. All allergies, including medication allergies; c. Substance abuse and use; and d. Significant past and present medical problems; and	Providers are always required to ensure documentation is accessible and up to date. The stricken language in subsection A is redundant. The added language is clarifying and allows for the repeal of section 820. This language is not necessary as providers are always required to ensure documentation is accessible and up to date.

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5. Written permission for emergency medical care, dental care, and obtaining immunizations or a procedure and contacts for obtaining consent. ~~C. Facilities approved to provide respite care shall update the information required by subsection B of this section at the time of each stay at the facility.~~	
12VAC35-46-820. ~~Written policies and procedures for a crisis or clinical emergency.~~ (Repealed.) ~~The provider shall develop and implement written policies and procedures for a crisis or clinical emergency that shall include:~~ ~~1. Procedures for crisis or clinical stabilization, and immediate access to appropriate internal and external resources, including a provision for obtaining physician and mental health clinical services if on-call physician back-up or mental health clinical services are not available; and~~ ~~2. Employee or contractor responsibilities.~~	With the amendments to section 810 A, this section is duplicative.
12VAC35-46-830. Documenting crisis intervention and clinical emergency services. A. The provider shall develop and implement a method for documenting the provision of crisis intervention and clinical emergency services. Documentation shall include the following: 1. Date and time; 2. Nature of crisis or emergency; 3. Name of resident; 4. Precipitating factors; 5. Interventions/treatment provided; 6. Employees or contractors involved;	

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7. Outcome; and 8. Any required follow-up. B. If a crisis or clinical emergency involves a resident who receives medical or mental health services, the crisis intervention documentation shall become part of his record. ~~C. There shall be written policies and procedures for referring to or receiving residents from:~~ ~~1. Hospitals;~~ ~~2. Law-enforcement officials;~~ ~~3. Physicians;~~ ~~4. Clergy;~~ ~~5. Schools;~~ ~~6. Mental health facilities;~~ ~~7. Court services;~~ ~~8. Private outpatient providers; and~~ ~~9. Support groups or others, as applicable.~~	The stricken language in C is unnecessary given current and amendment language in other sections, and the list has no impact on the referral process.
12VAC35-46-850. Medication. A. The provider shall develop and implement written policies and procedures regarding the delivery and administration of prescription and nonprescription medications used by residents. At a minimum these policies will address: 1. Identification of the staff member responsible for routinely communicating to the prescribing physician~~.~~ ~~a. The effectiveness of prescribed medications; and~~	Amendments to subsection A 1 a-b are covered remaining language in newly numbered 5. Amendments to the list bring two specifics from the stricken subsection J.

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~~b. Any adverse reactions, or any suspected side effects~~. 2. Storage of controlled substances; 3. Disposal of medication; 4. Distribution of medication off campus; ~~3.~~ 5. Documentation of medication errors and drug reactions; and ~~4.~~ 6. Documentation of any medications prescribed and administered following admission. B. All medication shall be securely locked and properly labeled. C. ~~All staff responsible for medication administration shall have successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications before they can administer medication~~ Training requirements necessary for employees or contractors who are authorized to administer medication. Medications shall be administered only by persons authorized to do so by The Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia) . D. Staff authorized to administer medication shall be informed of any known side effects of the medication and the symptoms of the side effects. E. A program of medication, including over-the-counter medication, shall be initiated for a resident only when prescribed in writing by a person authorized by law to prescribe medication. F. Medication prescribed by a person authorized by law shall be administered as prescribed. G. A medication administration record shall be maintained of all medicines received by each resident and shall include: 1. Date the medication was prescribed; 2. Drug name;	Simplifying and clarifying (also aligns with amendment to Chapter 105).

Section	Reasoning
3. Schedule for administration; 4. Strength; 5. Route; 6. Identity of the individual who administered the medication; and 7. Dates the medication was discontinued or changed. H. In the event of a medication error or an adverse drug reaction, first aid shall be administered if indicated. Staff shall promptly contact a poison control center, pharmacist, nurse, or physician and shall take actions as directed. If the situation is not addressed in standing orders, the attending physician shall be notified as soon as possible and the actions taken by staff shall be documented. I. Medication refusals shall be documented including action taken by staff. J. ~~The provider shall develop and implement written policies and procedures for documenting medication errors, reviewing medication errors and reactions and making any necessary improvements, the disposal of medication, the storage of controlled substances, and the distribution of medication off campus. The policy and procedures must be approved by a health care professional. The provider shall keep documentation of this approval.~~ ~~K.~~ The telephone number of a regional poison control center and other emergency numbers shall be posted on or next to each ~~nonpay~~ non-pay telephone that has access to an outside line in each building in which children sleep or participate in programs. L. Syringes and other medical implements used for injecting or cutting skin shall be locked.	This language in subsection J is repetitive of language above in the section, except that two items are moved to subsection A.
12VAC35-46-860. Nutrition. A. Each resident shall be provided a daily diet that (i) consists of at least three nutritionally balanced meals and an evening snack; (ii) includes an adequate variety and quantity of food for the age of the resident; and (iii) meets minimum nutritional requirements and the U.S. Department of	

Section	Reasoning
Health and Human Services and U.S. Department of Agriculture Dietary Guidelines for Americans, 2005, 6th Edition. B. ~~Menus of actual meals served shall be kept on file for at least six months.~~ ~~C.~~ Special diets shall be provided when prescribed by a physician and the established religious dietary practices of the ~~resident~~ residents shall be observed. ~~D~~ C . Staff who eat in the presence of the residents shall be served the same meals as the residents unless (i) a special diet has been prescribed by a physician for the staff or residents or (ii) the staff or residents are observing established religious dietary practices. ~~E~~ D . There shall not be more than 15 hours between the evening meal and breakfast the following day. ~~F~~ E . Providers shall assure that food is available to residents who need to eat breakfast before the 15 hours have expired. ~~G. Providers shall receive approval from the department if they wish to extend the time between meals on weekends and holidays. There shall never be more than 17 hours between the evening meal and breakfast the following day on weekends and holidays.~~	Subsection B is administratively burdensome and there is no need to review six month old menus. Subsection G is covered by subsection E.
12VAC35-46-880. Emergency telephone numbers. ~~A.~~ There shall be an emergency telephone number where a staff person may be immediately contacted 24 hours a day. ~~B. Residents who are away from the facility and the adults responsible for their care during the absence shall be furnished with the emergency phone number.~~	Subsection A covers every circumstance; language in subsection B is not necessary.
12VAC35-46-890. Searches. A. Strip searches and body cavity searches are prohibited ~~except:~~ ~~1. As permitted by other applicable state regulations; or~~	Strips searches are not appropriate and are not in line with the Human Rights Regulations.

Section	Reasoning
~~2. As ordered by a court of competent jurisdiction~~. B. ~~A provider that does not conduct pat downs shall have a written policy prohibiting them.~~ ~~C.~~ A provider that conducts pat downs shall develop and implement written policies and procedures governing ~~them that~~ their use ~~shall provide~~ providing that: 1. Pat downs shall be limited to instances where they are necessary to prohibit contraband; 2. Pat downs shall be conducted by personnel of the same gender as the resident being searched; 3. Pat downs shall be conducted only by personnel who are specifically trained and authorized to conduct searches by the written policies and procedures; and 4. Pat downs shall be conducted in such a way as to protect the resident's dignity in accordance with 12VAC35-115 and in the presence of one or more witnesses.	
12VAC35-46-900. Behavior support. A. Within 30 days of admission, the provider shall develop and implement a written behavior support plan that allows the resident to self-manage his own behaviors. Each individualized behavior support plan shall include: 1. Identification of positive and problem behavior; 2. Identification of triggers for behaviors; 3. Identification of successful intervention strategies for problem behavior; 4. Techniques for managing anger and anxiety; and	

Section	Reasoning
5. Identification of interventions that may escalate inappropriate behaviors. B. Individualized behavior support plans shall be developed in consultation with the: 1. Resident; 2. Legal guardian; 3. Resident's parents, if appropriate; 4. Program director; 5. Placing agency staff; and 6. Other appropriate individuals. C. Prior to working alone with an assigned resident each staff member shall demonstrate knowledge and understanding of that resident's behavior support plan. D. Each provider shall develop and implement written policies and procedures concerning behavior support plans and other behavioral interventions that are directed toward maximizing the growth and development of the resident consistent with the requirements of 12VAC35-115-105~~. In addition to addressing the previous requirements of this regulation, these policies and procedures shall:~~ ~~1. Define and list techniques that are used and are available for use in the order of their relative degree of intrusiveness or restrictiveness;~~ ~~2. Specify the staff members who may authorize the use of each technique;~~ ~~3. Specify the processes for implementing such policies and procedures;~~ ~~4. Specify the mechanism for monitoring the use of behavior support techniques; and~~	The language in subsection D is duplicative of language in Chapter 115.

Section	Reasoning
~~5. Specify the methods for documenting the use of behavior support techniques.~~	
12VAC35-46-940. Behavior interventions. A. The provider shall develop and implement written policies and procedures for behavioral interventions ~~and~~ consistent with the requirements of 12VAC35-115. Minimum provisions shall include rules of conduct and methods for documenting and monitoring the management of resident behavior. ~~Rules of conduct shall be included in the written policies and procedures. These policies and procedures shall:~~ ~~1. Define and list techniques that are used and available for use in the order of their relative degree of restrictiveness;~~ ~~2. Specify the staff members who may authorize the use of each technique; and~~ ~~3. Specify the processes for implementing such policies and procedures~~. B. Written information concerning the provider's behavioral support and intervention policies and procedures ~~of the provider's behavioral support and intervention programs~~ shall be provided prior to admission to prospective residents, legal guardians, and placing agencies. For court-ordered and emergency admissions, this information shall be provided to: 1. Residents within 12 hours following admission; 2. Placing agencies within 72 hours following the resident's admission; and 3. Legal guardians within 72 hours following the resident's admission. ~~This requirement does~~ The requirements of this subsection do not apply when a state psychiatric hospital is evaluating a child's treatment needs as provided by the Code of Virginia.	Appropriate cross references are made to the Human Rights regulations and language streamlined.

Section	Reasoning
C. When substantive revisions are made to policies and procedures governing management of resident behavior, written information concerning the revisions shall be provided to: 1. Residents prior to implementation; and 2. Legal guardians and placing agencies prior to implementation except when a state psychiatric hospital is evaluating a child's treatment needs as provided by the Code of Virginia. D. The provider shall develop and implement written policies and procedures governing use of physical restraint that shall ~~include~~ comply with the requirements of 12VAC35-115~~:~~ ~~1. The staff position who will write the report and timeframe;~~ ~~2. The staff position who will review the report and timeframe; and~~ ~~3. Methods to be followed should physical restraint, less intrusive interventions, or measures permitted by other applicable state regulations prove unsuccessful in calming and moderating the resident's behavior~~. E. All physical restraints shall be reviewed and evaluated to plan for continued staff development for performance improvement. F. Use of physical restraint shall be limited to that which is minimally necessary to protect the resident or others as required by 12VAC35-115. G. Trained staff members may physically restrain a resident only after less restrictive interventions. H. Only trained staff members may manage resident behavior. I. Each application of physical restraint shall be fully documented in the resident's record including: 1. Date;	Appropriate cross references are made to the Human Rights regulations and language streamlined. Appropriate cross references are made to the Human Rights regulations and language streamlined.

Section	Reasoning
2. Time; 3. Staff involved; 4. Justification for the restraint; 5. Less restrictive interventions that were unsuccessfully attempted prior to using physical restraint; 6. Duration; 7. Description of method or methods of physical restraint techniques used; 8. Signature of the person completing the report and date; and 9. Reviewer's signature and date. J. Providers shall ensure that restraint may only be implemented, monitored, and discontinued by staff who have been trained in the proper and safe use of restraint, including hands-on techniques. K. The provider shall review the facility's behavior intervention techniques and policies and procedures at least annually to determine appropriateness for the population served. L. Any time children are present staff shall be present who have completed all trainings in behavior intervention.	
12VAC35-46-950. Seclusion. Seclusion is allowed only as permitted by 12VAC35-115 and other applicable state regulations.	Appropriate cross reference added for clarity.
12VAC35-46-990. Recreation. A. The provider shall have a written description of its recreation program that describes activities that are consistent with the facility's total program and with the ages, developmental levels, interests, and needs of the residents that includes:	

Section	Reasoning
1. Opportunities for individual and group activities; 2. Free time for residents to pursue personal interests that shall be in addition to a formal recreation program, except this subdivision does not apply to secure custody facilities; 3. Use of available community recreational resources and facilities, except this subdivision does not apply to secure custody facilities; 4. Scheduling of activities so that they do not conflict with meals, religious services, educational programs, or other regular events; and 5. Regularly scheduled indoor and outdoor recreational activities that are structured to develop skills and attitudes. B. The provider shall develop and implement written policies and procedures to ensure the safety of residents participating in recreational activities that include: 1. How activities will be directed and supervised by individuals knowledgeable in the safeguards required for the activities; 2. ~~How residents are assessed for suitability for an activity and the supervision provided;~~ and ~~3.~~ How safeguards for water-related activities will be provided, including ensuring that a certified lifeguard supervises all swimming activities. C. For all overnight recreational trips away from the facility the provider shall document trip planning to include: 1. A supervision plan for the entire duration of the activity including awake and sleeping hours; 2. A plan for safekeeping and distribution of medication; 3. An overall emergency, safety, and communication plan for the activity including emergency numbers of facility administration; 4. Staff training and experience requirements for each activity;	The language stricken language is overly prescriptive, and to the point of possibly deterring providers from seeking these kinds of recreational activity. The general providers are always required to ensure documentation is accessible and up to date. Statements about the policies to 'ensure' are sufficient. Subsection C 5 would be covered in requirements within an ISP if additional time was needed to prepare for change. Item 9 of subsection C is covered under subsection B

Section	Reasoning
5. ~~Resident preparation for each activity;~~ ~~6. A plan to ensure that all necessary equipment for the activity is in good repair and appropriate for the activity;~~ ~~7. A trip schedule giving addresses and phone numbers of locations to be visited and how the location was chosen/evaluated;~~ ~~8.~~ A plan to evaluate residents' physical health throughout the activity and to ensure that the activity is conducted within the boundaries of the resident's capabilities, dignity, and respect for self-determination; ~~9. A plan to ensure that a certified life guard supervises all swimming activities in which residents participate;~~ and ~~10.~~ 6. Documentation of any variations from trip plans and reason for the variation. D. All overnight out-of-state or out-of-country recreational trips require written permission from each resident's legal guardian. ~~Documentation of the written permission shall be kept in the resident's record.~~	
12VAC35-46-1010. Clothing. A. Provision shall be made for each resident to have an adequate supply of clean, comfortable, and well-fitting clothes and shoes for indoor and outdoor wear. B. ~~Clothes and shoes shall be similar in style to those generally worn by children of the same age in the community who are engaged in similar activities, except this requirement does not apply to secure custody facilities.~~ ~~C.~~ Residents shall have the opportunity to participate in the selection of their clothing, except this requirement does not apply to secure custody facilities. ~~D. Residents shall be allowed to take personal clothing when leaving the facility.~~	Subsections A and C are sufficient.

Section	Reasoning
12VAC35-46-1020. Allowances and spending money. A. ~~The provider shall provide opportunities appropriate to the ages and developmental levels of the residents for learning the value and use of money.~~ ~~B. There shall be a written policy regarding allowances that shall be made available to legal guardians at the time of admission.~~ ~~C.~~ The provider shall develop and implement written policies for safekeeping and for recordkeeping of any money that belongs to residents. ~~D~~ B~~.~~. A resident's funds, including any allowance or earnings, shall be used for the resident's benefit.	Subsection C incorporates A and B. The department feels that subsection A is outside of the department's purview and should be covered by schooling which is required by section 970.
12VAC35-46-1040. ~~Visitation at the facility and to the resident's home.~~ (Repealed.) ~~A. The provider shall have and implement written visitation policies and procedures that allow reasonable visiting privileges and flexible visiting hours, except as permitted by other applicable state regulations.~~ ~~B. Copies of the written visitation policies and procedures shall be made available to the parents, when appropriate, legal guardians, the resident, and other interested persons important to the resident no later than the time of admission, except that when parents or legal guardians do not participate in the admission process, visitation policies and procedures shall be mailed to them within 24 hours after admission.~~	These requirements are covered by Chapter 115.
12VAC35-46-1060. Vehicles and power equipment. A. Transportation provided for or used by children shall comply with local, state, and federal laws relating to: 1. Vehicle safety and maintenance; 2. Licensure of vehicles; 3. Licensure of drivers; and	

Section	Reasoning
4. Child passenger safety, including requiring children to wear appropriate seat belts or restraints for the vehicle in which they are being transported. B. There shall be written safety rules for transportation of residents appropriate to the population served that shall include taking head counts at each stop. ~~C. The provider shall develop and implement written safety rules for use and maintenance of vehicles and power equipment.~~	Language in subsection C is covered by remaining language and general provisions for safety in this chapter and Chapter 115.
12VAC35-46-1090. ~~Grievance procedures~~ Human rights complaint process . The provider shall comply with the Office of Human Rights regulations including the Human Rights Complaint Process outlined in 12VAC35-115-175. ~~A. The provider shall develop and implement written policies and procedures governing the handling of grievances by residents. If not addressed by other applicable regulations, the policies and procedures shall:~~ ~~1. Be written in clear and simple language;~~ ~~2. Be communicated to the residents in an age or developmentally appropriate manner;~~ ~~3. Be posted in an area easily accessible to residents and their parents and legal guardians;~~ ~~4. Ensure that any grievance shall be investigated by an objective employee who is not the subject of the grievance; and~~ ~~5. Require continuous monitoring by the provider of any grievance to assure there is no retaliation or threat of retaliation against the child.~~ ~~B. All documentation regarding grievances shall be kept on file at the facility for three years unless other regulations require a longer retention period.~~	This language is duplicative of Section 150 of Chapter 115.

Section	Reasoning
12VAC35-46-1100. ~~Disaster or emergency planning.~~ (Repealed.) ~~The facility is required to have written procedures to follow in emergencies. It is also required that these plans be known by staff and, as appropriate, residents. It is advisable that the facility develop its emergency plans with the assistance of state or local public safety authorities.~~	This language is covered by section 1110.
12VAC35-46-1120. ~~Independent living programs.~~ (Repealed.)	Independent living falls under the authority of DSS, not DBHDS.
12VAC35-46-1130. ~~Mother/baby programs.~~ (Repealed.)	These programs are licensed by DSS, not DBHDS.
12VAC35-46-1140. ~~Campsite programs or adventure activities.~~ (Repealed.)	These programs are not licensed by DBHDS.

D. Action Item. Initiation of Fast Track: Regulatory Reduction [12VAC35-105].

Background: DBHDS Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services [12VAC35-105] were reviewed by the DBHDS Office of Licensing to identify **noncontroversial** amendments and developed drafts for consideration as fast track actions. A 30-day public comment forum was conducted (notice was sent to all providers), closing on September 6, 2024; six commenters responded.

Purpose: In accordance with Executive Directive 1, this action reduces the administrative burden and compliance costs on licensed providers by repealing or simplifying regulatory provisions that are obsolete, overly prescriptive, duplicative, or confusing.

Action Requested: Initiate the fast track process as these amendments are expected to be noncontroversial after receiving only six commenters. Of those, staff updated language with a cross-reference citation in section 530 and corrected language in 691 to remove 'facility' and 'resident' and instead use 'within the service' and 'individual,' respectively.

VAC Citation	Title	Last Activity	Date
12 VAC 35-105	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services	Final Exempt	07/17/2024

Next Steps: If approved, staff initiates the fast track.

Section	Reasoning
12VAC35-105-60. Modification. A. A provider shall submit a written service modification application at least ~~45~~ 30 days in advance of a proposed modification to its license. The modification may address the characteristics of individuals served (disability, age, or gender), the services offered, the locations where services are provided, existing stipulations, or the maximum number of individuals served under the provider license. B. Upon receipt of the completed service modification application, the commissioner may revise the provider license. Approval of such request shall be at the sole discretion of the commissioner. C. A change requiring a modification of the license shall not be implemented prior to approval by the commissioner. The department may send the provider a letter approving implementation of the modification pending the issuance of the modified license.	This change is a reflection of recent agency initiatives to change current practices within the Office of Licensing to lessen the intensity of the requirement for providers.
12VAC35-105-120. Variances. The commissioner may grant a variance to a specific regulation if he determines that such a variance will not jeopardize the health, safety, or welfare of individuals. A provider shall submit a request for such variance in writing to the commissioner. The request shall demonstrate ~~that complying with the regulation would be a hardship unique to the provider and~~ that the variance will not jeopardize the health, safety, or welfare of individuals. The department may limit the length of time a variance will be effective. The provider shall not implement a variance until it has been approved in writing by the commissioner.	Lessens the intensity of the mandate regarding demonstration for a variance.
12VAC35-105-170. Corrective action plan. A. If there is noncompliance with any applicable regulation during an initial or ongoing review, inspection, or investigation, the department shall issue a licensing report describing the noncompliance and requesting the provider to submit a corrective action plan for each violation cited. B. The provider shall submit to the department a written corrective action plan for each violation cited.	

Section	Reasoning
C. The corrective action plan shall include a: 1. Detailed description of the corrective actions to be taken that will minimize the possibility that the violation will occur again and correct any systemic deficiencies; 2. Date of completion for each corrective action; and 3. ~~Signature of the person responsible for oversight of the~~ Responsible person designated to oversee implementation of the pledged corrective action. D. The provider shall submit a corrective action plan to the department within 15 business days of the issuance of the licensing report. One extension may be granted by the department when requested prior to the due date, but extensions shall not exceed an additional 10 business days. An immediate corrective action plan shall be required if the department determines that the violations pose a danger to individuals receiving the service. E. Upon receipt of the corrective action plan, the department shall review the plan and determine whether the plan is approved or not approved. The provider has an additional 10 business days to submit a revised corrective action plan after receiving a notice that the department has not approved the revised plan. ~~If the submitted revised corrective action plan is not approved, the provider shall follow the dispute resolution process identified in this section.~~ F. ~~When the~~ If a provider disagrees with a citation of a violation or the disapproval of a revised corrective action plan, the provider shall discuss this disagreement with the licensing specialist initially. If the disagreement is not resolved, the provider may ask for a meeting with the licensing specialist's supervisor, in consultation with the director of licensing, to challenge a finding of noncompliance. The determination of the director is final. G. The provider shall implement ~~their~~ an approved written corrective action plan for each violation cited by the date of completion identified in the plan. H. The provider shall monitor implementation and effectiveness of approved corrective actions as part of its quality improvement program required by 12VAC35-105-620. If the provider determines that an approved corrective action	In C3, by changing from signature to responsible designee, the intensity is lessened and streamlines paperless processing. The last sentence of subsection E is duplicative of F. Changing from ‘when’ to ‘if’ at the beginning of subsection F clarifies that disagreement is not assumed. Disapproval of a provider’s revised plan is not the default result. In G, clarifies that the regulation requires implementation of a department-approved plan (not the provider’s submitted plan per se).

Section	Reasoning
was fully implemented, but did not prevent the recurrence of a regulatory violation or correct any systemic deficiencies, the provider shall: 1. Continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies; or 2. Submit a revised corrective action plan to the department for approval.	
12VAC35-105-180. Notification of changes. A. The provider shall notify the department in writing prior to implementing changes that affect ~~:~~ ~~1. Organizational or administrative structure, including the name of the provider;~~ ~~2. Geographic location of the provider or its services;~~ ~~3. Service description as defined in these regulations;~~ ~~4. Significant~~ significant changes to the staffing plan, position descriptions, or employee or contractor qualifications ~~; or~~ ~~5. Bed capacity for services providing residential or inpatient services~~ . B. ~~The provider shall not implement the specified changes without the prior approval of the department.~~ ~~C. The provider shall provide any documentation necessary for the department to determine continued compliance with these regulations after any of these specified changes are implemented.~~ ~~D.~~ A provider shall notify the department in writing of its intent to discontinue services at least 30 days prior to the cessation of services. The provider shall continue to provide all services that are identified in each individual's ISP after it has given official notice of its intent to cease operations and until each individual is appropriately discharged in accordance with 12VAC35-105-693. The provider shall further continue to maintain substantial compliance with all applicable regulations as it discontinues its services.	As these requirements are covered elsewhere, this will not reduce burden. This is a simplification of the regulations rather than a reduction of practical requirements. Technical amendments to subsection D to improve clarity for providers. The provider can determine where to document the communication occurred (it does not need to be in the ISP); this increases provider discretion. This may also reduce duplication of documentation.

Section	Reasoning
~~E.~~ C. All individuals receiving services and their authorized representatives shall be notified of the provider's intent to cease services in writing at least 30 days prior to the cessation of services. ~~This written notification shall be documented in each individual's ISP.~~	
12VAC35-105-190. Operating authority, governing body and organizational structure. A. The provider shall provide the following evidence of its operating authority: 1. Public organizations shall provide documents describing the administrative framework of the governmental department of which it is a component or describing the legal and administrative framework under which it was established and operates. 2. All private organizations , except sole ~~proprietorships~~ proprietors trading under their own name, shall provide a certificate from the State Corporation Commission pursuant to § 59.1-69 of the Code of Virginia. B. The provider shall provide an organizational chart that clearly identifies its governing body and organizational structure. ~~C. The provider shall document the role and actions of the governing body, which shall be consistent with its operating authority. The provider shall identify its operating elements and services, the internal relationship among these elements and services, and its management or leadership structure.~~	Technical amendment to subsection A 2 to improve clarity for applicants. Subsection C is somewhat duplicative of B and DBHDS does not need the additional detail for the health, safety, and welfare of individuals receiving services.
12VAC35-105-210. Fiscal accountability. A. The provider shall document financial arrangements or a line of credit that are adequate to ensure maintenance of ongoing operations for at least 90 days on an ongoing basis. The amount needed shall be based on a working budget showing projected revenue and expenses. ~~B. At the end of each fiscal year, the provider shall prepare, according to generally accepted accounting principles (GAAP) or those standards promulgated by the Governmental Accounting Standards Board (GASB) and the State Auditor of Public Accounts:~~	This language reduces administrative burden on providers and agency because CPA cert/review standard is less than full audit while acknowledging that DBHDS does not have the staff resources to analyze the information in a meaningful way. The remaining language still requires the provider to handle funds

Section	Reasoning
~~1. An operating statement showing revenue and expenses for the fiscal year just ended.~~ ~~2. A balance sheet showing assets and liabilities for the fiscal year just ended. The department may require an audit of all financial records by an independent Certified Public Accountant (CPA) or as otherwise provided by law or regulation.~~ ~~3. Providers operating as a part of a local government agency are not required to provide a balance sheet; however, they shall provide a financial statement.~~ ~~C~~B. ~~The~~ In addition to the indemnity coverage required pursuant to 12VAC35-105-220, the provider shall have written internal controls to minimize the risk of theft or embezzlement of provider funds. ~~D~~ E. The provider shall identify in writing the title and qualifications of the person ~~who has~~ with the authority and responsibility for the fiscal management of its services. ~~At a minimum, the person who has the authority and responsibility for fiscal management shall be bonded or otherwise indemnified.~~ ~~E~~ F. The provider shall notify the department in writing when its line of credit or other financial arrangement has been cancelled or significantly reduced at any time during the licensing period. ~~At a minimum, the person who has the authority and responsibility for fiscal management shall be bonded or otherwise indemnified.~~	responsibly and allow DBHDS to cite when necessary. Clarifying. Sec. 220 already requires general and professional liability coverage, so striking this from subsection E will not reduce burden. This is a simplification of the regulations rather than a reduction of practical requirements.
12VAC35-105-270. Building modifications. ~~A. The provider shall submit building plans and specifications for any planned construction at a new location, changes in the use of existing locations, and any structural modifications or additions to existing locations where services are provided for review by the department to determine compliance with the licensing regulations. This section does not apply to correctional facilities, jails, or home and noncenter-based services.~~ ~~B.~~ The provider shall submit ~~an interim~~ a plan to the department addressing safety and continued service delivery ~~if new~~ for any planned construction involving (i) changes in the use of existing locations or (ii) structural modifications ~~or additions~~ to new or existing buildings ~~is planned~~. This section does not apply to correctional facilities, jails, or home and noncenter-based services.	Simplification of language, and removes “specifications” requirement. This last sentence is moved from end of A.

Section	Reasoning
12VAC35-105-280. Physical environment. A. The physical environment, design, structure, furnishings, and lighting shall be appropriate ~~to~~ and safe for 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~~ 100-120°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.~~ H. 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.~~ I. For all program areas added after September 19, 2002, minimum room height shall be 7-1/2 feet. ~~K.~~ J. This section does not apply to home and noncenter-based services. Sponsored residential services shall certify compliance of sponsored residential homes with this section.	Added safe to capture provisions from stricken subsection G (i.e., lighted parking areas for safety). This amended temperature range in subsection F has been in the Childrens Residential regulations since 2009 and is reflective of other state agency regulations (DOE, DJJ). Subsection A covers the basic requirements in subsection G. This sentence can be stricken because the entire section does not apply to home/noncenter-based services.

Section	Reasoning
12VAC35-105-290. Food service inspections. A. Any location where the provider is responsible for preparing or serving food shall request inspection and shall obtain approval by state or local health authorities regarding food service and general sanitation at the time of the original application and annually thereafter in accordance with 12VAC5-421. B. Documentation of the most recent ~~three inspections~~ inspection and approval shall be kept on file. This section does not apply to sponsored residential services or to group homes ~~or~~ and community residential homes.	The reference to VDH regulations is made to make mandatory not discretionary, as appropriate based on service or setting. Amendment to (added) subsection B reduces recordkeeping compliance burden on providers.
12VAC35-105-320. Fire inspections. The provider shall document at the time of its original application and annually thereafter that buildings and equipment in residential service locations serving more than eight individuals are maintained in accordance with the Virginia Statewide Fire Prevention Code (13VAC5-51). This section does not apply to correctional facilities **~~or home and noncenter-based or sponsored residential home services~~.**	This language is stricken because it does not add to the regulation and can cause confusion as this section only applies to residential services. (The reference to correctional facilities remains as it corresponds to language in other sections.)
12VAC35-105-390. Confidentiality and security of personnel records. A. The provider shall maintain an organized system to manage and protect the confidentiality of personnel files and records. B. ~~Physical and data security controls shall exist for personnel records maintained in electronic databases.~~ ~~C.~~ Providers shall comply with requirements of the Americans with Disabilities Act and the Virginians with Disabilities Act regarding retention of employee health-related information in a file separate from personnel files.	Simplification of language.

12VAC35-105-400. Criminal background checks and registry searches. A. Providers shall comply with the requirements for obtaining criminal history background checks as outlined in §§ 37.2-416, 37.2-506, **37.2-416.1**,and **37.2-506.1**, 37.2-607 of the Code of Virginia ~~for individuals hired after July 1, 1999~~. B. The provider shall develop a written policy for criminal history background checks and registry searches that addresses what actions the provider must take if an applicant has certain prior convictions or a founded case of child abuse or neglect. The policy shall require at a minimum ~~a disclosure statement stating~~ that the applicant disclose whether the person (i) has ever been convicted of or is the subject of pending charges for ~~any~~ an offense listed in §§ 37.2-416, 37.2-416.1, 37.2-506, 37.2-506.1, or 37.2-607 of the Code of Virginia or (ii) has had a founded case of child abuse or neglect ~~and shall address what actions the provider will take should it be discovered that a person has a founded case of abuse or neglect or both, or a conviction or pending criminal charge~~. Any plea of nolo contendere shall be considered a conviction for purposes of this section. C. The provider shall submit all personally descriptive applicant information ~~required by the department~~ necessary to complete the criminal history background checks and registry searches. D. The provider shall maintain the following documentation: 1. The disclosure statement from the applicant ~~stating whether he has ever been convicted of or is the subject of pending charges for any offense~~ required pursuant to subsection B; and 2. ~~Documentation~~ Evidence that the provider submitted all information ~~required by the department~~ necessary to complete the : criminal history background checks and registry searches~~,~~ ; report from the Central Criminal Records Exchange; or memoranda from the department transmitting the results to the provider, ~~if~~ as applicable~~,~~ ; and the results from the Child Protective Registry search.	Updates and simplification of language. The changes in subsection B tightens the language to only barrier crimes and clarifies that the policy provisions on provider actions are determined by statute (not discretionary on the part of the provider). Clarification of language (information is actually required by VSP/CCRE and DSS to complete the background check processes). Simplification of language.

12VAC35-105-410. Job description. ~~A.~~ Each employee or contractor shall have ~~a~~ access to their current written job description that includes: 1. Job title; 2. Duties and responsibilities ~~required of the position~~; and 3. ~~Job title of the immediate supervisor; and~~ ~~4.~~ Minimum knowledge, skills, and abilities~~,~~ ; education or training; or experience or professional qualifications required for entry ~~level as specified in 12VAC35-105-420~~. ~~B. Employees or contractors shall have access to their current job description. The provider shall have written documentation of the mechanism used to advise employees or contractors of changes to their job responsibilities.~~	Simplification of language and elimination of an unnecessary requirement.
12VAC35-105-420. Qualifications of employees or contractors. ~~A. Any~~ Each person who assumes the responsibilities of ~~any~~ a position as an employee or a contractor shall meet the minimum qualifications of that position ~~as determined by~~ in accordance with the current job ~~descriptions~~ description. B. Employees and contractors shall comply, as required, with the regulations of the Department of Health Professions. The provider shall design, implement, and document the process used to verify professional credentials. ~~C. Supervisors shall have experience in working with individuals being served and in providing the services outlined in the service description.~~ ~~D. Job descriptions shall include minimum knowledge, skills and abilities, professional qualifications and experience appropriate to the duties and responsibilities required of the position.~~ E. ~~All staff~~ Each employee or contractor shall demonstrate a working knowledge of the policies and procedures that are applicable to his specific job or position.	Clarification of language. The language in subsection C is duplicative of Section 590. The language in subsection D is duplicative of Section 410. Clarification of language.

12VAC35-105-430. Employee or contractor personnel records. ~~A.~~ Employee or contractor personnel records~~, whether hard-copy or electronic,~~ shall include: 1. Individual identifying information; 2. Education and training history; 3. Employment history; and 4. ~~Results of any provider credentialing process including methods of verification of applicable professional licenses or certificates;~~ ~~5. Results of reasonable efforts to secure job-related references and reasonable verification of employment history;~~ ~~6. Results of the required criminal background checks and searches of the registry of founded complaints of child abuse and neglect;~~ ~~7. Results of performance evaluations;~~ ~~8.~~ A record of disciplinary action taken by the provider, if any ~~;~~ ~~9. A record of adverse action by any licensing and oversight bodies or organizations, if any; and~~ ~~10. A record of participation in employee development activities, including orientation~~. B. Each employee or contractor personnel record shall be retained in its entirety for a minimum of three years after the employee's or contractor's termination of employment.	Item 4 is duplicative of 12VAC35-105-420 B. Item 5 is duplicative of 12VAC35-105-420 A. Item 6 is duplicative of 12VAC35-105-400, Item 7 is duplicative of 12VAC35-105-480. Item 9 is duplicative of 12VAC35-105-420 B. Item 10 is duplicative of Section 440. As these items are required elsewhere in the regulations the requirement the Department is truly removing is the requirement that these items be stored within the employee or contractor personnel records. Providing discretion as to where the provider maintains documentation and allowing providers to find systems that work for their service was a key goal of the department throughout the regulatory reduction project.

12VAC35-105-440. Orientation of new employees, contractors, volunteers, and students. New employees, contractors, volunteers, and students shall be oriented commensurate with their function or job-specific responsibilities within 15 business days. The provider shall document that the orientation covers each of the following policies, procedures, and practices: 1. ~~Objectives and philosophy of the provider;~~ ~~2.~~ Practices of confidentiality including access, duplication, and dissemination of any portion of an individual's record; 3. Practices that assure an individual's rights including orientation to human rights regulations; 4. ~~Applicable personnel policies;~~ ~~5.~~ Emergency preparedness procedures; ~~6.~~ 5. Person-centeredness; ~~7.~~ 6. Infection control practices and measures; ~~8.~~ 7. Other policies and procedures that apply to specific positions and specific duties and responsibilities; and ~~9.~~ 8. Serious incident reporting, including when, how, and under what circumstances a serious incident report must be submitted and the consequences of failing to report a serious incident to the department in accordance with this chapter.	Items 1 and 4 are unnecessary and duplicative.
12VAC35-105-470. Notification of policy changes. The provider shall keep all employees ~~or~~ and contractors informed of policy changes that affect their performance of duties. ~~The provider shall have written documentation of the process used to advise employees or contractors of policy changes.~~	The second sentence is unnecessary and duplicative. Also, amended from passive to active for clarification.

12VAC35-105-490. ~~Written grievance policy.~~ (Repealed.) ~~The provider shall implement a written grievance policy and shall inform employees of grievance procedures. The provider shall have documentation of the process used to advise employees of grievance procedures.~~	It is up to the provider to follow employment laws. DBHDS does not administer or enforce employment laws.
12VAC35-105-500. ~~Students and volunteers.~~ (Repealed.) ~~A. The provider shall implement a written policy that clearly defines and communicates the requirements for the use and responsibilities of students and volunteers including selection and supervision.~~ ~~B. The provider shall not rely on students or volunteers to supplant direct care positions. The provider staffing plan shall not include volunteers or students.~~	The health, welfare, and safety concern of utilizing students and volunteers is in regard to the supervision aspect. Given the restrictions on use of volunteers and students and the reference to staffing plan, language in subsection B is moved to Section 590 where it fits more appropriately. DBHDS believes it should be within the provider's discretion whether to create a policy regarding students and volunteers outside of the restriction in the language now in 590.

12VAC35-105-510. Tuberculosis screening. A. Each new employee, contractor, student, or volunteer who will have direct contact with individuals receiving services shall obtain a statement of certification by a qualified licensed practitioner indicating the absence of tuberculosis in a communicable form within 30 days of employment or initial contact with individuals receiving services. The employee shall submit a copy of the original screening to the provider. A statement of certification shall not be required for a new employee who has separated from service with another licensed provider with a break in service of six months or less or who is currently working for another licensed provider. B. All employees, contractors, students, or volunteers in substance abuse co-occurring outpatient or residential treatment services shall ~~be certified as~~ receive tuberculosis education ~~free on~~ an annual basis by ~~a qualified licensed practitioner~~. The education shall focus on self-presentation in the event of exposure to active tuberculosis or the development of symptoms of active tuberculosis. C. Any employee, contractor, student, or volunteer who comes in contact with a known case of active tuberculosis disease or who develops symptoms of active tuberculosis disease (including, but not limited to fever, chills, hemoptysis, cough, fatigue, night sweats, weight loss , or anorexia) of three weeks duration shall be screened as determined appropriate for continued contact with employees, contractors, students, volunteers, or individuals receiving services based on consultation with the local health department. D. An employee, contractor, student, or volunteer suspected of having active tuberculosis shall not be permitted to return to work or have contact with employees, contractors, students, volunteers, or individuals receiving services until a physician has determined that the person is free of active tuberculosis.	Subsection B is corrected per guidance from VDH, and this reduces the burden for annual training.

12VAC35-105-530. Emergency preparedness and response plan. A. The scope of emergency preparedness in relation to this section applies to disasters and emergencies as defined by § 44-146.16 of the Code of Virginia. The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. ~~This plan shall include an analysis of potential emergencies that could disrupt the normal course of service delivery including emergencies that would require expanded or extended care over a prolonged period of time.~~ The plan shall address: 1. Specific procedures describing mitigation, preparedness, response, and recovery strategies, actions, and responsibilities for each emergency. 2. ~~Documentation of coordination with the local emergency authorities to determine local disaster risks and community-wide plans to address different disasters and emergency situations.~~ ~~3.~~ The process for notifying local and state authorities of the emergency and a process for contacting staff when emergency response measures are initiated. 4. Written emergency management policies outlining specific responsibilities for provision of administrative direction and management of response activities, coordination of logistics during the emergency, communications, life safety of employees, contractors, students, volunteers, visitors, and individuals receiving services, property protection, community outreach, and recovery and restoration. 5. ~~Written emergency response procedures for initiating the response and recovery phase of the plan including a description of how, when, and by whom the phases will be activated. This includes assessing the situation; protecting individuals receiving services, employees, contractors, students, volunteers, visitors, equipment, and vital records; and restoring services. Emergency procedures shall address~~ Procedures for: a. Warning , ~~and~~ notifying , and communicating with individuals receiving services ~~;~~ , ~~b. Communicating with~~ employees, contractors, and community responders;	Streamlining overly prescriptive language and simplifying language, while not changing expectations.

~~c. Designating alternative roles and responsibilities of staff during emergencies including to whom they will report in the provider's organization command structure and when activated in the community's command structure;~~ ~~d.~~ b. Providing emergency access to secure areas and opening locked doors; ~~e.~~ c. ~~Evacuation procedures, including~~ Evacuating ~~for individuals who need evacuation assistance;~~ ~~f. Conducting evacuations~~ to emergency shelters ~~,~~ , ~~or~~ other alternative sites , relocating individuals receiving residential or inpatient services to new service locations, and accounting for all individuals receiving services; ~~g. Relocating individuals receiving residential or inpatient services, if necessary;~~ ~~h.~~ d. Notifying family members or authorized representatives; ~~i. Alerting emergency personnel and sounding alarms;~~ ~~j Locating and shutting off utilities when necessary;~~ and ~~k.~~ e. Maintaining a 24-hour ~~telephone answering~~ communications capability to respond to emergencies for individuals receiving services. 6. Processes for managing the following under emergency conditions: a. Activities related to the provision of care, treatment, and services including scheduling, modifying, or discontinuing services; ~~controlling~~ protecting confidential information about individuals receiving services; providing medication; and coordinating transportation services; and b. Logistics related to critical supplies such as pharmaceuticals, food, linen, and water~~;~~ ~~c. Security including access, crowd control, and traffic control; and~~	Striking this language as duplicative of Section 440.

~~d. Back-up communication systems in the event of electronic or power failure~~.	
7. ~~Specific processes and protocols for evacuation of the provider's building or premises when the environment cannot support adequate care, treatment, and services.~~	
~~8. Supporting documents that would be needed in an emergency, including emergency call lists, building and site maps necessary to shut off utilities, designated escape routes, and list of major resources such as local emergency shelters.~~	Simplifying language.
~~9.~~ 7. ~~Schedule~~ Schedules for testing the implementation of the plan and conducting emergency preparedness drills. Fire and evacuation drills shall be conducted at least monthly.	
B. The provider shall evaluate each individual receiving services and, based on ~~that~~ the individualized ~~evaluation~~ evaluations, shall provide appropriate environmental supports and adequate staff to safely evacuate all individuals during an emergency.	F. is covered in sections 440 and 450.
C. The provider shall implement annual emergency preparedness and response training for all employees, contractors, students, and volunteers~~. This training shall also be provided as part of orientation for new employees and~~ that ~~cover~~ covers responsibilities for:	
1. Alerting emergency personnel and sounding alarms;	
2. Implementing evacuation procedures, including evacuation of individuals with special needs (i.e., deaf, blind, nonambulatory);	
3. Using, maintaining, and operating emergency equipment;	
4. Accessing emergency medical information for individuals receiving services; and	
5. Utilizing community support services.	
D. The provider shall review the emergency preparedness plan annually and make necessary revisions. Such revisions shall be communicated to employees, contractors, students, volunteers, and individuals receiving services and	

incorporated into orientation and training materials ~~for employees, contractors, students, and volunteers and into the orientation of individuals to services~~. E. ~~In the event of a disaster, fire, emergency, or any other condition that may jeopardize the health, safety, or welfare of individuals, the provider shall take appropriate action to protect the health, safety, and welfare of individuals receiving services and take appropriate actions to remedy the conditions as soon as possible.~~ ~~F. Employees, contractors, students, and volunteers shall be knowledgeable in and prepared to implement the emergency preparedness plan in the event of an emergency. The plan shall include a policy regarding regularly scheduled emergency preparedness training for all employees, contractors, students, and volunteers.~~ ~~G. In the event of a disaster, fire, emergency, or any other condition that may jeopardize the health, safety, or welfare of individuals, the provider should first respond and stabilize the disaster or emergency.~~ After the disaster or emergency is stabilized, the provider should report the disaster or emergency to the department, but no later than 24 hours after the incident occurs. ~~H.~~ Providers of residential services shall have at all times a three-day supply of emergency food and water for all ~~residents~~ individuals and staff. Emergency food supplies should include foods that do not require cooking. Water supplies shall include one gallon of water per person per day. ~~I.~~ F. All provider locations shall be equipped with at least one approved type ABC portable fire extinguisher with a minimum rating of 2A10BC installed in each kitchen. ~~J.~~ G. All provider locations shall have an appropriate number of properly installed smoke detectors based on the size of the location, which shall include at a minimum: 1. At least one smoke detector on each level of multi-level buildings, including the basement; 2. At least one smoke detector in each bedroom in locations with bedrooms; 3. At least one smoke detector in any area adjacent to any bedroom in locations with bedrooms; and	

4. Any additional smoke detectors necessary to comply with all applicable federal and state laws and regulations and local ordinances. ~~K.~~ H. Smoke detectors shall be tested monthly for proper operation. ~~L.~~ I. All provider locations shall maintain a floor plan identifying locations of: 1. Exits; 2. Primary and secondary evacuation routes; 3. Accessible egress routes; 4. Portable fire extinguishers; and 5. Flashlights. ~~M.~~ J. This section does not apply to home and noncenter-based services.	
12VAC35-105-570. ~~Mission statement.~~ (Repealed.) ~~The provider shall develop a written mission statement that clearly identifies its philosophy, purpose, and goals.~~	This language does not contribute to individual health, safety, and welfare, nor does DBHDS have the staff resources to analyze the information in a meaningful way.

12VAC35-105-580. Service description requirements.	
A. The provider shall develop~~,~~ and implement~~, review, and revise its~~ descriptions of services offered ~~according to the provider's mission~~ and shall make service descriptions available for public review.	With section 570 recommended to be rescinded, the mission language in subsection A is unnecessary.
B. The provider shall outline how each service offers a structured program of individualized interventions and care designed to meet the individuals' physical and emotional needs; provide protection, guidance and supervision; and meet the objectives of any required individualized services plan.	
C. ~~The provider shall prepare a written description of each service it offers.~~ Elements of each service description required by subsection A shall include:	The first sentence of subsection C is duplicative of A.
1. Service goals;	
2. A description of care, treatment, skills acquisition, or other supports provided;	
3. Characteristics and needs of individuals to receive services;	
4. Contract services, if any;	
5. Eligibility requirements and admission, continued stay, and exclusion criteria;	
6. Service termination and discharge or transition criteria; and	
7. Type and role of employees or contractors.	
D. ~~The provider shall revise the written service description whenever the operation of the service changes.~~	Subsection D is duplicative with the edit in subsection A.
~~E.~~ The provider shall not implement services that are inconsistent with its most current service description.	
~~F.~~ E. The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals receiving services.	
~~G.~~ F. The provider shall provide for the physical separation of children and adults in residential and inpatient services and shall provide separate group programming for adults and children, except in the case of family services. The provider shall provide for the safety of children accompanying parents receiving	This language in subsection G (new subsection F) is not current practice and is not encouraged.

services. ~~Older adolescents transitioning from school to adult activities may participate in developmental day support services with adults.~~ ~~H.~~ G. The service description for substance abuse treatment services shall address the timely and appropriate treatment of pregnant women with substance abuse (substance use disorders). ~~I. If the provider plans to serve individuals as of a result of a temporary detention order to a service, prior to admitting those individuals to that service, the provider shall submit a written plan for adequate staffing and security measures to ensure the individual can receive services safely within the service to the department for approval. If the plan is approved, the department shall add a stipulation to the license authorizing the provider to serve individuals who are under temporary detention orders.~~	This language in subsection I is not necessary as the license will clearly indicate the type of service that can be provided (for example, inpatient or residential mental health crisis services).

12VAC35-105-590. Provider staffing plan. A. The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. The provider staffing plan shall not include volunteers or students. This staffing plan shall reflect the: 1. Needs of the individuals receiving services; 2. Types of services offered; 3. Service description; 4. Number of individuals to receive services at a given time; and 5. Adequate number of staff required to safely evacuate all individuals during an emergency. B. <u>The provider staffing plan shall not include volunteers or students and shall not rely on students or volunteers to supplant direct care positions.</u> <u>C.</u> The provider shall develop a written transition staffing plan for new services, added locations, and changes in capacity. ~~C~~ <u>D</u>. The provider shall meet the following staffing requirements related to supervision. 1. The provider shall describe how employees~~, volunteers,~~ and contractors~~, and student interns~~ will be supervised in the staffing plan and how that supervision will be documented. 2. Supervision of employees~~, volunteers,~~ and contractors~~, and student interns~~ shall be provided by persons who have experience in working with individuals receiving services and in providing the services outlined in the service description. 3. Supervision shall be appropriate to the services provided and the needs of the individual. Supervision shall be documented. 4. Supervision shall include responsibility for approving assessments and individualized services plans, as appropriate. This responsibility may be	Simplification of language incorporating repeal of Section 500.

delegated to an employee or contractor who meets the qualification for supervision as defined in this section. 5. Supervision of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature such as outpatient, inpatient, intensive in-home, or day treatment shall be provided by a licensed mental health professional or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions. 6. Supervision of mental health, substance abuse, or co-occurring services that are of a supportive or maintenance nature, such as psychosocial rehabilitation or mental health supports, shall be provided by a QMHP-A, a licensed mental health professional, or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions. An individual who is a QMHP-E may not provide this type of supervision. 7. Supervision of developmental services shall be provided by a person with at least one year of documented experience working directly with individuals who have developmental disabilities and holds at least a bachelor's degree in a human services field such as sociology, social work, special education, rehabilitation counseling, nursing, or psychology. Experience may be substituted for the education requirement. 8. Supervision of brain injury services shall be provided at a minimum by a clinician in the health professions field who is trained and experienced in providing brain injury services to individuals who have a brain injury diagnosis including (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a psychiatrist who is a doctor of medicine or osteopathy specializing in psychiatry and licensed in Virginia; (iii) a psychologist who has a master's degree in psychology from a college or university with at least one year of clinical experience; (iv) a social worker who has a bachelor's degree in human services or a related field (social work, psychology, psychiatric evaluation, sociology, counseling, vocational rehabilitation, human services counseling, or other degree deemed equivalent to those described) from an accredited college or university with at least two years of clinical experience providing direct services to individuals with a diagnosis of brain injury; (v) a Certified Brain Injury Specialist; (vi) a registered nurse licensed in Virginia with at least one year of clinical	

experience; or (vii) any other licensed rehabilitation professional with one year of clinical experience. ~~D~~ E. The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals receiving services in residential services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary. ~~E~~ F. Providers of brain injury services shall employ or contract with a neuropsychologist or licensed clinical psychologist specializing in brain injury to assist, as appropriate, with initial assessments, development of individualized services plans, crises, staff training, and service design. ~~F~~ G. Staff in direct care positions providing brain injury services shall have at least a high school diploma and two years of experience working with individuals with disabilities or shall have successfully completed an approved training curriculum on brain injuries within six months of employment.	

12VAC35-105-645. Initial contacts, screening, and admission~~, assessment, service planning, orientation and discharge~~. A. The provider shall implement policies and procedures for initial contacts and screening, admissions, and referral of individuals to other services and designate staff to perform these activities. B. The provider shall maintain written documentation of ~~an~~ each individual's initial contact and screening ~~prior to his admission~~ including the: 1. Date of contact; 2. Name, age, and gender of the individual; 3. Address and telephone number of the individual, if applicable; 4. Reason why the individual is requesting services; and 5. Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service. C. ~~The provider~~ Providers of crisis or case management services shall assist individuals who are not admitted to identify other appropriate services. D. ~~The~~ For individuals who are not admitted, the provider shall retain documentation of the individual's initial ~~contacts~~ contact and screening referenced in subsection B for a period of six months. ~~Documentation shall be included in the individual's record if the individual is admitted to the service.~~	Clarifying language because the subsection applies whether or not individual is admitted to service. The amendment in subsection C reduces intensity by limiting to crisis and case management services. Clarifying edit in the first sentence. If an individual is admitted to a service, the documentation retention requirements are more stringent than six months and is duplicative of subsection 890 C 1.

12VAC35-105-690. Orientation of individuals and authorized representatives. A. The provider shall implement a written policy regarding the orientation ~~of~~ to services for individuals and their authorized representatives, if applicable ~~to services~~. B. As appropriate to the scope and level of services , the policy shall require the provision to individuals and authorized representatives , if applicable, the following information: 1. ~~The mission of the provider or service;~~ ~~2. Service confidentiality~~ Confidentiality practices and protections for individuals receiving services; ~~3.~~ 2. Human rights policies and protections and instructions on how to report violations; ~~4.~~ 3. Opportunities for participation in services and discharge planning; ~~5.~~ 4. Fire safety and emergency preparedness procedures, if applicable; ~~6.~~ 5. The provider's ~~grievance~~ complaint procedure; ~~7.~~ 6. Service guidelines including criteria for admission ~~to~~ and discharge or transfer ~~from services~~; ~~8.~~ 7. Hours and days of operation; ~~9.~~ 8. Availability of after-hours service; and ~~10.~~ 9. Any charges or fees due from the individual. C. In addition to the provisions of subsection B, orientation for individuals receiving treatment services in a correctional facility shall ~~receive an orientation to~~ cover the facility's security restrictions. ~~D.~~ The provider shall document that the individual and authorized representative, if applicable, received an orientation to services.	In subsection B, item 1 is unnecessary and was eliminated in Section 570; item 6 (now 5) is amended to reflect repeal of grievance procedure and to prevent confusion regarding staff versus provider.

12VAC35-105-691. Transition of individuals among ~~service~~ services by the same provider. ~~A. The provider shall implement written procedures that define the process for transitioning an individual between or among services operated by the provider. At a minimum the policy shall address:~~ ~~1. The process by which the provider will assure continuity of services during and following transition;~~ ~~2. The participation of the individual or his authorized representative, as applicable, in the decision to move and in the planning for transfer;~~ ~~3. The process and timeframe for transferring the access to individual's record and ISP to the destination location;~~ ~~4. The process and timeframe for completing the transfer summary; and~~ ~~5. The process and timeframe for transmitting or accessing, where applicable, discharge summaries to the destination service.~~ ~~B. The transfer summary shall include at a minimum the following:~~ ~~1. Reason for the individual's transfer;~~ ~~2. Documentation of informed choice by the individual or his authorized representative, as applicable, in the decision to and planning for the transfer;~~ ~~3. Current psychiatric and known medical conditions or issues of the individual and the identity of the individual's health care providers;~~ ~~4. Updated progress of the individual in meeting goals and objectives in his ISP;~~ ~~5. Emergency medical information;~~ ~~6. Dosages of all currently prescribed medications and over-the-counter medications used by the individual when prescribed by the provider or known by the case manager;~~ ~~7. Transfer date; and~~ ~~8. Signature of employee or contractor responsible for preparing the transfer summary.~~	The streamlining edits are for clarification for transfer across services by the same provider versus discharge procedures to address patient safety during those transitions. Much of the new language is from the current Children's Residential Regulations (12VAC35-46) in Section 760. It removes the requirement for a specific policy, which reduces burden.

~~C. The transfer summary may be documented in the individual's progress notes or in information easily accessible within an electronic health record.~~ A. Except when transfer is ordered by a court of competent jurisdiction, the receiving service shall document at the time of transfer: 1. Documentation by the sending service of: a. Informed choice by the individual or his authorized representative, as applicable, in the decision to and planning for the transfer; b. Notification to the family, if appropriate; and c. Signature of employee or contractor responsible for preparing the transfer summary and transfer date. 2. Receipt from the sending service of a written summary of the individual's progress while at the facility, justification for the transfer, and the individual's current strengths and needs; 3. Receipt of the individual's record including emergency medical information; and B. The sending service shall retain a copy of the face sheet and a written summary of the individual's progress while within the service and shall document the date of transfer and the name of the facility to which the individual was transferred.	

12VAC35-105-693. Discharge. A. The provider shall have written policies and procedures regarding the discharge or termination of individuals from ~~the~~ its 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~~ At a minimum, discharge instructions shall include~~ at a minimum~~ medications and dosages , if applicable ; names, phone numbers, and addresses of any successor providers to whom the individual is referred; current medical issues or conditions; and the identity of the individual's treating health care ~~providers~~ practitioners. C. The provider shall make appropriate arrangements or referrals to all ~~service~~ services or successor 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~~ The provider shall complete a written discharge summary ~~shall be completed~~ within 30 days of discharge ~~and shall~~ that ~~include~~ includes at a minimum the following: 1. Reason for the individual's admission to and discharge from the service; 2. Description of participation by the ~~individual's~~ individual or authorized ~~representative's~~ representative ~~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~~ were made for future services;	Subsection E is duplicative of F2. Streamlining edits are made for clarification in subsection F.

6. Progress made by the individual in achieving goals and objectives identified in the ISP and a summary of critical events during service provision; 7. ~~Discharge date~~ Date of discharge and when the discharge summary was actually written or documented; ~~8. Discharge , and medications prescribed by the provider, if applicable;~~ ~~9. Date the discharge summary was actually written or documented;~~ and ~~10.~~ 8. Signature of the ~~person who prepared~~ provider's employee or contractor responsible for preparing the discharge summary.	
12VAC35-105-700. Written policies and procedures for crisis or emergency interventions; required elements. A. The provider shall implement written policies and procedures for prompt intervention in the event of a crisis as defined in 12VAC35-105-20 or a behavioral, medical, or psychiatric emergency that may occur during screening and referral, at admission, or during the period of service provision. B. The policies and procedures shall include: 1. A service-specific working definition of what constitutes ~~a crisis or~~ behavioral, medical, or psychiatric emergency; 2. ~~Procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the emergency;~~ ~~3.~~ Employee or contractor responsibilities; and 4. Location of emergency medical information for each individual receiving services, including any advance psychiatric or medical directive or crisis response plan developed by the individual, which shall be readily accessible to employees or contractors on duty in an emergency or crisis.	Item B 2 is covered by subsection A, items 1 and 4 in B.

12VAC35-105-720. Health care policy. A. The provider shall implement a policy, appropriate to the scope and level of service offered, that addresses provision of adequate and appropriate medical care. This policy shall describe how: 1. Medical care needs will be assessed including circumstances that will prompt the decision to obtain a medical assessment. 2. Individualized services plans will address any medical care needs appropriate to the scope and level of service. 3. Identified medical care needs will be addressed. 4. The provider will manage medical care needs or respond to abnormal findings. 5. The provider will communicate medical assessments and diagnostic laboratory results to the individual and authorized representative, as appropriate. 6. The provider will keep accessible to staff and contractors on duty the names, addresses, and phone numbers of the individual's medical and dental providers. 7. The provider will ensure a means for facilitating and arranging, as appropriate, transportation to medical and dental appointments and medical tests, when services cannot be provided on site. B. The provider shall implement written policies to identify any individuals who are at risk for falls and develop and implement a fall prevention and management plan and program for each at risk individual. C. ~~Providers of residential or inpatient services shall provide or arrange for the provision of appropriate medical care. Providers of other services shall define instances when they shall provide or arrange for appropriate medical and dental care and instances when they shall refer the individual to appropriate medical care.~~ ~~D.~~ C. The provider shall implement written infection control measures including the use of universal precautions. E. The provider shall report outbreaks of infectious diseases to the Department of Health pursuant to § 32.1-37 of the Code of Virginia.	The language in subsection C is duplicative.

12VAC35-105-740. Physical examination for residential and inpatient services. A. ~~Providers~~ Within 30 days of an individual's admission, providers of residential ~~or inpatient~~ services shall either administer a physical examination or obtain results of ~~physical exams~~ an examination conducted within the previous 12 months ~~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.~~ A physical examination shall include the date of examination and signature of a qualified practitioner. 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.	A timeframe distinction is made for residential versus inpatient services. The change in B reflects the reality that physicians have professional standards to follow, and typically their own office forms and do not want to use a different or second form. The language in item B 5 is placed in subsection C; the stricken text in subsection C is covered by 12VAC35-115-50.

12VAC35-105-770. Medication management. A. The provider shall implement written policies addressing: 1. The safe administration, handling, storage, and disposal of medications; 2. The use of medication orders; 3. The handling of packaged medications brought by individuals from ~~home or other residences~~ outside the facility; 4. ~~Employees~~ Training requirements necessary for employees or contractors who are authorized to administer medication ~~and training required for administration of medication~~; and 5. ~~The use of professional samples; and~~ ~~6.~~ The window within which medications can be given in relation to the ordered or established time of administration. B. Medications shall be administered only by persons ~~who are~~ authorized to do so by ~~state law~~ The Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia) . C. Medications shall be administered as prescribed and only to the individuals for whom the medications are prescribed ~~and shall be administered as prescribed~~. D. The provider shall maintain a daily log of all medicines received and refused by each individual. This log shall identify the employee or contractor who administered the medication, the name of the medication and dosage administered or refused, and the time the medication was administered or refused. E. If the provider administers medications or supervises self-administration of medication in a service, a current medication order for all medications the individual receives shall be maintained on site. F. The provider shall promptly dispose of discontinued drugs, outdated drugs, and drug containers with worn, illegible, or missing labels according to the applicable regulations of the Virginia Board of Pharmacy.	Simplification by deleting subsection A.5; a professional sample would be handled the same as any other medication.

12VAC35-105-790. ~~Medication administration and storage or pharmacy operation.~~ <u>(Repealed.)</u> ~~A. A provider responsible for medication administration and medication storage or pharmacy operations shall comply with:~~ ~~1. The Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia);~~ ~~2. The Virginia Board of Pharmacy regulations;~~ ~~3. The Virginia Board of Nursing regulations; and~~ ~~4. Applicable federal laws and regulations relating to controlled substances.~~ ~~B. A provider responsible for medication administration and storage or pharmacy operation shall provide in-service training to employees and consultation to individuals and authorized representatives on issues of basic pharmacology including medication side effects.~~	Subsection A is duplicative of Section 150. Subsection B is covered elsewhere and this language is unnecessarily broad.

12VAC35-105-800. Policies and procedures on behavior interventions and supports. A. The provider shall implement written policies and procedures that describe conditions for the use of behavior interventions that comply with the requirements of 12VAC35-115, including seclusion, restraint, and time out. The policies and procedures shall: ~~1. Be consistent with applicable federal and state laws and regulations;~~ ~~2. Emphasize positive approaches to behavior interventions;~~ ~~3.~~ 1. List and define behavior interventions in the order of their relative degree of intrusiveness or restrictiveness and the conditions under which they may be used in ~~each service for each individual~~ accordance with each individual's ISP; ~~4.~~ 2. Protect the safety and well-being of the individual at all times, including during fire ~~and~~ or other emergencies; and ~~5.~~ 3. Specify the mechanism for monitoring and documenting the use of behavior interventions . ~~; and~~ ~~6. Specify the methods for documenting the use of behavior interventions.~~ B. Employees and contractors trained in behavior support interventions shall implement and monitor all behavior interventions. C. Policies and procedures related to behavior interventions shall be available to individuals, their families, authorized representatives, and advocates. Notification of policies does not need to occur in correctional facilities. D. Individuals receiving services shall not discipline, restrain, seclude, or implement behavior interventions on other individuals receiving services. E. Injuries resulting from or occurring during the implementation of seclusion or restraint shall be reported to the department as provided in 12VAC35-115-230 C.	Edits to subsection A correctly redirects the language to the Human Rights Regulations, and simplifies what the policies and procedures on behavior interventions and supports shall include. Language to mirror definition of “behavioral intervention”

12VAC35-105-870. ~~Paper and electronic records~~ Records management policy. A. The provider shall develop and implement a written records management policy that describes confidentiality, accessibility, security, and retention of ~~paper and electronic~~ records pertaining to individuals, including: 1. Access ~~and limitation of access~~, duplication, ~~or~~ dissemination, and acquiring of individual information only to persons ~~who are~~ legally authorized ~~to access such information~~ according to federal and state laws; 2. Storage, processing, and handling of active and closed records; 3. ~~Storage, processing, and handling of electronic records;~~ ~~4.~~ Security measures ~~that~~ to protect records from loss, unauthorized alteration, inadvertent or unauthorized access, disclosure of information, and transportation of records between service sites; ~~5.~~ 4. Strategies for service continuity and record recovery from interruptions that result from disasters or emergencies including contingency plans, electronic or manual back-up systems, and data retrieval systems; ~~6. Designation of the person responsible for records management;~~ and ~~7.~~ 5. Disposition of records in the event that the service ceases operation. If the disposition of records involves a transfer to another provider, the provider shall have a written agreement with that provider. B. The records management policy shall be consistent with applicable state and federal laws and regulations related to privacy of health records including: 1. Section 32.1-127.1:03 of the Code of Virginia; 2. 42 USC § 290dd; 3. 42 CFR Part 2; and 4. The Health Insurance Portability and Accountability Act (Public Law 104-191) and implementing regulations (45 CFR Parts 160, 162, and 164). C. The policy shall specify what information is available to the individual.	The edits are intended to simplify the language and requirements. New language in A is identical to that in Section 660 of Chapter 46 that succinctly covers necessary requirements. This edit to item 3 is a simplification. Electronic records have become more standard and singling them out when subsection A states the policy pertains to both paper and electronic records is not necessary. Item 6 of subsection A is not needed as it is up to the provider to ensure appropriate staffing for records management. Clarifying edits. New language in C, D, and E is identical to that in Section 660 of Chapter 46 that succinctly covers necessary requirements.

D. Active and closed records shall be kept in areas that are accessible to authorized staff and protected from unauthorized access, fire, and flood. E. Entries in the individual's record shall be current, dated, and authenticated by the person making the entry. Errors shall be corrected by striking through and initialing.	
12VAC35-105-880. ~~Documentation policy~~. (Repealed.) ~~A. The provider shall define, by policy, all records it maintains that address an individual's care and treatment and what each record contains.~~ ~~B. The provider shall define, by policy, and implement a system of documentation that supports appropriate service planning, coordination, and accountability. At a minimum this policy shall outline:~~ ~~1. The location of the individual's record;~~ ~~2. Methods of access by employees or contractors to the individual's record; and~~ ~~3. Methods of updating the individual's record by employees or contractors including the frequency and format of updates.~~ ~~C. Entries in the individual's record shall be current, dated, and authenticated by the persons making the entries. For paper records, errors shall be corrected by striking through and initialing the incorrect information. If records are electronic, the provider shall implement a written policy to include the identification of errors and corrections to the record.~~	These requirements are unnecessary as they are covered by Section 870.

12VAC35-105-890. Individual's service record. A. There shall be a separate primary record for each individual admitted for service. A separate record shall be maintained for each family member who is receiving individual treatment. <u>The provider shall maintain each individual's record in accordance with 32.1-127.1:03 of the Code of Virginia.</u> B. All individuals admitted to the service shall have identifying information readily accessible in the individual's service record. Identifying information shall include the following: 1. Identification number unique for the individual; 2. Name of individual; 3. Current residence, if known; 4. Social security number; 5. Gender; 6. Marital status; 7. Date of birth; 8. Name of authorized representative, if applicable; 9. Name, address, and telephone number for emergency contact; 10. Adjudicated legal incompetency or legal incapacity, if applicable; and 11. Date of admission to service. C. In addition an individual's service record shall contain, at a minimum: 1. Screening documentation; 2. Assessments; 3. Medical evaluation, as applicable to the service; 4. Individualized services plans and reviews; 5. Progress notes; and 6. A discharge summary, if applicable.	The amendment inserts an appropriate cross-reference to the Virginia Health Records Act for clarity.

12VAC35-105-900. ~~Record storage and security.~~ (Repealed.) ~~A. When not in use, active and closed paper records shall be stored in a locked cabinet or room.~~ ~~B. Physical and data security controls shall exist to protect electronic records.~~	This section is duplicative of Section 880 and HIPAA.
12VAC35-105-920. ~~Review process for records.~~ (Repealed.) ~~The provider shall implement a review process to evaluate both current and closed records for completeness, accuracy, and timeliness of entries.~~	This section is duplicative of Sections 870 and 880.
12VAC35-105-1055. ~~Description of level of care provided.~~ (Repealed.) ~~Article 2~~ ~~Medically Managed Withdrawal Services~~ ~~In the service description the provider shall describe the level of services and the medical management provided.~~	This is blended into an ASAM level of care.
12VAC35-105-1060. ~~Cooperative agreements with community agencies.~~ (Repealed.) ~~The provider shall establish cooperative agreements with other community agencies to accept referrals for treatment, including provisions for physician coverage if not provided on-site, and emergency medical care. The agreements shall clearly outline the responsibility of each party.~~	ASAM sections have language establishing expectations related to affiliations and coordination of services.
~~12VAC35-105-1080. Direct-care training for providers of detoxification services.~~ (Repealed.) ~~A. The provider shall document staff training in the areas of:~~ ~~1. Management~~ management ~~of withdrawal ; and~~ ~~2. First responder training.~~ ~~B. Untrained employees or contractors shall not be solely responsible for the care of individuals.~~	A 1 is still a licensed service but is an ASAM level of care, and the staffing requirements in those new sections are sufficient.

~~FORMS (12VAC35-105)~~(Repealed.) ~~Initial Provider Application For Licensing (rev.1/10).~~ ~~Renewal Provider Application For Licensing (rev. 2/09).~~ ~~Service Modification - Provider Request, DMH 966E 1140 (rev. 1/09).~~	The information gathered in these outdated forms are now incorporated into the DBHDS licensing online web-based system.

REGULATORY ACTIVITY STATUS REPORT: APRIL 2024 (REVISED 09/13/24)

Board STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

VAC CITATION	CHAPTER TITLE (FULL TITLE)	REGULATIONS IN PROCESS		
		PURPOSE	STAGE	STATUS
12 VAC 35-46 Certain sections **and NEW s**ections.	*Regulations for Children's Residential Facilities*	To provide the process and standards for licensing children's residential facilities.	• ***Draft in progress.***	• Public comment closed 5/16/2022. *Amend (overhaul); draft in progress.*
12 VAC 35-46 Certain sections	*same*	*To comply with EO1, removing noncontroversial language.*	• ***Fast Track.***	➢ ***Action requested: Initiate fast track.***
12 VAC 35-105 Certain sections.	**Rules and Regulations for Licensing Facilities and Providers of Mental Health, Mental Retardation and Substance Abuse Services**	Amendments to incorporate federal Drug Enforcement Administration (DEA) final rule permitting DEA registrants who are authorized to dispense methadone for opioid use disorder to add a "mobile component" to their existing registrations; due to provider interest in supplying these mobile medication assisted treatment (mobile MAT) services.	• **Fast Track.**	• With GOV 7/9/2024.
12 VAC 35-105 Section 40.	*same*	In accordance with HB 597 (2020), amendments to incorporate new requirements for initial applications for service providers licensed by the DBHDS requiring a statement of certain information including previous negative actions.	• **Fast Track.**	• Initiated and with OAG on 7/17/2023; changed to fast track 7/24/2024; with OAG.
12 VAC 35-105 All sections.	*same*	*Response to 2017 periodic review ('overhaul' to service-specific chapters).*	• ***Draft in progress.***	• *Expect NOIRA in December. Final drafts to OAG this month as completed.*
12 VAC 35-105 Certain sections.	*same*	*To comply with EO1, removing noncontroversial language.*	• ***Fast Track.***	➢ ***Action requested: Initiate fast track.***
12 VAC 35-105 Section 693.		*In accordance with Chapter 808 of the 2024 Acts of Assembly to amend the provider's responsibilities upon discharging an individual by adding a new subsection to effectuate an additional mandate on substance abuse (substance use disorder) treatment facilities.*	• ***Fast Track.***	➢ ***Action requested: Initiate fast track.***

12 VAC 35-115	***Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services***	*To protect the legal and human rights of all individuals who receive services in programs and facilities operated, funded, or licensed by DBHDS.*	• ***Draft in progress.***	• *Draft out for public comment this month. Expect fast track in December.*
12 VAC 35-190	**Regulations for Voluntary Admissions to State Training Centers**	To detail criteria and procedures for voluntarily admitting persons to a state training center. ↓↓	• **Fast Track.**	• Action initiated in July and with OAG on 7/25/2023. To GOV 9/3/2024.
12 VAC 35-200	**Regulations for Emergency and Respite Care Admission to State Training Centers**	To establish the conditions and procedures ↑↑ through which an individual can access emergency services and respite care in a state training center.	• **Fast Track.**	• Action initiated in July and with OAG on 7/25/2023. To GOV 9/3/2024.
12 VAC 35-225 Section 430.	***Requirements for Virginia's Early Intervention System***	*To provide the requirements for Virginia's early intervention services system designed to protect the health, safety, and welfare of children with disabilities from birth through the age of two and their families to ensure access to appropriate early intervention services. Adding professions.*	• ***Fast Track.***	➢ ***Action requested: Initiate fast track.***
12 VAC 35-225 Certain sections.	*same*	*To comply with EO1, removing noncontroversial language.*	• ***Fast Track.***	• *Draft in progress; expect in December.*
12 VAC 34-260	**Certified Recovery Residences**	To implement the changes in the Code of Virginia per SB19 (2024) mandating that any certified recovery residence report any death or serious injury that occurs in the recovery residence. Also, periodic review.	• **Fast track.**	• To OAG 7/22/2024.

STATE HUMAN RIGHTS COMMITTEE

Will Childers, Chairperson
Hardy
John Shepherd, Vice-Chairperson
Charlottesville
Betty Crance
Fincastle
Renee F. Valdez
Alexandria

Taneika Goldman
State Human Rights Director
Taneika.Goldman@dbhds.virginia.gov

Office of Human Rights
1220 Bank Street
Richmond, VA 23219

P.O. Box 1797
Richmond, VA 23218

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COMMONWEALTH of VIRGINIA

Department of Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, Virginia 23218-1797

NELSON SMITH, COMMISSIONER

August 20, 2024

Ms. Moira Mazzi, Chair
State Board of Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, Virginia 23218

Dear Ms. Mazzi:

On August 15, 2024, the State Human Rights Committee (SHRC) voted to recommend the appointment of Christopher Olivo to serve an initial term of July 1, 2024, to June 30, 2027.

Mr. Olivo holds bachelors degrees in Mathematics and Fine Arts and a master's degree in Secondary Education from the College of William and Mary. He is employed as a high school math teacher and has taught AP Statistics for over twenty years. He describes himself as a voracious consumer of data, and his ability to recognize when there exists a meaningful interpretation of a pattern and when it likely represents random variation would be a benefit to the current SHRC membership. Mr. Olivo served on the DBHDS State Board between July 2020 and June 2024 where he assembled a ready knowledge of systems issues and initiatives. As a parent of a teen-aged son with developmental disabilities and other physical health conditions, he has experience with the waiver system and understands the compulsory challenge to advocate for the right to have a meaningful lifestyle. Notably, he feels a strong commitment to ensuring the most vulnerable members of society are both valued and included. Mr. Olivo resides in Yorktown, Virginia and would serve as a family member on the SHRC.

On behalf of the State Human Rights Committee, please consider the appointment of Mr. Christopher Olivo at your September 25, 2024, Board meeting. Mr. Olivo's Application and the current SHRC roster are attached for your review. Thank you for your consideration.

Respectfully submitted,

Will Childers, Chairperson
State Human Rights Committee

c: Taneika Goldman, State Human Rights Director

COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

MEETING AGENDA

Tuesday, September 24, 2024
6:00 p.m. – 7:30 p.m.
Danville-Pittsylvania Community Services
245 Hairston St. (North Wing)
Danville, VA 24540

6:00 **Welcome and Introductions**
Moira Mazzi, Chair
State Board of Behavioral Health and Developmental Services

6:10 **DINNER**

6:25 **PRESENTATION – DANVILLE-PITTSYLVANIA COMMUNITY SERVICES**
Jim Bebeau, Executive Director

6:55 **REMARKS**
Robin Crews, Director
DBHDS Southern Virginia Mental Health Institute

7:05 **COMMENTS/DISCUSSION**

7:25 **CLOSING REMARKS**
Meghan McGuire, Deputy Commissioner, Policy and Public Affairs
Department of Behavioral Health and Developmental Services

Moira Mazzi

7:30 **ADJOURNMENT**

NO BUSINESS WILL BE CONDUCTED AT THIS MEETING.

REGULAR BOARD MEETING, 9:30 A.M., WEDNESDAY, SEPTEMBER 25, 2024 (INCLUDES A 10:45 A.M. BOARD MEMBER FACILITY TOUR)
DBHDS SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE, 382 TAYLOR DR., DANVILLE, VA. 24541

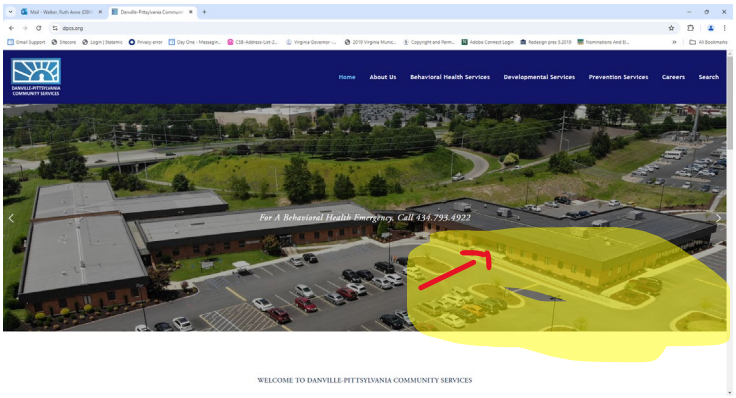
EVENT SCHEDULE

Tuesday-Wednesday, September 24-25, 2024

Tuesday, April 2nd	**COMMUNITY LOCATION TOURS AND DINNER MEETING**
5:15 – 5:55 p.m.	**BOARD MEMBER TOUR:** PARK AT CSB FOR TRANSPORT TO NEARBY CRISIS CENTER.
6:00 – 7:30 p.m.	**DINNER MEETING (SAME LOCATION)**
	ATTENDEES: STATE BOARD MEMBERS, DBHDS STAFF, DPCS STAFF, OTHER GUESTS. *NO BUSINESS WILL BE CONDUCTED.*
8:00 p.m.	**ARRIVE AT HOTEL.**
Wednesday, April 3rd	**REGULAR BOARD MEETING SCHEDULE**
	DBHDS SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
	5525 CATAWBA HOSPITAL DR, CATAWBA, VA 24070
8:30 a.m.	**Committee Meetings**
9:25 a.m.	**Regular Meeting at 9:30 a.m. (see Agenda, p.2)**
2:15 p.m.	**Adjournment**

9/24 Crisis Center location tour and dinner meeting location:

- 245 Hairston St. (North Wing), Danville, VA 24540. See photo with North Wing indicated.
- Members will be transported by van to the crisis center location down the street.



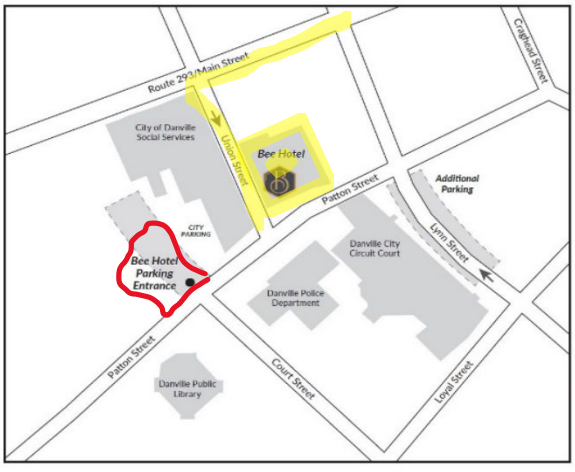
*→ For those members staying overnight, this page has **driving directions to the:***

9/24 Directions to The Bee Hotel from the CSB:

- Right onto Hairston St. Right onto Piney Forest Rd. Left onto Riverside Dr. Right onto M.L.K. Jr Mem Brg/Main St, continue to follow Main St. Left onto S Union St, hotel on the left at corner of Patton St.
- **The Bee Hotel, 420 Patton St, Danville, VA 24541.** Phone (434) 234-9440. **NOTE:** The **parking** is located on Patton Street one block up from the hotel, on the right after Social Services. Use parking places with the BEE LOGO, and check-in at the main lobby located on South Union Street

9/25 To SVMHI from The Bee Hotel:

- **Follow Patton St and S Ridge St to Main St.**
- **Turn left onto Main St.**
- **Follow directions next page.**



DIRECTIONS

Wednesday, September 25, 2024

Virginia Department of Behavioral Health and Developmental Services

DBHDS Southern Virginia Mental Health Institute, 382 Taylor Dr., Danville, VA 24541

Committees at 8:30 a.m., Regular Board Meeting at 9:30 a.m.

- **Planning and Budget Committee** will meet in the Norman Auditorium/Multipurpose Room.
- **Policy and Evaluation Committee** will meet in the BJ Conference Room.

Regular Meeting at 9:30 a.m.: Norman Auditorium/Multipurpose Room.

From Route 58:

- From Route 58 to Main Street.
- Continue to Central Blvd/S Main St.
- Turn left at the 1st cross street onto Central Blvd/S Main St.
- Continue to follow S Main St.
- Continue on College Park Dr.
- Drive to Taylor Dr.
- SVMHI, 382 Taylor Dr, Danville, VA 24541

Southern Virginia Mental Health Institute
434-799-6220

If you have any questions regarding directions to SVMHI, please call Marilyn Waller, 434-799-6220.
If you have any questions about the information in this meeting packet, contact ruthanne.walker@dbhds.virginia.gov.