THIS PACKET WAS UPDATED 12/4/2024! It includes a fifth regulatory item to amend Chapter 105 regarding MOUD, and the agenda is altered to allow board members to suspend the meeting and attend a Right Help Right Now event.

COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

DRAFT MEETING AGENDA

CONCURRENT COMMITTEE MEETINGS~~S~~

Wednesday, December 11, 2024
8:30 a.m. – 9:15 a.m.
DBHDS Central Office, Jefferson Building, 1220 Bank Street, Richmond, VA 23219
These meetings will be in person with a physical quorum present, but electronic or phone connection is available.

8:30	• **Policy and Evaluation Committee** ***Conference Room 844*** **OR* ***Teams Meeting:*** **Join the meeting** Meeting ID: 277 801 067 401 Passcode: 9XEqoS ***OR* call in (audio only)** *Phone:* +1 434-230-0065,,727106301# Phone conference ID: 727 106 301#	Madelyn Lent *Policy Manager* **Agenda p.22**
	• **Planning and Budget Committee** ***13th Floor Conference Room*** OR see main meeting info below (same login↓)	Ruth Anne Walker *Board Liaison* **Agenda p.17**
9:15	**Adjourn**	

CONTINUED -

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

REGULAR MEETING REVISED
Wednesday, December 11, 2024
9:30 a.m. – 2:00 p.m.
DBHDS Central Office, Jefferson Building, 1220 Bank Street, Richmond, VA 23219

***This meeting will be in person with a physical quorum present, but electronic or phone connection is available:**
Join the meeting now
Meeting ID: 237 701 272 734
Passcode: y7KVKC

OR Phone: (audio only)
+1 434-230-0065,,350047775#
Phone conference ID: 350 047 775#

1.	9:30	**Call to Order and Introductions** **Approval of December 11, 2024, Agenda** ➢ *Action Required* **Approval of Draft Minutes** **Nominating Committee Meeting, July 16, 2024** **Dinner Meeting, September 24, 2024** **Regular Meeting, September 25, 2024** ➢ *Action Required*	Moira Mazzi *Chair*	 **4** **4** **6**
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., December 10, 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 a.m. on December 11, 2024.		
3.	9:40	**Meeting Suspension for One Hour Event: Right Help Right Now.** ***Reconvene at 11:15***		
4.	11:15	**Commissioner's Report**	Nelson Smith *Commissioner*	
5.	12:00	**Lunch: Break and Collect Lunch**		
6.	12:10	**Semi-Annual Federal Grant Update**	Eric Billings *Grants Management Director* Ben Wakefield *Federal Grants Manager*	
7.	12:35	**Overview: Information Technology**	Russell Accashian *Chief Information Officer*	

8.	1:00	**Virginia Association of Community Services Boards**	Jennifer Faison *VACSB Executive Director*	
9.	1:30	**Committee Reports** **A. Planning and Budget** **B. Policy and Evaluation** **a. Revisions: POLICY 4010 (SYS) 83-6 Local Matching Requirements for Community Services Boards and Behavioral Health Authorities** ➢ *Action Required*	Ruth Anne Walker Madelyn Lent *Policy Manager*	**26** **27**
10.	1:50	**Overview: Clinical Quality Management**	Katherine Means *Senior Director, Clinical Quality Management*	
11.	2:10	**Regulatory Updates** ➢ *Action requested: Authorize three periodic reviews, one final exempt action, and one fast track action.* **A. Three Periodic Reviews.** **a. Public Participation Guidelines [12VAC35-12].** **b. Regulations to Govern Temporary Leave from State Facilities [12VAC35-210].** **c. Victims of Sterilization Fund Program [12 VAC35-240].** **B. Final Exempt: Ch. 105, QMHP Changes per SB403 (2024).** **C. Fast Track: Ch. 105, Amendments for Medication for Opioid Use Disorder (MOUD).** **D. Regulatory Activity Status Report**	Ruth Anne Walker *Regulatory Affairs Director* Jae Benz *Licensing Director* Susan Puglisi *Regulatory Research Specialist*	**39** **40** **83** **148**
12.	2:30	**A. Miscellaneous** **B. Review Annual Executive Summary.** **C. Board Member Spotlight:** **a. Sandy Chung** **b. Tony Vadella.** **D. Liaison Updates.** **E. Other Business.**	Moira Mazzi	
13.	3:00	**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
2025	
April 2 (Wed)	Western State Hospital **Staunton**
July 9 (Wed)	Southeastern Virginia Training Center **Chesapeake**
Late Sept/Early Oct TBA	TBA
December TBA	Central Office **Richmond**

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

NOMINATING COMMITTEE MEETING
DRAFT MINUTES
(CIRCULATED IN SEPTEMBER: SEE P. 5)

BOARD DINNER MEETING
DRAFT MINUTES

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

	Members Present: Sandy Chung; Rebecca Graser; Cindy Lamb; Sandra Price-Stroble; and Tony Vadella. **Staff Present:** Robin Crews; Madelyn Lent; Meghan McGuire; Ruth Anne Walker. **Invited Guests:** Jim Bebeau; Carol Cundiff; Sara Craddock; Amanda Oakes; Jennifer Thompson; Melanie Tosh. **CSB Member Attendees:** Sid Allgood; Maureen Belko; Gayle Breakley; Shakeva Frazier; Kaylyn McCluster; Pamela Saunders; Deborah Stowe; Kim Van Der Hyde; Adrian Watlington.
Welcome and Introductions	At 6:10 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. She noted that Moira Mazzi, Chair, was driving down that evening and would be present tomorrow.

	On behalf of the board, Ms. Price-Stroble thanked all who were present and called for introductions, beginning with have introductions, beginning with the location host, Jim Bebeau, Executive Director, Danville-Pittsylvania Community Services.
Dinner	At 6:15 p.m., Ms. Price-Stroble invited all to begin dinner.
Presentation – Colonial Behavioral Health	At 6:30 p.m., Jim Bebeau provided an overview of the services provided by Danville-Pittsylvania Community Services. He was joined in his presentation by Sara Craddock, Developmental Services Director; Amanda Oakes, Prevention Services Director; and Melanie Tosh, Behavioral Health Services Director.
Remarks	At 7:15 p.m., Robin Crews, Director of the DBHDS Southern Virginia Mental Health Institute, provided some remarks.
Comments/Discussion	At 7:20 p.m., members asked a few clarifying questions and gave comments regarding information presented.
Closing Remarks	At 7:30 p.m., Meghan McGuire, Deputy Commissioner, Policy and Public Affairs, provided closing remarks about the topics covered.
Adjournment	Ms. Price-Stroble expressed thanks to Mr. Bebeau and the staff for arranging the tour of the crisis center and for the board to use the space. She thanked Mr. Bebeau for his presentation, and Ms. Craddock, Ms. Oakes, and Ms. Tosh for participating. Ms. Price-Stroble adjourned the dinner meeting at 7:35 p.m.

REGULAR MEETING
DRAFT MINUTES
Wednesday, September 25, 2024
DBHDS Southern Virginia Mental Health Institute, 382 Taylor Dr., Danville, VA 24541
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	Sandra Price-Stroble, Vice Chair; Sandy Chung; Rebecca Graser; Cindy Lamb; Jane McDonald (virtual); and Tony Vadella.
Members Absent	R. Blake Andis; Varun Choudhary; and Moira Mazzi, Chair.
Staff Present	▪ Jae Benz, Licensing Director. (virtual) ▪ Robin Crews, Director, Southern Virginia Mental Health Institute. ▪ Lauren Cunningham, Communications Director. (virtual) ▪ Braden Curtis, Chief Deputy Commissioner. ▪ Taneika Goldman, State Human Rights Director. ▪ Colleen Grady-Koerner, Executive Budget Manager. (virtual) ▪ Ramona Howell, Budget Director. (virtual) ▪ Elizabeth Hunt, Forensic Evaluation Manager, Division of Forensic Services. (virtual) ▪ Madelyn Lent, Policy Manager. ▪ Josie Mace, Legislative Affairs Manager.(virtual) ▪ Suzanne Mayo, Assistant Commissioner, Facility Services. ▪ Meghan McGuire, Deputy Commissioner, Policy and Public Affairs. ▪ Nathan Miles, Chief Financial Officer. (virtual) ▪ Kyla Patterson, Early Intervention Program Manager. (virtual) ▪ Susan Puglisi, Regulatory Research Specialist. (virtual) ▪ Nelson Smith, Commissioner. ▪ Ruth Anne Walker, Regulatory Affairs Director and State Board Liaison.
Invited Guests:	▪ Will Childers, Chair, DBHDS State Human Rights Committee. (virtual) ▪ Jennifer Faison, Executive Director, Virginia Association of Community Services Boards. (virtual)
Other Guests:	Virtual: ▪ LeVar Bowers. ▪ Edmund Creekmore. ▪ Toni Donati. ▪ Adriana Gallego Gomez.

	▪ Virginia L. Heuple. ▪ Cara Kaufman, DARS. ▪ Bob Nickles. ▪ MiMi Sedjat. ▪ Teresa Smith, OSIG. ▪ John Welder. ▪ Carter T. Whitelow.
Call to Order and Introductions	At 9:30 a.m., Sandra Price-Stroble, Vice Chair, called the meeting to order and welcomed those present. A quorum of five members was physically present; one member participated remotely. On behalf of the State Board, Ms. Price-Stroble thanked Danville-Pittsylvania Community Services Executive Director Jim Bebeau and staff for the crisis center tour, meeting location, and presentation the day before at the dinner meeting; and Southern Virginia Mental Health Institute Director Robin Crews for her attendance the previous evening. She also thanked Ms. Crews and all the staff at SVMHI for the hospitality. Introductions were made of all board members and DBHDS staff.
Approval of Agenda	*At 9:34 a.m. the State Board voted to adopt the September 25, 2024, agenda. On a motion by Tony Vadella and a second by Cindy Lamb, the agenda was approved.*
Approval of Draft Minutes	*At 9:35 a.m., on a motion by Tony Vadella and a second by Ms. Lamb, the July 16, 2024, dinner meeting minutes and the July 17, 2024, regular meeting minutes were approved as final. It was noted that the July 16, 2024, nominating committee minutes would be approved in December as two of the three members were not present.*
Public Comment	At 9:36 a.m., Ms. Price-Stroble called for public comments. Written comments were submitted by Ed W. Creekmore, Jr. (see attachment) and he gave verbal comments. No other comments were received.
Regulatory Actions	At 9:40 a.m., Ms. Price-Stroble welcomed Jae Benz, Director, DBHDS Office of Licensing and Kyla Patterson, Early Intervention Program Manager. Ms. Walker gave a brief review of the impetus for and purpose of the actions as described in the materials sent in advance of the meeting. The State Board promulgated four fast track (noncontroversial) regulatory actions, listed under Agenda Item #3. **A. Valid Discharge Plans: Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services [12VAC35-**

105]. This action was developed in accordance with the mandated in HB434 (2024).

On a motion by Sandy Chung and a second by Ms. Lamb, the action was approved for fast track promulgation.

B. Addition to List of Practitioners in Requirements for Virginia Early Intervention System [12VAC35-225]. In response to a periodic review, this action was developed as a workforce initiative.

On a motion by Ms. Lamb and a second by Dr. Chung, the action was approved for fast track promulgation.

C. Regulatory Reduction: Children's Residential Facilities [12VAC35-46].
D. Regulatory Reduction: [12VAC35-105].

Both regulatory reduction actions were developed in compliance with the Governor's mandate in ED1.

In a motion by Jane McDonald and a second by Ms. Lamb, the regulatory reduction amendments to Chapter 46 were approved for fast track promulgation.

In a motion by Ms. Lamb and a second by Rebecca Graser, the regulatory reduction amendments to Chapter 105 were approved for fast track promulgation.

E. Regulatory Activity Status Update.
Ms. Walker directed members to the status matrix of all current actions and drafts in progress. She noted that since the packet went out to members:

- The action for Chapter 200 (and rescinding Chapter 190) regarding training centers was approved by the Governor and would be out for public comment late October through late November, with an expected effective date of December 5, 2024.
- Two sets of draft amendments were placed in a general notice for public comment and were expected to come to the State Board in December:
  - Chapter 115 to streamline and clarify the human rights regulations; and
  - Chapter 105 regarding federal requirements for opioid treatment programs.

Commissioner's Report	At 9:55 a.m., Commissioner Nelson Smith provided his report covering the planned closure of Hiram Davis Medical Center in Petersburg, VA. He updated members on steps taken to initiate the process for closure mandated by the Code of Virginia, and to ensure safe patient discharges and successful staff transitions. Information on building concerns, needs of current patients, and placement options for individuals was covered. Mr. Vadella asked how the members could help with the process. Staff indicated that, if asked, explaining to interested stakeholders that there is a code-mandated process that must be followed would be helpful. Mr. Vadella also asked whether additional Medicaid waiver slots would be needed for discharges; however, most current patients have waivers already. *Presentation available upon request.*
Facility Tours	At 10:20 a.m., Ms. Price-Stroble announced that the meeting would suspend while board members toured Southern Virginia Mental Health Institute. The meeting would resume at approximately 11:15 a.m. following the tour.
Facility Presentation: Southern Virginia Mental Health Institute	At 11:19 a.m., Ms. Crews presented an overview of the hospital built in 1977, beginning with the mission of the facility, "To provide a safe environment that promotes opportunities for people to improve their lives." Staffing challenges were being addressed through a variety of approaches. Quality initiatives have helped to ensure that SVMHI has been continuously accredited by The Joint Commission and CMS since it opened. Upcoming building renovations include window, generator, roof, and cook/chill replacements. Ms. Crews reviewed emerging issues and opportunities to address them. She highlighted the individual engagement success with the seven-day pilot program. Ms. Graser said she was intrigued about the Seven Day pilot, if individuals needing restoration can get it in seven days. Ms. Crews responded that the goal is seven days, but that has not been reached. However, time has been reduced by 20 days. This is achieved through contracting community evaluators and hiring a restoration coordinator whose sole job is this process, and to ensure there is not a lull where there is no active treatment. Mr. Vadella asked about the scenario for restoration codes, for example NGRI (not guilty by reason of insanity). Ms. Walker

	stated there would be a presentation on the basics of the competency restoration process later in the meeting. *Presentation available upon request.*
Legislative and Budget Update	At 11:40 a.m., on behalf of Nathan Miles, Chief Financial Officer, Ramona Howell, Budget Director, presented on recent budget requests submitted the previous week. Colleen Grady-Koerner, Executive Budget Manager, was also present. Information was presented on requests related to business operations, community services, youth services, and state facilities. Dr. Chung asked for clarification on a language-only request for Medicaid redesign. Mr. Vadella asked for clarification on General Fund and Nongeneral Fund categories. He also asked about the request for authority to be able to bill the CSBs at CCCA, which Ms. McDonald asked about as well. Mr. Miles explained that children at CCCA in DSS custody tend to stay longer. The goal is to move individuals to the least restrictive setting. The purpose of the language request is to encourage CSBs and DSS to communicate more about discharges, in other words that the community system partners will engage with one another to find solutions so the children can be served in the community. Ms. McGuire commented that there is a range of alternatives to placement in CCCA and this was just one of them. Dr. Chung asked if there was funding to support the infrastructure. Mr. Miles indicated that each time the General Assembly gave the department funds, permission must be granted to spend it. This would allow for the funds collected to be spent. Josie Mace, Legislative Affairs Manager, gave an update on General Assembly activity including required study workgroups, requests for legislative action, and bills already showing up on the system. Ms. McDonald asked whether the workgroup on the use of seclusion and restraint included DBHDS facilities. Madelyn Lent indicated it was both community providers and state facilities. *Presentation available upon request.*
Lunch: Break and Collect Lunch	*A brief lunch break was held from 12:10 p.m. to 12:30 p.m.*
Human Rights Annual Report	At 12:30 p.m., Taneika Goldman, State Human Rights Director, gave an update on human rights and the annual report. Her comments were prefaced by the State Human Rights

	Committee Chair, Will Childers, who stated wanted to share what a privilege it is to serve on the committee, and with Ms. Goldman. He complimented her by stating the Office of Human Rights is in extremely good hands. Mr. Childers stated that he finds the experience as an SHRC member to be very educational and very meaningful. He reported that the makeup of the SHRC is a strong committee. Ms. McDonald asked about the APS and CPS reports, in regard to 'alleged' abuses were 'valid.' She wondered if that meant the allegation was valid or, were the allegations found valid as the abuse found valid? Ms. Goldman explained that her meaning of 'valid' is the reports are valid to be reported to be reported to the Office of Human Rights in that there is a DBHDS-licensed provider and an individual receiving services from a provider. For example, complaints might be received regarding nursing home care, which is outside of the purview of the office. The data shows that there were 391 instances where a valid report was not made when it should have been made. Ms. McDonald had a follow up question asking whether the office gets the results of the APS or CPS investigation. Ms. Goldman stated the office gets all the initial reports but not all the dispositions of the investigations. Ms. Goldman has done a 'tour' to speak to all of the localities to remind them that that's important because if they identify some facts that, for example, a provider doesn't and their investigation was able to put those two together, her office is able to identify human rights violations where needed. (From Miscellaneous Item A.) Ms. Price-Stroble asked members to consider the SHRC recommendation for appointment of Christopher Olivo to the committee. *On a motion by Ms. Lamb and a second by Ms. Graser, the appointment of Mr. Olivo was approved.* *Presentation and report available upon request.*
Update: Virginia Association of Community Services Boards	At 12:53 p.m., Jennifer Faison, Executive Director, VACSB, reported on the association's activities since July. She reported the association was slowly honing down its requests to the General Assembly. 1. One of them would be the historic investment in the Priority One wait list. A handful of CSBs will get the majority of them do to population and need, and in those CSBs there is

	expected to be a significant need for additional support coordinators (case managers). Therefore, VACSB intends to have a budget request for $9-12M based on calculations for approximately six months it would take to get a support coordinator hired and ready to accept a caseload. During that period of onboarding, the support coordinators are not generating revenue to cover their salaries. This funding would allow boards to bring on the number of support coordinators needed according to how many additional slots the CSB is getting. 2. The association will also request funding for early intervention services to accommodate for the increased the 5% yearly increase in roughly in the number of kids that are served in early intervention. 3. The rate increase in the substance use disorder services as partial hospitalization and intensive outpatient never received a rate increase during the pandemic. She stated that when rate increases do not occur regularly, it is the functional equivalent of a cut. 4. Prevention services are going to be losing some significant funding from the withdrawal of federal ARPA funds and the association wants to make sure that those are replaced. Regarding two pieces of legislation that passed last year that required a workgroup, and also have a reenactment clause on them, which would disallow anyone with a developmental disability or dementia from going to a state hospital. Finally, Ms. Faison reported that the association would have a conference next week in in Roanoke.
Overview: Competency Restoration Orders	At 1:05 p.m., Elizabeth Hunt, Forensic Evaluation Manager, provided an overview of the process for competency restoration of individuals ordered by the court to receive them. Ms. Graser asked about the qualifications for the person performing a restoration to competency. Ms. Hunt responded that there is a mix of individuals providing the services; training is required following the DBHDS manual. DBHDS does offer such training. Ms. Graser commented that forensic peer recovery specialists might be very helpful with the individuals needing restoration. Ms. Hunt said she would pass on the suggestion as it seemed a great idea.

	Ms. McDonald asked about NGRI as a defense, when an individual was not competent at the time of an offense. Ms. Hunt explained that has to do whether an individual was competent at the time is one piece, and then if they are competent (restored to competency) to go to trial. Once an individual is restored to competency, then a decision is made on how to proceed based on the individual's feeling about how to plead regarding the offense (plea, trial, etc.). *Presentation available upon request.*
Committee Reports	**C. Planning and Budget** At 1:50 p.m., Ms. Walker reported that the meeting was canceled as there was not a quorum present. Ms. Walker briefly reviewed the existing chart of planned topics by board meeting date. The quarterly budget report was included in the board meeting packet. **D. Policy and Evaluation** At 1:55 p.m., Madelyn Lent, Public Policy Manager, reported out for the committee, and directed members' attention to the requests from the committee included in the meeting packet for the board's consideration. Ms. Price-Stroble asked members to vote en bloc on the amendments to the following three policies: **1007(SYS)86-2** Behavioral Health and Developmental Services for Children and Adolescents and Their Families **4023(CSB)**86-24 Housing Supports **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. *On a motion by Dr. Chung and a second by Ms. Graser, the amendments were approved en bloc.* Ms. Price-Stroble called for a motion to rescind the following 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? *On a motion by Ms. Lamb and a second by Mr. Vadella, the rescission was approved.* Ms. Lent reported that the committee received 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

	Members reviewed comments received from CSBs in the field review for Policy 4010(CSB)83-6 Local Match Requirements for Community Services Boards and voted on recommended revisions. Those changes would come to the board in December.
Miscellaneous	➢ **SHRC Appointments** At 12:50 p.m. on a motion by Ms. Lamb and second by Ms. Graser, Christopher Olivo was appointed to the SHRC. ➢ **Board Member Spotlight: Jane McDonald** Ms. McDonald shared that she is a 1988 Mary Washington University graduate. Her first job after graduating was as a mental health supervised apartment counselor with a focus on helping individuals discharged from Western State Hospital settled in housing. She gained her master's degree in rehabilitation counseling from Boston University. Ms. McDonald's experience working in services provided by community services boards is varied: in mental health residential, emergency services, in home services, quality assurance, human resources, psychosocial rehabilitation, deputy executive director, and finally as executive director from 2017-2022. She also gained inpatient experience at Snowden in Fredericksburg working in admissions and in a child and adolescent unit. At one point, Ms. McDonald worked at DBHDS Central Office in the Office of Mental Health. In total, she retired with over 30 years in the Virginia Retirement System. In her personal life, she has a 17 year old daughter who is freshman at Sewanee, University of the South. Ms. McDonald enjoys being outdoors including as a master gardener, fitness, and good food. She is active in community nonprofits and her church. ➢ **Liaison Updates: Confirmation of Assigned Areas** In the unexpected absence of the chair, the board members present confirmed by endorsement the liaison assignments as presented via a motion by Ms. Lamb and a second by Dr. Chung.
Other Business	**Next Meeting:** December 11, DBHDS Central Office, Richmond.
Adjournment	There being no other business, Ms. Price-Stroble 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	
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

Dr. Creekmore Public Comment to the September 25, 2024 DBHDS Regular Board Meeting in SVMHC

Thank you, DBHDS Board members. I am Dr. Edmund Creekmore, Licensed Clinical Psychologist. I consult regularly with medical professionals in a private community hospital setting where I serve as an independent contract forensic examiner in involuntary civil commitment court proceedings that regularly convene in that hospital location and judicial venue. I am also the National Shattering the Silence Coalition's Policy Action Co-Chair and its Virginia Policy Director and legislative advocate. The NSSC advocates for policies which affect the safety and vital interests and needs of families and adult peers in support of the seriously mentally ill.

COVID 19 was a tipping point in the US health care services industry for several years during both the pandemic crisis and post-pandemic periods. New and innovative "point of care" technologies have become industry standards in the care and provision of in-home care with chronically disabled adult patients transitioning from acute care units in the hospital. Many of these "at risk" populations

have chronic health conditions which require home-based care. These include medical conditions that often involve the care and management of complex co-morbid neuropsychiatric conditions, such as adults diagnosed with Traumatic Brain Injuries, Post-ICU Syndrome or PICS, and Schizophrenia.

For most of adults diagnosed with what have been called “serious mental illness”-- adults diagnosed with chronic “remitting” and “recurring” psychotic disorders, such as schizophrenia and bipolar disorders, including many of whom may also be “forensically involved”-- discharge is to the home with the assistance and support of their family members, to group homes, or even, when criminal charges are preferred in a “mental health emergency”, to jail. This is sometimes with the assistance of in-home services support in Virginia, such Assertive Community Treatment (ACT) teams or Forensic FACT teams, sometime not.

Discharge planning in the large majority of such cases post-acute care planning typically offers little more in the way of discharge planning than brief, often hastily developed case “boilerplate” goals and

objectives developed by case managers, instead of carefully crafted, “patient centered” discharge planning options taking place, as it should, in the home environments where so many of these individuals live, experience, and ultimately must cope with the day-to-day challenges of living with serious mental illness and disability. The lack of specificity in discharge planning goals and objective anchored in the actual experience of those with whom these patients live and are cared for presents practical “barriers” to placement in the community

Experience-Based Co-Design with its innovative model of “flipping” discharge planning from the hospital to the home is accepted and practiced as an international standard of care in use with these “at risk” populations in many English-speaking countries around the world, including in recent years the US and Canada

EBCD considered as a generic care model provides, or should provide, a “place at the table” for those adults capable of giving consent and their “carers’, almost always family members but also in many instances adult peer supporters, who should be

heard and acknowledged on a “co-equal” basis in the care, planning, and provision of health care services for their loved ones. This should include family participation and involvement upon discharge—whether this be from private community hospitals, publicly funded specialty “teaching hospitals”, or state hospitals where many of these difficult to treat patients ultimately end up and find their bed of “last resort”. It is recommended that “flipped” post-discharge planning be undertaken by Assertive Community Teams for individuals with SMIs capable of consenting to a care plan and with a civil MOT court order “over objection” for those who are not but who are nonetheless capable of abiding by such a order.

EBCD also offers an attractive public forum for policy advocacy, as well, by the families of all those and their advocates with “lived experience” who have mental health disabilities, such as the seriously mentally ill, but also those with co-morbid psychiatric disabilities, such as PICS, and those with developmental disorders, such as autism spectrum and developmental disorders.

Thank you for your time and attention.

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.14-16)
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
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.

MEMBERS PRESENT: Sandra Price-Stroble
Rebecca Graser
Cindy Lamb

STAFF PRESENT: Madelyn Lent, Policy Manager
Suzanne Mayo, Assistant Commissioner of Facilities Services
Nathan Miles, Chief Financial Officer (virtual)
Ramona Hollowell, Director, Office of Planning and Budget (virtual)
Robert Johnston, Director, Office of Environment of Care (virtual)
Josie Mace, Legislative Director (virtual)

I. Call to Order
Sandra Price-Stroble called the meeting to order at 8:38 AM.

II. Welcome and Introductions (5 min)
Board members and DBHDS staff present provided a brief introduction.

III. Adoption of Minutes, July 17, 2024
Cindy Lamb moved to adopt the minutes. Rebecca Graser seconded. The minutes were adopted unanimously.

IV. Adoption of Agenda, September 25, 2024
Cindy Lamb moved to adopt the agenda. Ms. Graser seconded. The agenda was adopted unanimously.

V. Review of Policy Review Plan for FY2025 (10 min)
Madelyn Lent presented the policy review plan to the Policy Committee.

VI. Presentation of Background Reviews (20 min)

Ramona Hollowell present background information for Policy 2010 (ADM ST BD)10-1 Review and Comment on Behavioral Health and Developmental Services Budget Priorities and Policy. DBHDS is not recommending revisions at this time.

Robert Johnston presented background information for Policy 5006(FAC)86-29 Demolition of Dilapidated Buildings on the Grounds of State Facilities. Mr. Johnston answered questions from committee members on how the policy is currently being implemented. DBHDS will present recommended revisions at the next policy committee meeting.

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, the DBHDS procedure for issuing waivers, and additional data on waivers issued by DBHDS. Rebecca Graser moved to recommend the revisions to the State Board of Behavioral Health and Developmental Services. Cindy Lamb seconded. The revisions were recommended to the state board unanimously.

VIII. Next Quarterly Meeting: December 11, 2024.

IX. Adjournment

Sandra Price-Stroble adjourned the meeting at 9:15 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

DECEMBER 11, 2024

DBHDS CENTRAL OFFICE, 13TH FLOOR
1220 BANK STREET, RICHMOND, VA 23218

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

III. Adoption of Minutes

a. April 4, 2024 (see pages 14-16)

b. July 17, 2024

IV. Adoption of Agenda, December 11, 2024

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.*

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.

VI. Other Business

A. State Board Budget Quarterly Report.	*Handout*
B. General Updates	*Meghan McGuire, Deputy Commissioner, Policy and Public Affairs*

VII. 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 April 2, 2024, Staunton.

VIII. Adjournment

Policy and Evaluation Committee
DRAFT AGENDA
DECEMBER 11, 2024
DBHDS CENTRAL OFFICE, 8TH FLOOR
1220 BANK STREET, RICHMOND, VA 23218
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, September 25, 2024

IV. Adoption of Agenda, December 11, 2024

V. Review of Policy Review Plan for FY2025 (5 min)

VI. Presentation of Draft Policy Plan for Adoption FY2025 - FY2030 (10 min)

VII. Presentation of Background Reviews (15 min)

DBHDS Staff present background information for Policy 5008 (FAC) 87-12 Accreditation/Certification and Policy 5010 (FAC) 00-1 ST BD)10-1 State Facility Uniform Clinical and Operational Policies and Procedures.

VIII. Introduce Draft Revisions (15 min)

The Committee received background information from DBHDS Staff for Policy 2010 (ADM ST BD) 10-1 Review and Comment on BHDS Budget Priorities and 5006 (FAC) 86-29 Razing of Dilapidated Buildings at the September 25 meeting. Committee members and DBHDS staff may introduce draft revisions for these policies for committee review.

IX. Next Quarterly Meeting: April 2, 2025.

X. 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 the July 17, 2024, 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.

Renewed 4/27/88
Updated 3/22/90
Revised 9/28/94
Revised 10/7/08
Updated 10/7/16
Revised ??/?/24

POLICY MANUAL

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

POLICY 4010 (SYS) 83-6 Local Matching Requirements for Community Services Boards and Behavioral Health Authorities

Authority

Board Minutes Dated: June 22, 1983
Effective Date: July 1, 1983
Approved by Board Chairman: s/Charles H. Osterhoudt

References

§ 37.2-500, § 37.2-509, § 37.2-601, and § 37.2-611 of the Code of Virginia
Current Community Services Performance Contract

Background

Sections 37.2-500 and 37.2-601 of the Code of Virginia authorize the Department to provide funds to assist cities and counties in establishing, maintaining, and promoting the development of mental health, developmental, and substance use disorder services. Sections 37.2-509 and 37.2-611 establish criteria for allocation of these funds to community services boards and behavioral health authorities, hereafter referred to as CSBs, by the Department and limit these allocations to no more than 90 percent of the total amount of state and local matching funds provided for operating expenses, including salaries and other costs, or the construction of facilities, unless a waiver is granted by the Department pursuant to policy adopted by the Board. This provision establishes the minimum local matching funds requirement reciprocally at 10 percent.

Historically, the Department has encouraged CSBs to pursue funds and revenues aggressively and to maintain the highest level of local matching funds possible so that they can provide more services to individuals with mental illnesses, substance use disorders, intellectual disability, or co-occurring disorders who need those services. Periodically, economic conditions cause some local governments to limit or reduce funds available for human services. Decreased local matching funds and additional allocations of state funds have made the maintenance of high local match levels more difficult for some CSBs.

Purpose

To promote maximum financial support for community mental health, developmental, and substance use disorder services from local governments. This policy also is intended to afford enough flexibility for CSBs and the Department to accommodate local matching funds shortfalls and still preserve current state grants and obtain additional state funds to maintain and expand services.

Policy

It is the policy of the Board that the following funds are acceptable as local match for grants of state funds:

- ~~l~~*L*ocal government appropriations;
- ~~p~~*P*hilanthropic cash contributions;
- ~~i~~*I*n-kind contributions of space, equipment, and professional services; and
- ~~i~~*I*nterest revenue in certain circumstances.

All other ~~funds or~~ revenues, including fees, federal grants, and other funds and uncompensated volunteer services, are not acceptable as local match. ~~It also is the policy of the Board that a CSB should maintain the same match ratio of all state to local matching funds that existed in the preceding fiscal year whenever possible.~~ Exhibit A in the CSB's Community Services Performance Contract displays total local matching funds and the local match percent~~. If sufficient funds are not available to continue the same ratio, then a CSB should maintain at least the total amount of local matching funds received in the preceding fiscal year.~~ Local matching funds shortages should be restored whenever possible because they:

- ~~t~~*T*hreaten the viability of existing services,
- ~~e~~*E*liminate opportunities to expand services,
- ~~l~~*L*essen chances of obtaining additional local matching funds in the future, and
- ~~j~~*J*eopardize maintenance of current state funding.

Further, it is the policy of the Board that, ~~the maximum acceptable aggregate CSB-wide ratio of all state to local matching funds is 90 percent to 10 percent of the total amount of those funds.~~ *in accordance with § 37.2-509 of the of the Code of Virginia allocations to any community services board for operating expenses, including salaries and other costs, or the construction of facilities shall not exceed 90 percent of the total amount of state and local matching funds provided for these expenses or such construction.* If ~~sufficient local funds are not available to sustain at least that ratio, that is~~ local matching funds fall below 10 percent, the CSB can request a waiver of this policy requirement in accordance with procedures established by the Department pursuant to § 37.2- 509 of the of the Code of Virginia and distributed with the current Performance Contract. Waivers ~~are~~ *shall be* given annually on a renewable basis if the CSB provides adequate justification based on local

economic factors so that service reductions and their consequent adverse effects on individuals receiving services can be avoided.

~~Sections 37.2- 509 and 37.2- 611 of the Code of Virginia limit state participation to 90 percent of the total amount of state and local matching funds provided to a CSB for operating expenses, including salaries and other costs, or the construction of facilities.~~ If that state participation percentage *established by § 37.2-509* would be exceeded because of insufficient local matching funds~~, it also is the policy of the Board that~~ state funds shall be reduced by the amount necessary to comply with that limit, unless the Department has granted a waiver of the matching funds requirement pursuant to § 37.2-509 of the of the Code of Virginia, this policy, and procedures established by the Department. *The Department shall notify the governing body of each city or county that established the community services board before implementing any reduction of state-controlled funds as required by § 37.2-509.*

Finally, it is the policy of the Board that the Department shall implement this policy and monitor and evaluate its effectiveness.

State Board of Behavioral Health and Developmental Services
Policy Development and Evaluation Committee

Date: 07/17/2024
COMMENTS ON POLICY 4010 (CSB) 83-6 LOCAL MATCHING REQUIREMENTS:
WINDOW (JUNE 20 – JULY 15, 2024)

CSB Contact	Comment
Southside Behavioral Health	The policy puts the CSB in the seat of requesting funds that the Code of VA requires of the local governments. However there is no recourse available to the CSB for local governments who consistently do not provide their local match year after year. It is reasonable to understand shortfalls in local entities that occur when there are unexpected expenses, but those localities that fail to provide the 10% match in an ongoing manner have no pressure put on them by anyone outside of the CSB to follow the Code of VA. It would be nice to have some means to address this issue in the Code of VA and in the policy.
Highlands	With significant challenges in many jurisdictions getting the necessary amount of locality funding to accomplish the 10% minimum local match, perhaps consideration should be given to the local match waiver being the responsibility of/requested by/granted to the locality rather than the CSB. if a locality cannot or chooses not to provide funding to reach the 10% local match, they should have some accountability and responsibility rather than just the CSB. This is how it works on the public school system funding split. Based on an established configuration and formula, there is a set percentage that is the non-negotiable local funding requirement for public schools and the balance defaults to state funding. If local funding falls short, it is not the school system's responsibility to request a waiver for the locality. The locality is obligated to provide their identified percentage (which can change every two years with a new local formula review).
Western Tidewater	WTCSB has been submitting a request to waive the Minimum Local Matching Funds requirement as it is calculated in the CARS report due to the increasing funding that is Regional. The most recent submission was 4.8% before and 10.55% after applying prorated amounts. DBHDS has been helpful in working through the adjustments with WTCSB. Consideration of any Regional Funding at the CSB needs to continue. Additionally, the timing of Local requests for funding and DBHDS / GA approval of funding has not been in sync in my opinion. Local Government requests are due before calendar end and DBHDS/GA award notifications don't occur until spring/summer. This makes it difficult to request accurate amounts from localities to meet the expected match
Mt. Rogers	We, as a CSB, have no authority to require or enforce matching funds with our 6 localities. Only 1 of 6 localities fund at 10%

	match. We are very successful in obtaining matching funds through local foundations, grants & donations.

Date: 09/25/2024

COMMENTS ON DRAFT REVISIONS REVIEWED BY COMMITTEE ON JULY 17, 2024, TO POLICY 4010 (CSB) 83-6 LOCAL MATCHING REQUIREMENTS:

WINDOW (AUGUST 6 – SEPTEMBER 13, 2024)

CSB Contact	Comment
Dr. Kimberly McClanahan, Valley CSB, Executive Director	I appreciate the opportunity to comment on the proposed changes to Policy 4010 (SYS) 83-6 Local Matching Requirements for CSBs and BHAs. My comments will be a brief restatement of the comments I made earlier. I do not understand the reasoning behind asking CSBs to explain the economic status of the localities the CSB serves. Why is it not the localities responsibility to explain "why" they cannot match the 10% ask? I continue to believe that, at least with regard to the localities Valley Community Service Board (VCSB) serves, VCSB will not receive the 10% match from all four localities until such time as the locality takes responsibility for its explanation of the reasons it cannot meet its obligation.

LOCAL MATCH SUMMARY STATISTICS

		2024	2023	2022
Region 1	CSBs in Compliance	6 / 9	5 / 9	5 / 9
	CSBs issued Waiver	3	4	4
	Min / Max	5.61 / 23.03	6.86 / 24.89	7.93 / 21.95
	Median	10.14	12.18	10.73
	Average	11.15	12.34	12.07
Region 2	CSBs in Compliance	5/5	5/5	5/5
	CSBs issued Waiver	0	0	0
	Min / Max	65.63 / 86.39	71.15 / 89.61	68.77 / 88.79
	Median	74.52	76.49	75.25
	Average	75.89	78.46	77.23
Region 3	CSBs in Compliance	4 / 10	5 / 10	6 / 10
	CSBs issued Waiver	6	4	4
	Min / Max	3.58 / 16.51	4.37 / 18.05	3.11 / 15.21
	Median	8.35	9.99	10.01
	Average	8.92	10.24	9.26
Region 4	CSBs in Compliance	5/7	5/7	6/7
	CSBs issued Waiver	2	1	1
	Min / Max	6.91 / 69.57	9.64 / 73.15	9.71 / 70.58
	Median	14	14.81	10.8
	Average	33.47	35.60	34.6
Region 5	CSBs in Compliance	6 / 9	7 / 9	8/9
	CSBs issued Waiver	3	1	1
	Min / Max	4.8 / 60.81	5.38 / 58	4.84 / 59.66
	Median	10.67	12.91	14.28
	Average	22.77	24.12	24.08
Statewide	**CSBs in Compliance**	**26 / 40**	**27 / 40**	**30 / 40**
	CSBs issued Waiver	**14/40**	**10/40**	**10/40**
	Min / Max	**3.58 / 86.39**	**4.37 / 89.61**	**3.11 / 88.79**

	Median	**10.36**	**12.55**	**10.89**
	Average	**25.21**	**26.80**	**26.16**

MINIMUM TEN PERCENT LOCAL MATCHING FUNDS WAIVER REQUEST PROCESS

A CSB should maintain its local matching funds at least at the same level as that shown in its FY 2023 performance contract. Item 322 A. of the 2021 Appropriation Act prohibits using state funds to supplant local governmental funding for existing services. If a CSB is not able to include at least the minimum 10 percent local matching funds required by § 37.2-509 of the Code of Virginia and State Board Policy 4010 in its performance contract or its end of the fiscal year performance contract report, it must submit a written request for a waiver of that requirement, pursuant to that Code section and policy, to the Office of Management Services (OMS).

The local match waiver request must be submitted to the OMS performanceonctractsupport@dbhds.virginia.gov mailbox for review. Once reviewed and meet the waiver criteria, the OMS will provide a signed waiver letter from the commissioner for your records.

Automatic Waiver Request Procedures

If only a CSB's receipt of state funds as the fiscal agent for a regional program, including regional DAP, regional REACH, acute inpatient (LIPOS), or state facility reinvestment project funds, causes it to be out of compliance with the 10 percent local matching funds requirement in § 37.2-509, the Department may grant an automatic waiver of that requirement related to the funds for a regional program allocated to the other participating CSBs.

The request for an automatic waiver must include a complete explanation of the funds allocated to other CSBs and a recalculation of the local match percentage resulting from allocation out of those state funds. The amount of state funds the CSB uses for its own participation in the regional program is not eligible for this automatic waiver. The CSB must submit a written request for the automatic waiver, identifying the specific amounts and types of those funds that cause it to be out of compliance with the local matching funds requirement to include items 1 and 2 listed below.

Justified Waiver Request Procedures

All other waiver requests must be justified and meet the requirements in items 1 through 5.

Waiver Requirements

1. State Board Policy 4010 defines acceptable local matching funds as local government appropriations, philanthropic cash contributions from organizations and people, in-kind contributions of space, equipment, or professional services for which the CSB would otherwise have to pay, and, in certain circumstances, interest revenue. All other funds, including fees, federal grants, other funds, and uncompensated volunteer services, are not acceptable.
2. Section 37.2-509 of the Code of Virginia states that allocations of state funds to any CSB for operating expenses, including salaries and other costs, shall not exceed 90 percent of the total amount of state and local matching funds provided for these expenses. This section effectively defines the 10 percent minimum amount of local matching funds as 10 percent of the total amount of state and local matching funds.
3. The written waiver request must include an explanation of each local government's inability to provide sufficient local matching funds at this time. This written explanation could include, among other circumstances, the following factors:
   a. an unusually high unemployment rate compared with the statewide or regional average unemployment rate,
   b. a decreasing tax base or declining tax revenues,
   c. the existence of local government budget deficits, or
   d. major unanticipated local government capital or operating expenditures (e.g., for flood damage).

4. Additionally, the waiver request must include information and documentation about the CSB's efforts to obtain sufficient local matching funds. Examples of such efforts could include newspaper articles, letters from CSB members to local governing bodies outlining statutory matching funds requirements, and CSB resolutions.
5. Finally, the waiver request must include a copy of the CSB's budget request that was submitted to each local government and a copy or description of the local government's response to it.

Agenda Item 5

MEMORANDUM

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

Fr: Ruth Anne Walker, Director of Regulatory Affairs

Date: November 27, 2024

Re: Five Regulatory Action Items

A. Action Item. Initiation of Three Periodic Reviews.

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

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

1. **Periodic Review Initiation Request: Public Participation Guidelines [12 VAC 35-12]**

   Purpose: This regulation provides the guidelines for involvement of the public in the development and promulgation of regulations of the State Board of Behavioral Health and Developmental Services. This chapter does not apply to regulations, guidelines, or other documents exempted or excluded from the provisions of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia). The last periodic review was conducted in August 2021. Following that review, the regulation was retained without amendment.

2. **Periodic Review Initiation Request: Regulations to Govern Temporary Leave from State Facilities[12VAC35-210]**

   Purpose: This regulation establishes the general process and requirements related to temporary leave from state facilities, including the conditions for granting leave and provisions to ensure accountability and appropriate care for persons who are on leave status. The last periodic review was conducted in August 2021. Following that review, the regulation was retained without amendment.

3. **Periodic Review Initiation Request: Victims of Sterilization Fund Program [12 VAC35-240]**

   Purpose: In accordance with Chapter 665 of the 2015 Acts of Assembly, this regulation provides administrative guidelines for appropriate documentation to verify the claim of individuals who were victims of forced sterilization to be compensated pursuant to the Virginia Eugenical Sterilization Act and who were living as of February 1, 2015 (up to $25,000 per individual). It also provides an administrative process for handling all claims. The last periodic review was conducted in April 2021. Following that review, the regulation was retained without amendment.

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

VAC Citation	Title	Last Review
12 VAC 35-12	Public Participation Guidelines	8/4/2021
12 VAC 35-210	Regulations to Govern Temporary Leave from State Facilities	8/4/2021
12 VAC 35-240	Victims of Sterilization Fund Program	4/23/2021

Next Steps:
If approved, staff initiates the periodic reviews. At the conclusion of the 21-day (minimum) comment period for each regulation, staff develops recommended Board action on the regulations. The choices for action following periodic review are:

A. Propose to retain the regulation in its current form.
B. Propose to abolish (rescind) the regulation.
C. Propose to amend the regulation.

B. Action Item. Initiation of Final Exempt: Amendments for Qualified Mental Health Professional (QMHP) and QMHP-Trainee (QMHP-T) pursuant to Chapter 595 (SB 403) of the 2024 Acts of Assembly [12VAC35-105].

Background: DBHDS is responsible for regulating providers by establishing and enforcing minimum health, safety, and welfare requirements to protect individuals receiving services; however, regulatory boards at the Department of Health Professions (DHP) set the qualifications and scope of practice for health care practitioners. Under the current Licensing Regulations, any qualified mental health professional (QMHP) is allowed to supervise supportive or maintenance mental health services, without additional training or experience prerequisites.

Prior to enactment of Chapter 595 of the 2024 Acts of Assembly (SB403), the following subsets of QMHPs were used: “QMHP-A” meant a qualified mental health professional who provides services to adults; and “QMHP-C” meant a qualified mental health professional who provides services to children. Chapter 418 of the 2017 Acts of Assembly required QMHP-As and QMHP-Cs to register with the Department of Health Professions if they have the education and experience to be deemed professionally qualified by the Board of Counseling in accordance with 18VAC115-80. This registration of QMHPs provided a structure for more professional accountability of education, experience, and scope of practice for those professionals.

QMHPs and QMHP-Trainees (QMHP-Ts, previously -Eligibles) provide “collaborative behavioral health services” as employees or independent contractors of DBHDS, or providers licensed by the department. Also, there are no longer subsets for adult and children’s services.

Purpose: This exempt, nondiscretionary action mandated by the 2024 Session of the General Assembly would amend the DBHDS Licensing Regulations regarding QMHPs

and QMHP-Ts to align staffing and supervision requirements with competency and qualification standards established by the Board of Counseling. Specifically, it will require licensed providers that employ or contract with QMHPs to impose more stringent supervision standards. Only QMHPs with at least three years of experience and completion of DHP's supervisor training will qualify to supervise non-acute, non-clinical collaborative behavioral health services.

Action Requested: Initiate the final exempt process as these amendments are expected to be noncontroversial because they are mandated by state law.

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 ("Licensing Regulations")	Final Exempt	7/17/2024

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

NOTE: A second mandate from the same legislation requires the department amend regulations regarding the newly created behavioral health technicians (BHTs) and behavioral health technician assistants (BHT-As). This will occur in 2025 after DMAS consultants conclude a study related to those new professional categories.

Final Exempt: Amendments for Qualified Mental Health Professional (QMHP) and QMHP-Trainee (QMHP-T) pursuant to Chapter 595 (SB 403) of the 2024 Acts of Assembly.

12VAC35-105-20. Definitions.

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

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

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

2. Assault or battery;

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

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

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

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

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

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

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

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

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

"ASAM" means the American Society of Addiction Medicine.

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

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

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

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

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

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

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

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

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

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

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

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

"Behavior intervention" means those principles and methods employed by a provider to help an individual receiving services to achieve a positive outcome and to address challenging behavior in a constructive and safe manner. Behavior intervention principles and methods shall

be employed in accordance with the individualized services plan and written policies and procedures governing service expectations, treatment goals, safety, and security.

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

1. Improved behavioral functioning and effectiveness;

2. Alleviation of symptoms of psychopathology; or

3. Reduction of challenging behaviors.

"Board" or "state board" means, as defined by § 37.2-100 of the Code of Virginia, the State Board of Behavioral Health and Developmental Services. The board has statutory responsibility for adopting regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the commissioner or the department.

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

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

"Case management service" or "support coordination service" means services that can include assistance to individuals and their family members in accessing needed services that

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

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

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

"Clinically managed low-intensity residential care" or "Level of care 3.1" means providing an ongoing therapeutic environment for individuals requiring some structured support in which treatment is directed toward applying recovery skills; preventing relapse; improving emotional functioning; promoting personal responsibility; reintegrating the individual into work, education, and family environments; and strengthening and developing adaptive skills that may not have been achieved or have been diminished during the individual's active addiction. A clinically

managed low-intensity residential care program also provides treatment for individuals suffering from chronic, long-term alcoholism or drug addiction and affords an extended period of time to establish sound recovery and a solid support system.

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

"Collaborative behavioral health services" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

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

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

center, community-based service. The goal of community-based crisis stabilization services is to stabilize the individual within the community and support the individual or the individual's support system (i) as part of an initial mobile crisis response; (ii) during the period between an initial mobile crisis response and entry into an established follow-up service at the appropriate level of care; (iii) as a transitional step-down from a higher level of care if the next level of care service is identified but not immediately available for access; or (iv) as a diversion to a higher level of care.

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

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

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

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

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

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

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

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

"Crisis education and prevention plan" or "CEPP" means a department-approved, individualized, client-specific document that provides a concise, clear, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist an individual who may be experiencing a behavioral loss of control. The goal of the CEPP is to identify problems that have

arisen in the past or are emergent in order to map out strategies that offer tools for the natural support system to assist the individual in addressing and de-escalating problems in a healthy way and provide teaching skills that the individual can apply independently.

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

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

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

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

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

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

"Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or a combination of mental and physical impairments other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence

of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to nine years of age, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual without services and supports has a high probability of meeting those criteria later in life.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Inpatient psychiatric service" means intensive 24-hour medical, nursing, and treatment services provided to individuals with mental illness or substance abuse (substance use

disorders) in a hospital as defined in § 32.1-123 of the Code of Virginia or in a special unit of a hospital.

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

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

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

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

"Intermediate care facility/individuals with intellectual disability" or "ICF/IID" means a facility or distinct part of a facility certified by the Virginia Department of Health as meeting the federal certification regulations for an intermediate care facility for individuals with intellectual disability

and persons with related conditions and that addresses the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, providing active treatment as defined in 42 CFR 435.1010 and 42 CFR 483.440.

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

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

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

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

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

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

"Medically managed intensive inpatient service" or "Level of care 4.0" means an organized service delivered in an inpatient setting, including an acute care general hospital, psychiatric unit in a general hospital, or a freestanding psychiatric hospital. This service is appropriate for

individuals whose acute biomedical and emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care. Services at this level of care are managed by a physician who is responsible for diagnosis, treatment, and treatment plan decisions in collaboration with the individual.

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

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

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

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

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

to provide treatment of substance use disorders. Medication assisted treatment includes medications for opioid use disorder as well as medications for treatment of alcohol use disorder.

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

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

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

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

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

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

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

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

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

"Mental illness" means, as defined by § 37.2-100 of the Code of Virginia, a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior,

capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others.

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

"Mobile crisis response" means a type of community-based crisis stabilization service that is available 24 hours per day, seven days per week, 365 days per year to provide rapid response, assessment, and early intervention to individuals experiencing a behavioral health crisis. Services are deployed in real time to the location of the individual experiencing a behavioral health crisis. The purpose of this service is to (i) de-escalate the behavioral health crisis and prevent harm to the individual or others; (ii) assist in the prevention of the individual's acute exacerbation of symptoms; (iii) develop an immediate plan to maintain safety; and (iv) coordinate care and linking to appropriate treatment services to meet the needs of the individual.

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

"Neglect" means, as defined by § 37.2-100 of the Code of Virginia, the failure by a person or a program or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse.

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

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

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

"Provider" means, as defined by § 37.2-403 of the Code of Virginia, any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders) or (ii) residential services for individuals with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601, and 54.1-3701 of the Code of Virginia.

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

structure and environment. Psychosocial rehabilitation includes skills training, peer support, vocational rehabilitation, and community resource development oriented toward empowerment, recovery, and competency.

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

"Qualified mental health professional" or "QMHP" means ~~a person who by education and experience is professionally qualified and registered by the Board of Counseling in accordance with 18VAC115-80 to provide collaborative mental health services for adults or children~~ the same as the term is defined in § 54.1-3500 of the Code of Virginia. ~~A QMHP does not engage in independent or autonomous practice. A QMHP provides services as an employee or independent contractor of the department or a provider licensed by the department.~~

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

~~"Qualified mental health professional-child" or "QMHP-C" means a person who by education and experience is professionally qualified and registered with the Board of Counseling in~~

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

"Qualified mental health professional-trainee" or "QMHP-T" means ~~a person receiving supervised training in order to qualify as a QMHP in accordance with 18VAC115-80 and who is registered with the Board of Counseling~~ the same as the term is defined in § 54.1-3500 of the Code of Virginia.

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

"Quality improvement plan" means a detailed work plan developed by a provider that defines steps the provider will take to review the quality of services it provides and to manage initiatives to improve quality. A quality improvement plan consists of systematic and continuous actions

that lead to measurable improvement in the services, supports, and health status of the individuals receiving services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Restraints for protective purposes" means using a mechanical device to compensate for a physical or cognitive deficit when the individual does not have the option to remove the device. The device may limit an individual's movement, for example, bed rails or a gerichair, and

prevent possible harm to the individual or it may create a passive barrier, such as a helmet to protect the individual.

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

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

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

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

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

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

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

"Level II serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider that results in a significant harm or threat to the health and safety of an individual that does not meet the definition of a Level III serious incident. "Level II serious incident" includes a significant harm or threat to the health or safety of others caused by an individual. Level II serious incidents include:

1. A serious injury;

2. An individual who is or was missing;

3. An emergency room visit;

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

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

6. Ingestion of any hazardous material; or

7. A diagnosis of:

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

b. A bowel obstruction; or

c. Aspiration pneumonia.

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

1. Any death of an individual;

2. A sexual assault of an individual; or

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

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

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

"Shall" means an obligation to act is imposed.

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

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

"Skills training" means systematic skill building through curriculum-based psychoeducational and cognitive-behavioral interventions. These interventions break down complex objectives for

role performance into simpler components, including basic cognitive skills such as attention, to facilitate learning and competency.

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

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

"Substance abuse (substance use disorders)" means, as defined by § 37.2-100 of the Code of Virginia, the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

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

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

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

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

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

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

and care, but whose illness has progressed so as to require consistent near-daily treatment intervention.

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

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

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

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

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

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

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

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

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

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

12VAC35-105-590. 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. 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. The provider shall develop a written transition staffing plan for new services, added locations, and changes in capacity.

C. The provider shall meet the following staffing requirements related to supervision.

1. The provider shall describe how employees, volunteers, contractors, and student interns will be supervised in the staffing plan and how that supervision will be documented.

2. Supervision of employees, volunteers, 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 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~~ collaborative behavioral 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 (i) a ~~QMHP-A,~~ registered QMHP who has practiced for three years and completed the supervisor training required by the Department of Health Professions; (ii) a licensed mental health professional who has completed the supervisor training required by the Department of Health Professions ~~,~~; or (iii) a ~~mental health professional~~ person under supervision who is license-eligible ~~and~~, registered with ~~a board of~~ the Board of Counseling, Board of Psychology, or Board of Social Work, and has completed the supervisor training required by the Department of Health Professions. ~~An individual who is a QMHP-T may not provide this type of supervision.~~ A registered QMHP who meets these requirements may supervise activities within his scope. This supervision must occur under the broader required direction of, and in collaboration with, the LMHP or licensed eligible mental health professional.

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. 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. 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. 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.

12VAC35-105-1370. Treatment team and staffing plan.

A. ACT services are delivered by interdisciplinary teams.

1. ACT teams shall have sufficient staffing composition to meet the varying needs of individuals served by the team as required by this section. Each ACT team shall meet the following minimum position and staffing requirements:

a. Team leader. There shall be one full-time LMHP with three years of work experience in the provision of mental health services to adults with serious mental illness; a resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; a supervisee, in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; or one full-time registered ~~QMHP-A~~ QMHP with at least three years of experience in the provision of ~~mental~~ collaborative behavioral health services to adults with serious mental illness who was employed by the provider as a team leader prior to July 1, 2020. The team leader shall oversee all aspects of team operations and shall provide direct services to individuals in the community.

b. Nurses. ACT nurses shall be full-time employees or contractors with the following minimum qualifications: a registered nurse shall have one year of experience in the provision of mental health services to adults with serious mental illness, or a licensed

practical nurse shall have three years of experience in the provision of mental health services to adults with serious mental illness.

(1) Small ACT teams shall have at least one full-time nurse, who shall be either an RN or an LPN;

(2) Medium ACT teams shall have at least one full-time RN and at least one additional full-time nurse who shall be an LPN or RN; and

(3) Large ACT teams shall have at least one full-time RN and at least two additional full-time nurses who shall be LPNs or RNs.

c. Vocational specialist. There shall be one or more full-time vocational specialist, who shall be a registered QMHP with demonstrated expertise in vocational services through experience or education.

d. Co-occurring disorder specialist. There shall be one or more full-time co-occurring disorder specialists, who shall be a LMHP; a resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; a supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10; registered QMHP; or certified substance abuse specialist (CSAC) with training or experience working with adults with co-occurring serious mental illness and substance use disorder.

e. ACT peer specialists. There shall be one full-time equivalent peer recovery specialists who is or has been a recipient of mental health services for severe and

persistent mental illness. The peer specialist shall be certified as a peer recovery specialist in accordance with 12VAC35-250, or shall become certified in the first year of employment. The peer specialist shall be a fully integrated team member who provides peer support directly to individuals and provides leadership to other team members in understanding and supporting each individual's recovery goals.

f. Program assistant. There shall be one full-time or two part-time program assistants with skills and abilities in medical records management shall operate and coordinate the management information system, maintain accounts and budget records for individual and program expenditures, and perform administrative support activities.

g. Psychiatric care provider. There shall be one physician who is board certified in psychiatry or who is board eligible in psychiatry and is licensed to practice medicine in Virginia or a psychiatric nurse practitioner practicing within the scope of practice as defined in 18VAC90-30-120. An equivalent ratio of 16 hours of psychiatric time per 50 individuals served must be maintained. The psychiatric care provider shall be a fully integrated team member who attends team meetings and actively participates in developing and implementing each individual ISP.

h. Generalist clinical staff. There shall be additional clinical staff with the knowledge, skill, and ability required, based on the population and age of individuals being served, to carry out rehabilitation and support functions, at least 50% of whom shall be LMHPs, ~~QMHP-As~~ QMHPs, QMHP-Ts, or QPPMHs.

(1) Small ACT teams shall have at least one generalist clinical staff;

(2) Medium ACT teams shall have at least two generalist clinical staff; and

(3) Large ACT teams shall have at least three generalist clinical staff.

2. Staff-to-individual ratios for ACT Teams:

a. Small ACT teams shall maintain a caseload of no more than 50 individuals and shall maintain at least one staff member per eight individuals, in addition to a psychiatric care provider and a program assistant.

b. Medium ACT teams shall maintain a caseload of no more than 74 individuals and shall maintain at least one staff member per nine individuals, in addition to a psychiatric care provider and a program assistant.

c. Large ACT teams shall maintain a caseload of no more than 120 individuals and shall maintain at least one staff member per nine individuals, in addition to a psychiatric care provider and a program assistant.

B. ACT teams shall be available to individuals 24 hours per day and shall operate a minimum of 12 hours each weekday and eight hours each weekend day and each holiday.

C. The ACT team shall make crisis services directly available 24 hours a day but may arrange coverage through another crisis services provider if the team coordinates with the crisis services provider daily.

D. The ACT team shall operate an after-hours on-call system and shall be available to individuals by telephone and in person when needed as determined by the team.

E. ACT teams in development may submit a transition plan to the department for approval that will allow for "start-up" when newly forming teams are not in full compliance with the ACT model relative to staffing patterns and individuals receiving services capacity. Approved transition plans shall be limited to a six-month period.

12VAC35-105-1840. Staffing.

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

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

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

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

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

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

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

2. All staff are required to utilize a working global positioning system (GPS) enabled smart phone or GPS-enabled tablet;

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

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

(1) One licensed staff member; or

(2) One certified pre-screener.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Action Item. Initiation of Fast Track: Amendments for Amendments for Medication for Opioid Use Disorder (MOUD) [12VAC35-105].

Background: Part 8 of Title 42 of the Code of Federal Regulations (CFR) includes the regulations that guide opioid treatment programs (OTPs), which initially took effect in 2001. The U.S. Department of Health and Human Services (HHS), through the Substance Abuse and Mental Health Services Administration (SAMHSA), revised these regulations and released the final rule in February 2024. The amendments updated the regulations with the intent to increase access to lifesaving, evidence-based medications for opioid use disorder (MOUD) and to advance treatment retention through the promotion of person-centered and compassionate interventions. The revised federal rules went into effect on April 2, 2024.

Purpose: This fast track action amends the Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (12VAC35-105) (the "Licensing Regulations") to align with those federal changes where appropriate. Additionally, federal regulations grant flexibility to states in certain areas. In response to Virginia's opioid crisis, this action utilized this latitude to incorporate three regulatory amendments recommended by the DBHDS clinical team that are slightly more stringent than required by the federal rule.

Action Requested: Initiate the fast track process as these amendments are expected to be noncontroversial because they are mandated by federal law.

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 ("Licensing Regulations")	Final Exempt	7/17/2024

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

townhall.virginia.gov

Fast-Track Regulation
Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services (DBHDS)
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC35-105
VAC Chapter title(s)	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services
Action title	Amendments for Medication for Opioid Use Disorder (MOUD)
Date this document prepared	December 4, 2024

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code.*

Brief Summary

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

Part 8 of Title 42 of the Code of Federal Regulations (CFR) includes the regulations that guide opioid treatment programs (OTPs), which initially took effect in 2001. The U.S. Department of Health and Human Services (HHS), through the Substance Abuse and Mental Health Services Administration (SAMHSA), revised these regulations and released the final rule in February 2024. The amendments updated the regulations with the intent to increase access to lifesaving, evidence-based medications for opioid use disorder (MOUD) and to advance treatment retention through the promotion of person-centered and compassionate interventions. The revised federal rules went into effect on April 2, 2024.

This action amends the Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (12VAC35-105) (the "Licensing Regulations") to align with those federal changes where appropriate. Additionally, federal regulations grant flexibility to states in certain areas. In response to Virginia's opioid crisis, this action utilized this latitude to incorporate three regulatory amendments recommended by the DBHDS clinical team that are slightly more stringent than required by the federal rule.

Acronyms and Definitions

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

Commissioner – Commissioner of the DBHDS
CSB – Community services board
DBHDS or Department – Department of Behavioral Health and Developmental Services
HHS – U.S. Department of Health and Human Services
Licensing Regulations – Rules and Regulations for Licensing Providers by the DBHDS (12VAC35-105)
MOUD – Medication for opioid use disorder
OTP – Opioid treatment program
SAMHSA – US Substance Abuse and Mental Health Services Administration
State Board – State Board of Behavioral Health and Developmental Services

Statement of Final Agency Action

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

At its meeting on December 11, 2024, the State Board of Behavioral Health and Developmental Services approved this fast-track action to amend the Licensing Regulations (12VAC35-105) to align with federal updates.

Mandate and Impetus

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

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

This action amends the Licensing Regulations (12VAC35-105) to incorporate federal changes that became effective on April 2, 2024, regarding OTPs. HHS, through SAMHSA, revised regulations with the intent to increase access to lifesaving, evidence-based MOUD and to advance treatment retention through the promotion of person-centered and compassionate interventions.

The federal regulations grant flexibility to states in certain areas. In response to Virginia's opioid crisis, this action utilized this latitude to incorporate three regulatory changes recommended by the DBHDS clinical team that are slightly more stringent than required by the federal rule.

Because this state-level action is incorporating federal regulations, it is expected to be noncontroversial. Moreover, in an effort to ensure these additional restrictions would be appropriate for the fast-track process, DBHDS published the regulatory action's draft language as a general notice on Virginia's Regulatory Town Hall from September 24 through October 24, 2024, to receive public comment.

Legal Basis

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

Section 37.2-203 of the Code of Virginia authorizes the State Board to adopt regulations that may be necessary to carry out the provisions of Title 37.2 and other laws of the Commonwealth administered by the commissioner and DBHDS.

Purpose

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

1. This action is following a mandate by the federal government to incorporate federal regulatory changes. In response to Virginia's opioid crisis, this action increases flexibilities related to take-home medication, initial evaluations and telehealth for counseling while remaining slightly more stringent than the federal schedule and allowances.
2. These amendments are essential to the health, safety, and welfare of citizens because they will increase access to lifesaving, evidence-based MOUD and advance treatment retention through the promotion of person-centered and compassionate interventions. These elements were identified as being essential to promoting effective treatment in OTPs and reflect an OTP accreditation and treatment environment that has evolved over the past 20 years.
3. The federal final rule changes promote practitioner autonomy, remove stigmatizing or outdated language, support a patient-centered approach, and reduce barriers to receiving care. The changes also permanently codify COVID-19 flexibilities related to take-home medication and telehealth for counseling. SAMSHA found that increased flexibilities related to take-home medication during the pandemic improved outcomes without increasing rates of diversion, and that reducing barriers telehealth expanded access to care which increased engagement in treatment.

Substance

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

Provision	What Changed?	Why Has This Changed?
Terminology	The amendments replace outdated terms such as "medication assisted opioid treatment" and "detoxification" and adds new definitions such as "medication for opioid use disorder" and "withdrawal management."	Aligns with current evidence-based practices and terminology to promote individual-centered treatment activities.

Provision	What Changed?	Why Has This Changed?
Admissions	The amendments eliminate the one-year opioid addiction history requirement; promotes priority treatment for pregnant individuals; and removes the requirement for two documented instances of unsuccessful treatment for people under age 18. The amendments also allow screening examinations to be performed by practitioners external to the OTP under certain conditions.	Removes unnecessary barriers to medication access by focusing on individual needs. Adds protections for vulnerable groups.
Treatment Standards	The amendments incorporate harm reduction principles into treatment.	Recognizes the need to meet individuals where they are with their opioid and other substance use disorders, and helps individuals make positive change, reducing harm in the process.
Take-Home Doses	The amendments update criteria for consideration of take-home doses of methadone and allow individuals to receive a single take-home dose from the first week of treatment, with additional flexibilities with continued treatment under certain conditions. Safeguards like diversion control procedures remain. The take-home schedule proposed is slightly stricter than the federal standard, as recommended by the DBHDS clinical team.	Makes permanent the COVID-19 flexibilities which demonstrated that wider access to methadone improves outcomes, without increasing rates of diversion, when paired with individualized, clinical judgment, safeguards, and education.
Telehealth	The amendments allow screening of individuals for admission via audio-only or audio-visual telehealth technology if certain requirements are met. The amendments also allow counseling to occur via telehealth.	Telehealth is an evidence-based practice that has been shown to be safe and effective. Its use expands access to care and promotes activities known to support recovery such as employment.
Drug screens	The amendments reduce the number of required drug screens a year. The amendments also change the frequency of drug screens when an individual's drug screen indicates continued illicit drug use from weekly to a frequency that is in accordance with generally accepted clinical practice as determined by the clinician.	Monitoring is essential for safety and progress within treatment; however, frequent drug screenings can lead to feelings of distrust, shame, and stigma. This change is intended to reduce barriers for individuals receiving services.

Issues

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

The primary advantages to the agency, public, and Commonwealth are to align the regulations to federal changes; increase access to lifesaving, evidence-based MOUD; and to advance treatment retention through the promotion of person-centered and compassionate interventions. There are no known disadvantages to the agency, public, or Commonwealth.

Requirements More Restrictive than Federal

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

This action incorporates two regulatory changes more restrictive than applicable federal requirements. The DBHDS clinical team recommended the slightly more stringent standards in response to Virginia's opioid crisis and to protect the health, safety, and welfare of the Commonwealth's citizens.

Currently, 12VAC35-105-990 allows a single take home dose for when a clinic is closed for business, a single dose each week during the first 90 days of treatment, two doses per week in the second 90 days of treatment, three doses per week in the third 90 days of treatment, a six-day supply in the remaining months of the first year of treatment, a two-week supply after one year of continuous treatment and a one month's supply after two years of continuous treatment. The proposed amendments allow for one take home dose for the first seven days of treatment, a five day consecutive supply of take home doses from eight days of treatment to 30 days of treatment, a 14-day supply of take-home doses from 31 days of treatment to 60 days of treatment, and a 28-day consecutive supply of take-home medication after 60 days of treatment. This regulatory change is stricter than the federal criteria that allow up to seven days of take-home doses during the first 14 days of treatment, up to 14 take-home doses from 15 days of treatment, and up to 28 take-home doses from 31 days in treatment.

Currently, the regulations do not allow for the use of telemedicine or audio-only evaluations. The proposed amendments allow the use of audio-visual evaluations and audio-only evaluations to take place when audio-visual evaluations are not available, but only if the individual is in the presence of a licensed practitioner who is registered to prescribe and dispense controlled medications. This is slightly stricter than the federal regulations which does not require an audio-visual evaluation to be attempted and unavailable or the presence of a licensed practitioner for evaluations for treatment with buprenorphine or naltrexone.

Currently, 12VAC35-105-970 requires a provider conduct face-to-face counseling sessions at least every two weeks for the first year of an individual's treatment and every month in the second year of the individual's treatment. After two years, the number of face-to-face counseling sessions are based on the individual's progress in treatment. Currently, the Licensing Regulations do not allow counseling to occur via telehealth. The proposed amendments allow for counseling to occur via telehealth however they require that an individual have one in-person counseling session every month during the first year of treatment and one in-person counseling session quarterly during the second year of treatment. This is

stricter than federal regulations, which do not require in-person counseling and do not require a minimum number of counseling sessions, instead requiring the frequency to be tailored to each individual based on an individualized assessment and an individual's care plan that was created after shared decision-making between the individual and the clinical team.

Agencies, Localities, and Other Entities Particularly Affected

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

Other State Agencies Particularly Affected

There are no other state agencies particularly affected.

Localities Particularly Affected

There are no other localities particularly affected.

Other Entities Particularly Affected

Providers licensed to provide these services will be affected, the regulatory changes represent a lessening of administrative burden and may result in a reduction in cost for providers which may be passed onto individuals receiving services.

Economic Impact

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

Impact on State Agencies

For your agency: projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources	There is no fiscal impact on DBHDS from this regulatory action other than to require modifications in its licensing web-based reporting application to update regulatory section information. Those costs can be absorbed.
For other state agencies: projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.	There is no fiscal impact on other state agencies due to this regulatory action.

For all agencies: Benefits the regulatory change is designed to produce.	The increased access to lifesaving, evidence-based MOUD, and advance treatment retention through the promotion of person-centered and compassionate interventions.

Impact on Localities

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

Projected costs, savings, fees or revenues resulting from the regulatory change.	There is no fiscal impact on localities from this regulatory action.
Benefits the regulatory change is designed to produce.	The regulatory changes will align the regulations to federal changes; increase access to lifesaving, evidence-based MOUD, and advance treatment retention through the promotion of person-centered and compassionate interventions.

Impact on Other Entities

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

Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.	Opioid treatment providers and individuals served by those providers shall be affected by this regulatory change.
Agency's best estimate of the number of such entities that will be affected. Include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	The agency currently has 35 OTP licenses, four of which are licenses for a community services board (CSB) and 31 are private providers. An unknown number of the private providers are small businesses.
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	As this action decreases regulatory burden, the changes should reduce costs on businesses, specifically OTP providers. It is possible that the reduction in costs may be passed on to individuals receiving services.
Benefits the regulatory change is designed to produce.	The regulatory change will align the regulations to federal changes; increase access to lifesaving, evidence-based MOUD, and advance treatment retention through the promotion of person-centered and compassionate interventions.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

The purpose of this regulatory action is to align the Licensing Regulations with changes to federal regulations and to lessen regulatory burden while preserving or improving the health, safety, and welfare protections for individuals. As such, there are no alternatives to the regulatory changes.

Regulatory Flexibility Analysis

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

Implementing this regulatory change is required due to changes in federal law, therefore, there is no alternative.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below.

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

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

DBHDS is providing an opportunity for comments on this regulatory proposal, including (i) the costs and benefits of the regulatory proposal and any alternative approaches, (ii) the potential impacts of the regulation, and (iii) the agency's regulatory flexibility analysis stated in this background document.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail, email or fax to Susan Puglisi, P.O. Box 1797, Richmond, VA

23218-1797, fax 804-371-4609, and email susan.puglisi@dbhds.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

If an existing VAC Chapter(s) is being amended or repealed, use Table 1 to describe the changes between existing VAC Chapter(s) and the proposed regulation. If existing VAC Chapter(s) or sections are being repealed and replaced, ensure Table 1 clearly shows both the current number and the new number for each repealed section and the replacement section.

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
12VAC35-105-20. Definitions.			Update of the term "Diagnostic and Statistical Manual of Mental Disorders" and "state opioid treatment authority;" removal of the terms "medical detoxification" and "medication assisted opioid treatment;" addition of the terms "medication for opioid use disorder," "opioid treatment practitioner," and "withdrawal management." Likely impact: Clearer regulations. Alignment with federal changes and current evidence-based practices and terminology to provide person-centered treatment.
12VAC35-105-30. Licenses.			Update the name of the license from "medication assisted opioid treatment" to "medication for opioid use disorder treatment." Likely impact: Clearer regulations. Alignment with federal changes and current terminology.
12VAC35-105-925. Standards for the evaluation of new license for			Update of staffing requirements to align with federal changes and update of terminology from medication assisted opioid treatment to medication for opioid use disorder.

providers of services to individuals with opioid addiction.			Likely impact: Clearer regulations. Alignment with federal changes and current terminology. Less regulatory burden on licensed providers.
12VAC35-105-930 Registration, certification, or accreditation.			Update of terminology from medication assisted opioid treatment to medication for opioid use disorder. Likely impact: Clearer regulations. Alignment with federal changes and current terminology.
12VAC35-105-935. Criteria for patient admission.			Update of terminology from medication assisted opioid treatment to medication for opioid use disorder. The amendments eliminate the one-year opioid addiction history requirement and promote priority treatment for pregnant individuals. It also removes the requirement for two documented instances of unsuccessful treatment for people under age 18. Likely impact: Clearer regulations. Alignment with federal changes. Removes unnecessary barriers to medication access by focusing on individual needs. Adds protections for vulnerable groups.
12VAC35-105-945. Criteria for patient discharge.			Update of terminology from medication assisted opioid treatment to medication for opioid use disorder. Likely impact: Clearer regulations. Alignment with federal changes and current terminology.
12VAC35-105-960. Initial and periodic assessment services.			Update of the requirements for initial medical examinations. The amendments allow screening examinations to be performed by practitioners external to the OTP under certain conditions. The amendments allow screening of individuals for admission via audio-only or audio-visual telehealth technology if certain requirements are met. Likely impact: Clearer regulations. Alignment with federal changes and current terminology. Telehealth is an evidence-based practice that has been shown to be safe and effective. Its use expands access to care.

12VAC35-105-970. Counseling sessions.			Update of the regulations to allow for telehealth counseling. Reduction in the required frequency of counseling sessions. The proposed amendments to this section are somewhat stricter than the federal requirement. Likely impact: Removes unnecessary barriers to treatment access by focusing on individual needs. Telehealth is an evidence-based practice that has been shown to be safe and effective. Its use expands access to care.
12VAC35-105-980. Drug screens.			Update the regulations to reduce the number of mandatory drug screens, including those required if a screen indicates continued illicit drug use. Likely impact: Reduction of feelings of distrust, shame and stigma. This change is intended to reduce barriers for individuals served and increase treatment retention.
12VAC35-105-990. Take-home medication.			Update the regulations to align the criteria for assessment for suitability for take-home medication with the federal regulations. Update the schedule for take-home medications and update terminology. The proposed amendments to this section are somewhat stricter than the federal requirement. Likely impact: Removes unnecessary barriers to treatment access. Increases access to lifesaving, evidence-based MOUD and increased treatment retention. Reduces regulatory burden as a simplified take-home schedule will result in less administrative burden on providers.
12VAC35-105-1000. Preventing duplication of medication services.			Update of terminology from medication assisted opioid treatment to medication for opioid use disorder. Likely impact: Clearer regulations. Alignment with federal changes and current terminology.
12VAC35-105-1010. Guests.			Update of terminology from medication assisted opioid treatment to medication for opioid use disorder, and a small clarifying edit.

			Likely impact: Clearer regulations. Alignment with federal changes and current terminology.
12VAC35-105-1020. Withdrawal management prior to involuntary discharge.			Update of terminology from medication assisted opioid treatment to medication for opioid use disorder, update of "state methadone authority" to "state opioid treatment authority" or "SOTA." Clarifying edit that incorporates DBHDS policy into regulations by stating that providers may immediately discharge an individual who has exhibited violent behavior if the provider has defined the circumstances under which such discharge would be appropriate within their policies. Likely impact: Clearer regulations. Alignment with federal changes and current terminology. Safer treatment environments for individuals receiving services and staff.
12VAC35-105-1055. Description of care provided			Repeal unnecessary section of a service that is no longer licensed. Likely impact: Clearer regulations.
12VAC35-105-1060. Cooperative agreements with community agencies.			Repeal unnecessary section of a service that is no longer licensed. Likely impact: Clearer regulations.
12VAC35-105-1070. Observation area.			Repeal unnecessary section of a service that is no longer licensed. Likely impact: Clearer regulations.
12VAC35-105-1080. Direct-care training for providers of detoxification services.			Repeal unnecessary section of a service that is no longer licensed. Likely impact: Clearer regulations.
12VAC35-105-1090. Minimum number of employees or contractors on duty.			Repeal unnecessary section of a service that is no longer licensed. Likely impact: Clearer regulations.
12VAC35-105-1100. Documentation.			Repeal unnecessary section of a service that is no longer licensed. Likely impact: Clearer regulations.
12VAC35-105-1110.			Repeal unnecessary section of a service that is no longer licensed.

Admission assessments.			Likely impact: Clearer regulations.
12VAC35-105-1120. Vital signs.			Repeal unnecessary section of a service that is no longer licensed. Likely impact: Clearer regulations. `
12VAC35-105-1130. Light snacks and fluids.			Repeal unnecessary section of a service that is no longer licensed. Likely impact: Clearer regulations.

Fast Track: Ch105: MOUD Amendments to Align with Federal Updates (2024)

12VAC35-105-20. Definitions.

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

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

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

2. Assault or battery;

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

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

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

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

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

"Activities of daily living" or "ADLs" means personal care activities and includes bathing, dressing, transferring, toileting, grooming, hygiene, feeding, and eating. An individual's degree of

independence in performing these activities is part of determining the appropriate level of care and services.

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

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

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

"ASAM" means the American Society of Addiction Medicine.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Improved behavioral functioning and effectiveness;

2. Alleviation of symptoms of psychopathology; or

3. Reduction of challenging behaviors.

"Board" or "state board" means, as defined by § 37.2-100 of the Code of Virginia, the State Board of Behavioral Health and Developmental Services. The board has statutory responsibility for adopting regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the commissioner or the department.

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

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

"Case management service" or "support coordination service" means services that can include assistance to individuals and their family members in accessing needed services that are responsive to the individual's needs. Case management services include identifying potential users of the service; assessing needs and planning services; linking the individual to services and supports; assisting the individual directly to locate, develop, or obtain needed services and

resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; discharge planning; and advocating for individuals in response to their changing needs. "Case management service" does not include assistance in which the only function is maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs.

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

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

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

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

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

"Community-based crisis stabilization" means services that are short term and designed to support an individual and the individual's natural support system following contact with an initial crisis response service or as a diversion to a higher level of care. Providers deliver community-based crisis stabilization services in an individual's natural environment and provide referrals and linkage to other community-based services at the appropriate level of care. Interventions may include mobile crisis response, brief therapeutic and skill-building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services. Coordination of specialized services to address the needs of co-occurring developmental disabilities and substance use disorders are also available through this service. Services include advocacy and networking to provide linkages and referrals to appropriate community-based services and assist the individual and the individual's family or caregiver in accessing other benefits or assistance programs for which the individual may be eligible. Community-based crisis stabilization is a non-center, community-based service. The goal of community-based crisis stabilization services is to stabilize the individual within the community and support the individual or the individual's support system (i) as part of an initial mobile crisis response; (ii) during the period between an initial mobile crisis response and entry into an established follow-up service at the appropriate level of care; (iii) as a transitional

step-down from a higher level of care if the next level of care service is identified but not immediately available for access; or (iv) as a diversion to a higher level of care.

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

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

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

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

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

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

"Credentialed addiction treatment professional" means a person who possesses one of the following credentials issued by the appropriate health regulatory board: (i) an addiction-

credentialed physician or physician with experience or training in addiction medicine; (ii) a licensed nurse practitioner or a licensed physician assistant with experience or training in addiction medicine; (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical social worker; (vi) a licensed professional counselor; (vii) a licensed nurse practitioner with experience or training in psychiatry or mental health; (viii) a licensed marriage and family therapist; (ix) a licensed substance abuse treatment practitioner; (x) a resident who is under the supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and is registered with the Virginia Board of Counseling; (xi) a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology (18VAC125-20-10); or (xii) a supervisee in social work who is under the supervision of a licensed clinical social worker and is registered with the Virginia Board of Social Work (18VAC140-20-10).

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

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

"Crisis planning team" means the team who is consulted to plan the individual's safety plan or crisis ISP. The crisis planning team consists, at a minimum, of the individual receiving services, the individual's legal guardian or authorized representative, and a member of the provider's crisis

staff. The crisis planning team may include the individual's support coordinator, case manager, the individual's family, or other identified persons, as desired by the individual, such as the individual's family of choice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Informed choice" means a decision made after considering options based on adequate and accurate information and knowledge. These options are developed through collaboration with the individual and the individual's authorized representative, as applicable, and the provider with the

intent of empowering the individual and the individual's authorized representative to make decisions that will lead to positive service outcomes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Medication for opioid use disorder" or "MOUD" means medications, including opioid agonist medications, approved by the Food and Drug Administration for the use in the treatment of opioid use disorder.

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

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

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

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

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

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

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

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

"Mental illness" means, as defined by § 37.2-100 of the Code of Virginia, a disorder of thought, mood, emotion, perception, or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others.

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

"Mobile crisis response" means a type of community-based crisis stabilization service that is available 24 hours per day, seven days per week, 365 days per year to provide rapid response, assessment, and early intervention to individuals experiencing a behavioral health crisis. Services are deployed in real time to the location of the individual experiencing a behavioral health crisis.

The purpose of this service is to (i) de-escalate the behavioral health crisis and prevent harm to the individual or others; (ii) assist in the prevention of the individual's acute exacerbation of symptoms; (iii) develop an immediate plan to maintain safety; and (iv) coordinate care and linking to appropriate treatment services to meet the needs of the individual.

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

"Neglect" means, as defined by § 37.2-100 of the Code of Virginia, the failure by a person or a program or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse.

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

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

"Opioid treatment practitioner" means a health care professional who is appropriately licensed to prescribe or dispense medications in Virginia for opioid use disorders and, as a result, is authorized to practice within an opioid treatment program.

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

"Provider" means, as defined by § 37.2-403 of the Code of Virginia, any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders) or (ii) residential services for individuals with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601, and 54.1-3701 of the Code of Virginia.

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

"Qualified developmental disability professional" or "QDDP" means a person who possesses at least one year of documented experience working directly with individuals who have a

developmental disability and who possesses one of the following credentials: (i) a doctor of medicine or osteopathy licensed in Virginia, (ii) a registered nurse licensed in Virginia, (iii) a licensed occupational therapist, or (iv) completion of at least a bachelor's degree in a human services field, including sociology, social work, special education, rehabilitation counseling, or psychology.

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

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

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

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

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

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

"Recovery" means a journey of healing and transformation enabling an individual with a mental illness to live a meaningful life in a community of his choice while striving to achieve his full potential. For individuals with substance abuse (substance use disorders), recovery is an incremental process leading to positive social change and a full return to biological, psychological, and social functioning. For individuals with a developmental disability, the concept of recovery does not apply in the sense that individuals with a developmental disability will need supports

throughout their entire lives although these may change over time. With supports, individuals with a developmental disability are capable of living lives that are fulfilling and satisfying and that bring meaning to themselves and others they know.

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

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

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

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

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

"Residential crisis stabilization service" means (i) providing short-term, intensive treatment to nonhospitalized individuals who require multidisciplinary treatment in order to stabilize acute

psychiatric symptoms and prevent admission to a psychiatric inpatient unit; (ii) providing normative environments with a high assurance of safety and security for crisis intervention; and (iii) mobilizing the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

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

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

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

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

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

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

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

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

"Restraints for protective purposes" means using a mechanical device to compensate for a physical or cognitive deficit when the individual does not have the option to remove the device. The device may limit an individual's movement, for example, bed rails or a gerichair, and prevent possible harm to the individual or it may create a passive barrier, such as a helmet to protect the individual.

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

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

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

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

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

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

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

"Level II serious incident" means a serious incident that occurs or originates during the provision of a service or on the premises of the provider that results in a significant harm or threat to the health and safety of an individual that does not meet the definition of a Level III serious incident. "Level II serious incident" includes a significant harm or threat to the health or safety of others caused by an individual. Level II serious incidents include:

1. A serious injury;

2. An individual who is or was missing;

3. An emergency room visit;

4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services, except that a psychiatric

admission in accordance with an individual's wellness plan shall not constitute an unplanned admission for the purposes of this chapter;

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

6. Ingestion of any hazardous material; or

7. A diagnosis of:

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

b. A bowel obstruction; or

c. Aspiration pneumonia.

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

1. Any death of an individual;

2. A sexual assault of an individual; or

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

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

"Service" means~~, as defined by § 37.2-403 of the Code of Virginia,~~ (i) planned individualized interventions intended to reduce or ameliorate mental illness, developmental disabilities, or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders). Services include outpatient services,

intensive in-home services, medication ~~assisted opioid~~ for opioid use disorder treatment services, inpatient psychiatric hospitalization, community gero-psychiatric residential services, assertive community treatment and other clinical services; day support, day treatment, partial hospitalization, psychosocial rehabilitation, and habilitation services; case management services; and supportive residential, special school, halfway house, in-home services, crisis stabilization, and other residential services; and (ii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports provided in residential services for persons with brain injury.

"Shall" means an obligation to act is imposed.

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

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

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

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

~~"State methadone authority"~~ "State opioid treatment authority" or "SOTA" means the Virginia Department of Behavioral Health and Developmental Services, which is authorized by the federal Center for Substance Abuse Treatment to exercise the responsibility and authority for governing the treatment of ~~opiate addiction with an opioid drug~~ opioid use disorder with MOUD.

"Substance abuse (substance use disorders)" means, as defined by § 37.2-100 of the Code of Virginia, the use of drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior; and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care.

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

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

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

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

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

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

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

"Supervised living residential service" means the provision of significant direct supervision and community support services to individuals living in apartments or other residential settings. These services differ from supportive in-home service because the provider assumes responsibility for management of the physical environment of the residence, and staff supervision and monitoring are daily and available on a 24-hour basis. Services are provided based on the

needs of the individual in areas such as food preparation, housekeeping, medication administration, personal hygiene, treatment, counseling, and budgeting.

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

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

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

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

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

and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills; and individual, group, and family counseling.

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

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

"Withdrawal management" means the dispensing of MOUD in decreasing doses to an individual to alleviate adverse physical effects incident to withdrawal from the continuous or sustained use of an opioid and as a method of bringing the individual to an opioid-free state within such a period. Long-term withdrawal management refers to the process of medication tapering that exceeds 30 days.

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

12VAC35-105-30. Licenses.

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

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

1. Assertive community treatment (ACT);

2. Case management;

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

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

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

6. Community gero-psychiatric residential;

7. Community-based crisis stabilization;

8. Crisis receiving center;

9. Crisis stabilization unit;

10. Day support;

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

12. Group home and community residential;

13. ICF/IID;

14. Inpatient psychiatric;

15. Intensive in-home;

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

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

18. ~~Medication assisted opioid~~ Medication for opioid use disorder treatment;

19. Mental health community support;

20. Mental health intensive outpatient;

21. Mental health outpatient;

22. Mental health partial hospitalization;

23. Psychosocial rehabilitation;

24. REACH CTH;

25. REACH mobile crisis response;

26. Residential treatment;

27. Respite care;

28. Sponsored residential home;

29. Substance abuse intensive outpatient;

30. Substance abuse outpatient;

31. Substance abuse partial hospitalization;

32. Supervised living residential; and

33. Supportive in-home.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The medical director shall be a ~~board-certified addictionologist or have successfully completed or will complete within one year a course of study in opiate addiction that is approved by the department~~ physician licensed to practice medicine in the Commonwealth of Virginia with relevant training or experience in the treatment of individuals with opioid addiction; and:

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

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

4. A minimum of one ~~pharmacist~~ health care professional who is appropriately licensed by the Commonwealth of Virginia to prescribe and dispense medications for opioid use disorders.

5. Nurses.

6. Counselors shall be licensed or certified by the applicable Virginia health regulatory board or eligible for this license or certification.

7. Personnel to provide support services.

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

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

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

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

F. The applicant may provide peer recovery specialists (PRS). Peer recovery specialists shall be professionally qualified by education and experience in accordance with 12VAC35-250. A registered peer recovery specialist shall be a PRS registered with the Board of Counseling in accordance with 18VAC115-70 and provide such services as an employee or independent contractor of DBHDS, a provider licensed by the DBHDS, a practitioner licensed by or holding a permit issued from the Department of Health Professions, or a facility licensed by the Virginia Department of Health.

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

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

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

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

3. Proposed hours and days of operation;

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

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

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

1. General.

a. Psychological services;

b. Social services;

c. Vocational services;

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

e. Employment services.

2. Initial medical examination services.

3. Special services for pregnant patients.

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

5. Counseling services.

6. Drug abuse testing services.

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

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

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

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

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

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

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

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

1. The federal Drug Enforcement Administration;

2. The federal Department of Health and Human Services; and

3. The Virginia Board of Pharmacy.

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

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

A. Before a ~~medication assisted opioid treatment program~~ medication for opioid use disorder treatment provider may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to (i) meet diagnostic criteria for opioid use disorder as defined within the

DSM; and (ii) meet the admission criteria of Level 1.0 of ASAM. The policies shall be consistent with subsections B through E of this section.

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

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

D. ~~A person younger than 18 years of age is required to have had two documented unsuccessful attempts at short-term detoxification or drug-free treatment within a 12-month period to be eligible for maintenance treatment.~~ No individual ~~younger than~~ under 18 years of age may be admitted to maintenance treatment ~~unless~~ without written consent from a parent, legal

guardian, or responsible adult designated by the relevant state authority ~~consents in writing to such treatment~~.

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

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

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

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

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

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

12VAC35-105-960. Initial and periodic assessment services.

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

1. A screening examination to ensure that the individual meets the criteria for admission in accordance with 12VAC35-105-935 and that there are no contraindications to treatment with MOUD; and

2. A full health history and examination, including a physical examination, to determine the individual's broader health status, with lab testing as determined by an appropriately licensed practitioner. An individual's refusal to undergo lab testing for co-occurring physical health conditions should not preclude access to treatment, provided such refusal does not have the potential to negatively impact treatment with medications. The individual's full health history and examination shall be completed within 14 days of admission.

~~B. The program physician shall review a consent to treatment form with the patient and sign the form prior to the individual receiving the first dose of medication.~~ B. Both the screening examination and the full health history and examination shall be completed by an appropriately licensed practitioner. When the initial medical examination is performed outside of the provider's service:

1. The written results, narrative of the initial medical examination, and available lab testing results must be transmitted, consistent with applicable privacy laws, to the provider and verified by an opioid treatment practitioner; and

2. If the original screening examination was not conducted by an opioid treatment practitioner, the screening shall occur not more than seven days prior to admission to the provider's service.

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

D. The ~~program~~ provider shall have a policy to ensure that coordination of care is in place with any prescribing physician.

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

F. Serology testing and other testing as deemed medically appropriate by the provider's physician based on the screening and full health history and examination, drawn not more than 30 days prior to admission to the provider’s service, may form part of the initial medical examination.

G. An evaluation of an individual for treatment shall occur in person or use audio-visual telemedicine platforms. When not available, a provider may use audio-only devices, but only when the individual is in the presence of a licensed practitioner who is registered to prescribe and dispense controlled medications. The licensed practitioner shall document being physically present during the audio-only evaluation through signature in the individual's record. The provider's physician shall review the initial medical examination results and order MOUD as indicated.

H. Qualified personnel shall review a consent to treatment form with the patient and shall document informed written consent prior to the individual receiving the first dose of MOUD.

I. Assuming no contraindications, an individual may begin MOUD treatment after the screening examination is completed.

12VAC35-105-970. Counseling sessions.

A. For the purposes of this section, "face-to-face" shall include telemedicine.

B. The provider shall conduct face-to-face counseling sessions (either individual or group) ~~at least every two weeks for the first year of an individual's treatment and every month in the second~~

~~year of the individual's treatment~~ at a frequency tailored to each individual based on an individualized assessment and the individual's care plan that was created after shared decision-making between the individual and the clinical team. At a minimum, the provider shall conduct one in-person session once a month for the first year of the individual's treatment and quarterly during the second year. ~~After two years, the number of face-to-face counseling sessions that an individual receives shall be based on the individual's progress in treatment.~~ The failure of an individual to participate in counseling sessions shall be addressed as part of the overall treatment process.

12VAC35-105-980. Drug screens.

A. The provider shall perform at least ~~one~~ eight random drug ~~screen~~ screens per ~~month~~ year unless the conditions in subsection B of this section apply.

B. Whenever an individual's drug screen indicates continued illicit drug use or when clinically and environmentally indicated, random drug screens shall be performed ~~weekly~~ at a frequency that is in accordance with generally accepted clinical practice and as indicated by the individual's response to stability in treatment.

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

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

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

A. Determinations for take-home approval shall be based on the clinical judgment of the provider's physician in consultation with the treatment team and shall be documented in the individual's service record. Prior to dispensing regularly scheduled take-home medication, the

~~provider~~ medical director or opioid treatment practitioner shall ensure the individual demonstrates ~~a level of current lifestyle stability~~ that the therapeutic benefits of unsupervised doses outweigh the risk as evidenced by the following criteria:

1. ~~Regular clinic attendance, including dosing and participation in counseling or group sessions~~ Absence of active substance use disorders, other physical or behavioral health conditions that increase the risk of harm as it relates to the potential for overdose, or the ability to function safely;

2. ~~Absence of recent alcohol abuse and illicit drug use~~ Regularity of attendance for supervised medication administration;

3. Absence of ~~significant behavior~~ serious behavioral problems that endanger the individual, the public, or others;

4. Absence of ~~recent criminal activities, charges, or convictions~~ known recent diversion activity;

5. ~~Stability of the individual's home environment and social relationships~~ Whether take-home medication can be safely transported and stored; and

6. ~~Length of time in treatment~~ Any other criteria that the medical director or opioid treatment practitioner considers relevant to the individual's safety and the public's health~~;~~

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

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

B. ~~Determinations for the take-home approval shall be based on the clinical judgment of the physician in consultation with the treatment team and shall be documented in the individual's service record~~ Any individual in comprehensive maintenance treatment that is assessed to be

appropriate to handle take-home medication shall undergo continued assessment and management to ensure suitability.

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

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

2. ~~A single dose each week during the first 90 days of treatment (beyond that in subdivision 1 of this subsection). The individual shall ingest all other doses under the supervision of a medication administration trained employee.~~ A maximum of a five-day consecutive supply of take-home doses from eight days of treatment to 30 days of treatment.

3. ~~Two doses per week in the second 90 days of treatment (beyond that in subdivision 1 of this subsection).~~ A maximum of a 14-day supply of take-home doses from 31 days of treatment to 60 days of treatment.

4. ~~Three doses per week in the third 90 days of treatment (beyond that in subdivision 1 of this subsection).~~ A maximum of a 28-day consecutive supply of take-home medication after 60 days of treatment.

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

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

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

D. Exceptions to the take-home schedule listed within subsection C may be made if approved by the SOTA or designee.

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

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

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

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

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

12VAC35-105-1010. Guests.

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

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

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

12VAC35-105-1020. ~~Detoxification~~ Withdrawal management prior to involuntary discharge.

A. The provider shall give an individual who is being involuntarily discharged an opportunity to ~~detoxify~~ withdraw from opioid agonist medication not less than 10 days or not more than 30 days prior to his discharge from the service, unless the ~~state methadone authority~~ SOTA has granted an exception.

B. Providers may immediately discharge an individual who has exhibited violent behavior if the provider has defined within their policies the circumstances under which such discharge would be appropriate.

~~Article 2~~

~~Medically Managed Withdrawal Services~~

12VAC35-105-1055. ~~Description of level of care provided.~~ (Repealed.)

In the service description the provider shall describe the level of services and the medical management provided.

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.~~

12VAC35-105-1070. ~~Observation area.~~ (Repealed.)

~~The provider shall provide for designated areas for employees and contractors with unobstructed observation of individuals.~~

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 of withdrawal; and~~

~~2. First responder training.~~

~~B. Untrained employees or contractors shall not be solely responsible for the care of individuals.~~

12VAC35-105-1090. ~~Minimum number of employees or contractors on duty.~~ (Repealed.)

~~In detoxification service locations, at least two employees or contractors shall be on duty at all times. If the location is within or contiguous to another service location, at least one employee or contractor shall be on duty at the location with trained backup employees or contractors immediately available. In other managed withdrawal settings the number of staff on duty shall be appropriate for the services offered and individuals served.~~

12VAC35-105-1100. ~~Documentation.~~ (Repealed.)

~~Employees or contractors on each shift shall document services provided and significant events in the individual's record.~~

12VAC35-105-1110. ~~Admission assessments.~~ (Repealed.)

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

~~1. Identify individuals with a high-risk for medical complications or who may pose a danger to themselves or others;~~

~~2. Assess substances used and time of last use;~~

~~3. Determine time of last meal;~~

~~4. Administer a urine screen;~~

~~5. Analyze blood alcohol content or administer a breathalyzer; and~~

~~6. Record vital signs.~~

12VAC35-105-1120. ~~Vital signs.~~ (Repealed.)

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

~~1. At admission and discharge;~~

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

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

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

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

~~D. This section does not apply to crisis services as crisis services shall comply with Part VIII of this chapter.~~

12VAC35-105-1130. ~~Light snacks and fluids.~~ (Repealed.)

~~The provider shall offer light snacks and fluids to individuals who are not in danger of aspirating.~~

REGULATORY ACTIVITY STATUS REPORT: NOVEMBER 2024 (REVISED 11/27/24)

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. ("Overhaul.")	• ***Draft in progress.***	• *Expect NOIRA in April. Final drafts under review by the OAG.*
12 VAC 35-46 Certain sections	same	To comply with EO1, removing noncontroversial language.	• **Fast Track.**	• To DPB 11/25/2024.
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.**	• Effective 12/05/2024.
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 April. Final drafts under review by the OAG.*
12 VAC 35-105 Certain sections.	same	To comply with EO1, removing noncontroversial language.	• **Fast Track.**	• To DPB 11/25/2024.
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	• **Fast Track.**	• To OAG 10/04/2024.

		additional mandate on substance abuse (substance use disorder) treatment facilities.		
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.***	• *OAG comments on draft received 11/25/2024; under review. Expect action in April.*
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.**	• Rescission effective 12/5/2024.
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.**	• Effective 12/5/2024.
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.**	• To OAG 10/4/2024.
12 VAC 35-225 Certain sections.	*same*	*To comply with EO1, removing noncontroversial language.*	• ***Fast Track.***	• *Draft in progress; expect in April.*
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 BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

DBHDS Central Office, Jefferson Building
1220 Bank Street, Richmond, VA

Wednesday, December 11, 2024

Committees at 8:30 – 9:25 a.m.

- **Planning and Budget Committee** will meet in the 13th Floor Conference Room.
- **Policy and Evaluation Committee** will meet in the 8th Floor Conference Room.

Regular Board Meeting at 9:30 a.m.

- **Regular Board Meeting Location:** 13th Floor Conference Room.

This page has **driving directions to the DBHDS Central Office in the Jefferson Building**, 1220 Bank Street. Below are general directions based on your starting point. View a Capitol Square map.

FROM I-64 EAST AND WEST OF RICHMOND

- Driving on I-64 towards Richmond, get onto I-95 South and continue into the downtown area on I-95.
- Take Exit 74B, Franklin Street.
- Follow directions below: 'Continue Downtown'

FROM I-95 NORTH OF RICHMOND

- Continue south on I-95 into the downtown area.
- Take Exit 74B, Franklin Street.
- Follow directions below: 'Continue Downtown'

FROM I-95 SOUTH OF RICHMOND

- Cross the bridge over the James River.
- Exit to your right on exit 74C– Route 360 (17th Street is one-way) and continue to Broad Street.
- Turn right onto Broad Street
- Turn left onto 14th Street (first light after crossing over I-95)
- Follow directions below: 'Continue Downtown'

CONTINUE DOWNTOWN - DIRECTIONS AFTER EXITING I-95

- Turn right onto Franklin Street at the traffic light at the bottom of the exit.
- Cross through the next light at 14th Street (Franklin Street becomes Bank Street)
- Look for on-street meter parking in the block between 14th and 13th Streets, or on 14th or Main streets. If you do not see parking on this block other parking options are available. View the parking map and parking fee table for the area.

➢ **The location for the committee meetings and Regular Board Meeting is in the Jefferson Building** on the south-east corner of Capitol Square, at the intersection of Governor (13th) Street and Bank Street.

If you have any questions about the information in this meeting packet, contact Ruth Anne Walker, ruthanne.walker@dbhds.virginia.gov, 804.225-2252. After 12/19/2024, contact susan.puglisi@dbhds.virginia.gov, 804-385-6542.

Future meeting dates are listed below the regular meeting agenda.