COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

DRAFT MEETING AGENDA

Monday, December 4 & Tuesday December 5, 2018

Regular Meeting

Tuesday December 4, 2018 3:00 p.m. – 4:30 p.m.

DBHDS Central State Office, 13th Floor Main Conference Room, Jefferson Building
1220 Bank Street, Richmond, VA

	3:00	**Policy Committee Meeting**	Beth Hilscher *Vice-Chair*	

Dinner & Tour

5:00 p.m. – 6:30 p.m.

Richmond Behavioral Health Authority
107 S 5th St, Richmond, VA 23219

5:00 – 6:30 p.m.	**Dinner & Tour**	

Regular Meeting

Wednesday, December 5, 2018 12:45 p.m.

Virginia Department of Aging and Rehabilitation Services
1610 Forest Avenue, Suite 100, Henrico, VA 23229

1.	12:45	**Call to Order and Introductions** **Approval of December 5, 2018 Agenda** ➢ *Action Required*	Paula Mitchell *Chair*	
2.	12:50	**Approval of Draft Minutes** **Regular Meeting, October 3, 2018** ➢ *Action Required*	Paula Mitchell *Chair*	
3.	1:00	**Public Comment** (*3 minute limit per speaker*)		
4.	1:15	**Commissioner's Report**	S. Hughes Melton, M.D. *Commissioner, DBHDS*	
5.	1:45	**Regulatory Actions**: **A. Approval of Draft Minutes Special Called Meeting, October 15, 2018** ➢ *Action Required*	Ruth Anne Walker *Director Regulatory Affairs*	

		B. Results of Public Hearing, November 19, 2018 **C. General Update – Matrix of Current Actions**	Cheryl DeHaven, *Recovery Services Coordinator*	
6.	2:15	**DBHDS Budget Submissions**	Nathan Miles, *Director of Budget Development and Financial Analysis.*	
7.	2:45	**Committee Reports** A. Policy Development & Evaluation	Holly Mortlock *Director, Policy*	
8.	3:00	**Miscellaneous** A. Board Liaison Reports B. State Board Annual Report	Paula Mitchell *Chair*	
9.	3:15	**Next Meeting Information**	Will Frank *Director, Legislative Affairs*	
10.	3:30	**Adjournment**	Paula Mitchell *Chair*	

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
DRAFT MEETING MINUTES
October 3, 2018
Catawba Hospital
5525 Catawba Hospital Dr, Catawba, VA 24070

Wednesday October 3, 2018	**Regular Meeting**
Members Present	Paula N. Mitchell **Chair**, Elizabeth Hilscher **Vice-Chair**, Sandra Price-Stroble, Jack Bruggeman, Moira Mazzi, Djuna Osborne, Becky Graser, and Calendria Jones
Members Absent	
Staff Present	Will Frank, Legislative Affairs Director Ruth Anne Walker, Administrative and Regulatory Coordinator Mira Signer, Chief Deputy Commissioner for Community Behavioral Health Services Heidi Dix, Deputy Commissioner for Compliance, Legislative, and Regulatory Affairs Mellie Randall, Substance Use Disorder Policy Director
Call to Order	At 9:05 a.m. Chair Paula Mitchell called the meeting to order.
Approval of Draft Agenda	The Board unanimously adopted the October 3, meeting agenda.
Approval of Draft Minutes- April 11 meeting	The Board unanimously approved the minutes.
Introductions	Chair Paula Mitchell called for the introductions of those present.
Public Comment	There was no public comment.
Crisis Intervention Training (CIT) Overview	Cathy Shenal, CIT Assessment Center Coordinator for Blue Ridge Behavioral Health presented on the areas work to train law enforcement in Crisis Intervention Training and the benefits and challenges of this program.
Regulatory Actions:	Ruth Anne Walker, Administrative and Regulatory Coordinator provided an update on DBHDS regulatory actions. DBHDS Chapter 180 of Title 12- Human Research The Board unanimously approved all regulatory action.

Facility Presentation and Tour	Walton Mitchell, facility director for Catawba Hospital and his staff provided the board with an overview of the facility and a tour.
Lunch: Break and Collect Lunch	The Board collected their lunches.
Commissioner's Report	Mira Signer, Chief Deputy Commissioner for Community Behavioral Health Services provided an update on agency activities on behalf of Commissioner Melton.
Opioid Epidemic and State Actions	Mellie Randall, Substance Use Disorder Policy Director, DBHDS presented to the board on current DBHDS and state efforts to combat the opioid epidemic in Virginia.
Miscellaneous	
Board Liaison Reports	Board members reported on their liaison visits since the last meeting.
Other	
Next Meeting Information	The next meeting will be held in December 2018.
Adjournment	Having no other business, Paula Mitchell adjourned the meeting at 3:15pm.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Policy and Evaluation Committee
DRAFT AGENDA

DECEMBER 4, 2018
RICHMOND, VA

I. Call to Order

II. Welcome and Introductions

III. Policy Discussion

- POLICY 6005 (FIN) 94-2 Retention of Unspent State Funds by Community Services Boards
- POLICY 4010 (CSB) 83-6 Local Matching Requirements for Community Services Boards and Behavioral Health Authorities

VII. Next Meeting: April 2019

VIII. Other Business

IX. Adjournment

	Renewed 4/27/88 Updated 3/22/90 Revised 9/28/94 Revised 10/7/08 Updated 10/7/16
POLICY MANUAL **State Board of Behavioral Health and Developmental Services** **Department of Behavioral Health and Developmental Services**	
	POLICY 4010 (CSB) 83-6 Local Matching Requirements for Community Services Boards and Behavioral Health Authorities
Authority	Board Minutes Date: 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: ● local government appropriations; ● philanthropic cash contributions; ● in-kind contributions of space, equipment, and professional services; and ● interest 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: ● threaten the viability of existing services, ● eliminate opportunities to expand services, ● lessen chances of obtaining additional local matching funds in the future, and ● jeopardize 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. If sufficient local funds are not available to sustain at least that ratio, that is if 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 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. • Define ability to pay • Some members are not making their 10% match • How you calculate waiver 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 would be exceeded because of insufficient local matching funds, it also is the policy of the Board that state funds

Comment [VP1]: Ratio of overall budget of what they pay to CSB services

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Comment [VP2]: Andrew will provide formula, Emily and Connie will come up with language

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

Updated: 07/26/11

POLICY MANUAL

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

POLICY 6005(FIN)94-2 Retention of Unspent State Funds by Community Services Boards

Authority

Board Minutes Dated: July 27, 1994
Effective Date: July 1, 1994
Approved by Board Chairman: James G. Lumpkin

References

Realizing the Vision: Barriers to an Integrated System, Department of Mental Health, Mental Retardation and Substance Abuse Services, January 27, 1993
State Board Policy 4018 (CSB) 86-9 Community Services Performance Contracts
Community Services Performance Contract
§ 37.2-508 and § 37.2-509 of the Code of Virginia (1950)

Supercedes

STATE BOARD POLICY 3002 (CO) 86-16 System-wide Staff Training

Background

Before FY 1995, the Department applied year-end balances of unspent state funds at community services boards and the behavioral health authority, hereafter referred to as CSBs, to the next year's state fund allocations for CSBs so that the state appropriation and balances equaled state awards. If state balances reported in the fall were below the estimates projected in the previous spring's budget deliberations, a deficit could occur. This happened in FY 1993, and a deficit was averted only by a transfer of funds to the CSB appropriation.

Realizing the Vision: Barriers to an Integrated System, the Visions Task Force report, recommended preserving any unbudgeted and unspent revenues within the system. The Visions Financial Resources Committee proposed amending § 37.1-199(a) of the Code of Virginia so that CSBs could retain unspent revenues to expand and enhance services. The State Board supported this amendment, but it was not introduced, based on a determination that it could be implemented administratively.

Subsequently, the Virginia Association of Community Services Boards and the Department developed a proposal, the basis for this policy, that prevented future deficits, instituted a budget process in which CSB awards equaled the state appropriation, and implemented the Visions recommendation.

Purpose

To establish the ability of CSBs to retain balances of unspent state general funds.

Policy

It is the policy of the Board that:

Continued on next page

- the Department shall allow CSBs to retain balances of unspent state general funds after the end of the fiscal year in which the Department granted those funds;

- the Department shall allocate the funds in the CSB state appropriation without applying estimated year-end balances of unspent state general funds to the next year's CSB awards of state general funds;

- based on the General Assembly Appropriations Act prohibition against using state funds to supplant the funds provided by local governments for existing services, there should be no reduction of local matching funds as a result of a CSB's retention of any balances of unspent state general funds; and

- if a CSB delivers less than the levels of services in its final approved Community Services Performance Contract, established pursuant to § 37.2-508 of the Code of Virginia and State Board Policy 4018, while generating significant balances of unspent state general funds, it may have to return some of its balances to the Department or its state fund allocations in the next fiscal year may be reduced.

It is also the policy of Board that the Department shall apply procedures, which are authorized by § 37.2-509 of the Code of Virginia and are consistent with those in the Community Services Performance Contract, to retrieve unspent state general funds from or reduce future state general fund allocations to a CSB that delivers less than the levels of services in its final approved Performance Contract while generating significant balances of unspent state general funds.

Finally, it is the policy of the Board that the Community Services Performance Contract shall contain principles and procedures for the more effective and consistent utilization of unexpended state general fund balances from previous fiscal years by CSBs.

REGULATORY ACTIVITY STATUS REPORT: OCTOBER 2018 (REVISED 11/26/18)

Board STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

VAC CITATION	CHAPTER TITLE (FULL TITLE)	REGULATIONS IN PROCESS			LAST ACTIVITY	LAST PERIODIC REVIEW*
		PURPOSE	STAGE	STATUS		
12 VAC 35-46	**Children's Residential** (*Regulations for Children's Residential Facilities*)	To articulate requirements to assure the health, safety, care, and treatment for children who receive services from providers licensed by DBHDS.	**Periodic Review Completed; *under development***	• ***Current:*** *Comment period ended 02/08/2018. Staff will initiate draft revisions and seek stakeholder comment in coming months.*	01/22/2013	12/05/2017
12 VAC 35-105 Certain sections.	**Licensing-Adult** (*Rules and Regulations for Licensing Facilities and Providers of Mental Health, Mental Retardation and Substance Abuse Services*)	In accordance with the CMS Final Rule and the Settlement Agreement: clarifications for the health, safety, care and treatment for adults who receive services from providers of residential services.	**Emergency/ NOIRA to *Proposed***	• **Current:** Emergency effective 09/1/2018 (expires 02/29/2020). • A public comment forum for the NOIRA was held 08/06 – 09/05/2018. • ***Next:*** *Agency response to comments; finalize proposed stage text. Next stage must be filed by03/03/2019.*	09/01/2018	12/05/2017
12 VAC 35-105 Sections 20, 590, and 1370.		In accordance with Chapter 136 of the 2017 General Assembly to include OTs and OTAs as QMHPs.	**NOIRA to *Proposed***	• **Current:** Emergency regulation effective 12/18/2017 (expires on 06/17/2019). • Proposed draft approved by the Governor on 11/21/2018. Public comment period 12/10/2018 – 02/08/2019.		
12 VAC 35-105 Section 20.		In accordance with SB762 (2018), which requires the addition of behavior analysts (LBAs) to the definition of licensed mental health professional (LMHP).	**Fast Track per GA Mandate**	• **Current:** Approved by the Governor 09/24/2018; 30-day public comment period ended 11/14/2018. • **Effective: 11/29/2018.**		
12 VAC 35-105 Section 20.		To add nurse practitioners to the definition of licensed mental health professional (LMHP).	**Fast Track**	• **Current:** Submitted to Governor's Office on 10/24/2018.		
12 VAC 35-105 Section 675.		ISPs: To allow documentation of each quarterly review or a revised assessment 'no later than 15 calendar days from the date the review was due to be completed.'	**Fast Track**	• **Current:** Submitted to Governor's Office on 10/22/2018.		

12 VAC 35-105		To provide specific standards for licensing of organizations and facilities providing behavioral health and developmental disability services. ('Overhaul')	***Periodic Review Completed***	• ***Current:*** *Comment period 12/15/2017. Staff initiated draft revisions and will seek stakeholder comment.*		
12 VAC 35-115 Sections 30 and 105.	**Human Rights** (*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 update the existing regulation by adding LBAs to the definition of 'Licensed Professional' in relation to 12 VAC35-115-105 (B and C) only.	**Effective**	• **Current:** Initiated 10/04/2017; approved by the Governor on 08/22/2018. A public comment period closed on 10/17/2018. • **Effective: 11/01/2018.**	02/09/2017	02/09/2017
12 VAC 35-180	**Human Research** (*Regulations to Assure the Protection of Participants in Human Research*)	To define policy and review requirements to protect individuals who are participants in human research performed by facilities or programs operated, funded, or licensed by the department.	**Fast Track as the result of a Periodic Review**	• **Current:** From OAG to DPB on 11/02/2018.	11/12/2009	10/05/2017
12 VAC 35-190	**Training Center Admissions** (*Regulations for Voluntary Admissions to State Training Centers*)	To clearly articulate requirements and actions required to admit a person to a training center; define due process protections afforded to persons who are being admitted and to their families.	**Fast Track as the result of a Periodic Review**	• **Current:** Governor approved 10/23/2018; comment period 11/12-12/12/2018. • *Expected* effective date: 12/27/2018.	07/20/2009	07/19/2017
12 VAC 35-200	**Facility Respite/Emergency Admissions** (*Regulations for Respite and Emergency Care Admission to Mental Retardation Facilities*)	To clearly articulate requirements required to access emergency services and respite care in a training center.	**Fast Track as the result of a Periodic Review**	• **Current:** Governor approved 10/23/2018; comment period 11/12-12/12/2018. • *Expected* effective date: 12/27/2018.	08/17/2009	07/19/2017
12 VAC 35-210	**Facility Temporary Leave** (*Regulations to Govern Temporary Leave from State Mental Health and Mental Retardation Facilities*)	To establish the general process and requirements related to temporary leave from state facilities, including the conditions for granting leave.	**Fast Track as the result of a Periodic Review**	• **Current:** Submitted to the Governor on 09/05/2018.	11/1/2011	07/19/2017
12 VAC 35-230	**IFSP** (*Operation of the Individual and Family Support Program*)	To assist individuals with developmental disabilities (DD) who are on a waiting list for waiver services and their family members to access needed services.	***Periodic Review***	• ***Current:*** *Comment period ended 02/08/2018; per OAG, revised draft under development.*	12/02/2013	12/05/2017
12VAC35-250	**Peers** (*Peer Recovery Specialists*)	To establish certification requirements for peer recovery specialists (Item 311.B. of the *2016 Appropriation Act*).	**Proposed *to Final***	• **Current:** Final text to OAG 10/15/2018. Public hearing held 11/19/2018 (see below).	05/12/2017	--

*Shows the last time the Periodic Review feature on Town Hall was used for this regulation. A comprehensive periodic review may also have been included during other standard regulatory actions.

COMMONWEALTH of VIRGINIA
DEPARTMENT OF
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MEMORANDUM

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

Fr: Ruth Anne Walker, Director of Regulatory Affairs

Date: November 26, 2018

Re: Regulatory Package

I. Draft Minutes – Special Called Meeting

(http://townhall.virginia.gov/UM/chartstandardstate.pdf)

SPECIAL CALLED MEETING
Monday, October 15, 2018
2:00 p.m.
DBHDS, Central Office, 1220 Bank Street, Richmond, VA 23218

DRAFT MINUTES

Pursuant to Section 2.2-3708.2 of the Code of Virginia and Article 5 Item J of the State Board Bylaws, one member called in remotely due to being more than 60 miles from the primary meeting location.

Members in attendance: Paula Mitchell, Chair (by phone); Beth Hilscher, Vice Chair; Jack Bruggeman; Becky Graser; Calendria Jones; Sandra Price-Stroble.

DBHDS staff in attendance: Cheryl DeHaven, Acting Director of Recovery Services; Ruth Anne Walker, Director of Regulatory Affairs.

I. Call to Order

At 2:40 p.m. Paula Mitchell, Chair, called the meeting to order. A quorum of members was present in Richmond.

II. Approval of the Agenda

Ms. Mitchell confirmed all members had the meeting information packet and that the only business to be taken up at the meeting would one item regarding 12VAC35-250 Peer Recovery Specialists.

III. **Regulatory Action Item:** Initiate Final Stage for Permanent Adoption of 12VAC35-250 Peer Recovery Specialists

Ms. Mitchell stated that board members had received the final draft as amended with a request to initiate the final stage for the new peer recovery specialist regulation. She asked if there was any discussion.

Calendria Jones asked if there would be any changes to the qualifying factors to be a peer. Ruth Anne Walker stated there were no changes in the action before the board to change any qualifying factors. Ms. Jones stated her main concern was that individuals were being trained, certified, and registered to be peer recovery specialists, but were having difficulty being hired. She wondered if this regulatory action was a vehicle to give a statement of that concern. Ms. Walker suggested a letter from the board to Governor Northam might be an appropriate vehicle to highlight concerns; however, confirming the current status of various efforts first with the board liaison (both legislative and other) would be important.

Discussion continued among members on the topic of the current status of peer recovery specialists in Virginia – their importance in the behavioral health system, the steps forward with these regulations and the Medicaid ARTS Waiver, and issues that may keep peers from being hired, i.e. barrier crimes. Becky Graser stated that there are a lot of openings, but backgrounds are a problem to be able to work. Discussion included the possibility of a legislative 'carve out' for such crimes that are part of a peer's lived experience.

Cheryl DeHaven drew the board's attention to the Joint Commission on Health Care's (JCHC) meeting earlier in the day and in particular, to a presentation given at the meeting that touched on these issues (http://jchc.virginia.gov/4.%20Addiction%20Relapse%20Prevention%20Study%20FINAL.pdf). This information of the discussion at JCHC reinforced the need to confirm with the DBHDS legislative liaison the current status of various efforts on peer-related issues.

Ms. Mitchell called for the vote on the business before the Board. A motion was approved by Beth Hilscher, and seconded by Jack Bruggeman. The regulation and initiation of the final stage were approved unanimously, with one abstention by Ms. Graser due to a possible conflict of interest.

IV. Adjournment

There being no further business, Ms. Mitchell adjourned the meeting at 3 p.m.

The next regular meeting of the State Board will be on December 4-5, 2018.

II. Agency Response to Public Hearing Comments

Background: The purpose of the hearing held on November 19, 2018, was to receive comment on the proposed-stage text of the new regulation (12VAC35-250, Peer Recovery Specialists), which provides administrative structure for DBHDS qualifications, education, and experience for peer recovery specialists to ensure that individuals providing peer recovery services in Virginia's public system of behavioral health services demonstrate a baseline of practical knowledge. The hearing was staffed by Ruth Anne Walker, and two staff from the Office of Recovery Services: Cheryl DeHaven, then-Acting Director and now Recovery Services Coordinator; and, Mary McQuown, Peer Recovery Specialist Liaison (and former State Board member). Board member Becky Graser was present at the hearing.

Staff Review and Recommendation: As with all public comments, DBHDS staff prepared a response to comments. The attached chart includes responses developed by the Office of Recovery Services and was communicated directly to all commenters on November 26, 2018.

Purpose: Staff in the Office of Recovery Services considered all comments in relation to the standard regulatory action to make Chapter 250 a permanent regulation. While a number of important issues about the peer system were raised by commenters, of those comments made regarding the draft text, staff recommended no additional edits be made to the language for the final stage as a result of the comments, and confirmed the language as approved by the State Board on October 15, 2018.

Action Requested: No action requested.

III. Regulatory Updates

- Regulatory Activity Status Report Matrix (chart above)
- Planned Regulatory Action Workplan (handout at meeting)

State Board of Behavioral Health and Developmental Services
Office of Recovery Services
PUBLIC HEARING COMMENTS ON: PROPOSED STAGE REGULATION 12VAC35-250, Peer Recovery Specialists.

Stage	Proposed
VAC	Chapter 250 [Under Development]
Hearing:	**November 19, 2018**

#	Commenter Name	Commenter Organization	Comments	DBHDS Response – UPDATED 11/26/18 4:30 p.m.**
1	Becky Bowers-Lanier	Virginia Association of Addiction Providers (VAAP)	Ms. Bowers-Lanier stated she appreciated that in the development of the regulation, the agencies were mindful of the dual roles of the three agencies (DBHDS, DMAS, DHP's Board of Counseling, "BOC") in regulating the registry, education, and experience under supervision. The BOC regulations don't seem to address the nature of the supervision. VAAP asks that DBHDS detail the supervision of specialists, of the supervisor's training and education. Also, require content of ethical and boundary issues. The entire section of continuing education is not in the DBHDS proposed regulation. VAAP is very concerned of the boundary and ethical issues. (Comments submitted in writing)	Thank you for the comments on behalf of VAAP. The continuing education for supervisors is based upon their own credentials through certifying bodies (CPRS, CSAC, those licenses listed under LMHP, etc.). The continuing education for PRS is also based on their certifying body. DBHDS thinks this topic is well-covered through the following: The Code of Ethics is part of the regulation as a document incorporated by reference. Also, ethical and boundary training is part of the PRS and supervisor curricula. Subsection 50 B.10 includes a requirement for ethics and boundary training for PRS. There are requirements for supervision of PRS in the DMAS Peer Supplemental Manual.
2	Beth Tolley	Self	Request that 'family support partner' be added to definitions. 'an individual who has met all requirements of PRS and who is a parent or caregiver of a minor….. Broaden definition of 'individual' to include 'a caregiver….' Or, have 'family member/caregiver' added to the definition. (Comments submitted in writing.)	Thank you for your comments. **Update: DBHDS does not recommend adding "family support partner" (FSP) as a separate definition in the regulation for the following reasons: In the DMAS Peer Services Supplement Manual, DBHDS regulations are listed in the PRS definition, and not in the FSP definition. PRS is the umbrella term, and FSP is a type of PRS. DHBDS regulations must address (only needs to address) all PRS, and it is cleaner to use the umbrella term, with the explanation of FSP is included in Subsection 20 B 1-2. Listing both

#	Commenter Name	Commenter Organization	Comments	DBHDS Response – UPDATED 11/26/18 4:30 p.m.**
				terms together throughout the regulation (as DMAS does, 'peer recovery specialist or family support partner') makes it sound like FSP is a different profession with different requirements when it is not. DBHDS does not recommend adding "caregiver" to the definition of PRS because the definition of "caregiver" is defined by DMAS regulation (12VAC30-130-5160) as someone who is "not being paid." Therefore, persons under that category could not be a PRS.
3	Laura May	Self, and as an employer	I would like to have the definition of 'parent' include 'or caregiver.' Even though in other places in the regulation it includes 'family member,' sometimes the person providing care is outside the realm of family.	Thank you for your comments. DBHDS does not recommend adding "caregiver" to the definition of PRS because the definition of "caregiver" is defined by DMAS regulation (12VAC30-130-5160) as someone who is "not being paid." Therefore, persons under that category could not be a PRS.
4	Kelvin Manurs	Arm and Arm, a nonprofit peer to peer re-entry organization that does counseling and support as well as training	The organization is part of a Prince William and George Mason project working on the opioid crisis. Mr. Manurs requested that some of the peer trainings be focused on smaller groups. These two different spectrums – individuals that have great talent and ability to work with other people, but the larger groups frighten them. He and the organization have been working in a couple different conduits to address, and some letters have come down the pike about this issue. Some individuals have stressed they have mental health issues in larger forums.	DBHDS appreciates the concern described; however, this does not pertain to the proposed regulation.
5	Cristy Corbin	Self	Ms. Corbin stated how great it is that this is the process now in place to recognize peer recovery specialists. She sees this time as a huge celebration for those of us working in the field. Some of the wording in the regulation is confusing. For instance, the title of the regulation versus the certification title. What are specialists being referred to as? In the definitions, there is 'PRS' definition, a 'registered' PRS, but not a 'certified'	Thank you for your comments. 'Peer recovery specialist' is the main term. Those who qualify as a PRS in accordance with regulatory requirements, who then choose to register with the Board of Counseling (at the Department of Health Professions) are considered a 'registered peer recovery specialist.' However, the Board stated that registration is only required for the

#	Commenter Name	Commenter Organization	Comments	DBHDS Response – UPDATED 11/26/18 4:30 p.m.**
			PRS. There is reference to certification further down in the regulation. Being that you don't have to be registered but must be certified, it might be helpful to add clarification to be supportive in what attempting to accomplish. Also, under PRS in subsection 20, 'shall provide such services of employee or contractor…..,' Change 'shall' 'may.' There needs to be more information about being a contractor or employee of DBHDS.	purposes of Medicaid billing. Conversely, if someone is registered, they can still provide non-Medicaid services. Before the regulations took effect, the term 'certified' was used for everyone who went through the DBHDS training and received a DBHDS-issued certificate. In the regulation, there is a definition of 'certifying body; which refers to 'an organization approved by DBHDS that has as one of its purposes the certification of peer recovery specialists.' This is referring to a nationally recognized, and for purposes of this regulation DBHDS-recognized (as listed in the regulation), professional accrediting body (that certifies successful completion of its requirements, and there upon awards a license or certificate. The most general type of certification is profession-wide. This type of certification is developed in various professions in order to apply professional standards, increase the level of practice, and protect the public. In regard to the reference to subsection 20, the language referring to being an 'employee or contractor' must be in the regulation as 'shall' because that is the scope of DBHDS authority.
6	Lynn Taylor		She was not sure if the hearing was the appropriate venue to discuss it, but a whole array of folks are training peers and she has found that it is very person-dependent, as there is no regulation of the trainer's skill set, how they are doing the training, what they are doing, no standardization. It is simply, 'Here's your 80 hours.' As a coach you're getting a whole mixed bag of tricks as an employer because you are not sure what training someone has, and sometimes have to retrain a new hire. She would like to know if there are reports of inconsistencies and not good training, and how that gets fed back to DBHDS to help train and educate more.	Thank you for your comments. The regulation states that everyone must take the 72-hour DBHDS training. This is to ensure that everyone has the same foundation of training. The trainers are to be teaching to the curriculum. Further, DBHDS performs random audits of trainings, monitors the class size, hours for the training (72), and content. Trainers must present training within those guidelines in order for the participants to receive a certificate of course completion.

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				If this topic is considered for future action (meaning, if the current audit and monitoring are required to expand), additional resources would likely be required.
7	Bruce Cruser	Executive Director of Mental Health America-Virginia	He had stated he had nothing controversial to say. DBHDS and the other agencies are commended for what has been done with the regulations over the past year or so to address an amazing emergence of this new workforce. The regulations do a great job covering the ground of what will be a professional level. He pointed out that some of the folks present at the hearing were part of who worked on the curriculum. His complaints have to do with reimbursement rates, and that is beyond the scope of these DBHDS regulations. He thanked DBHDS for including the workforce in the developments to date, and ask that inclusion continue in whatever else is developed.	Thank you for your comments.
8	Elizabeth Sluder	Middle Peninsula-Northern Neck CSB PRS and coordinator, speaking for the CSB	The CSB is not billing due to the reimbursement rate because it is too low. It has gone from initially $66 to $26.50 and it does need to be raised considerably. PRS work not in just the ID population, but for the community as a whole, the workforce and reentry. It is not just for mentoring, but for the whole person. There is a lot of value delivered in that reimbursement.	DBHDS appreciates the concern described; however, this does not pertain to the proposed regulation.
9	Lyn Groover	MPNN CSB employee in the PRS division	I worked for two years as supportive employment specialist. Regarding the definitions of PRS, PRS services, and the definition of recovery, resiliency, wellness plan. Across the state we train PRS, and they come to me and want to be a PRS but they have a criminal background. I have to tell them 'sorry, you can't do direct care if barrier crime,' and then some break out in tears. It is demoralizing to them and to me. Employment was a stepping stone to recovery for me. I enjoy my job and enjoy helping people get past their illness…I don't have a criminal justice background. Who better to work with people with a criminal justice background than those who have one? The training is as far as they can currently go. I hope it will be addressed.	DBHDS appreciates the concern described; however, this does not pertain to the proposed regulation. A legislative change would have to occur to address concerns about current barrier crime restrictions.

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10	Yaritza Ilarraza-Santos	Provides peer specialist services in the Veterans Health Administration Hunter Holmes McGuire Veterans Medical Center, speaking for herself	She stated that regarding the section on who may act as a PRS, it mentions a parent of a minor or adult child, or an adult with personal experience with a family member. She recommends adding a third type of person: a person who self-identifies as being in recovery from mental illness or substance use disorder or co-occurring, similar to the individuals to whom they are providing services.	Thank you for your comments. This is covered in the definitions of PRS and the recovery experience requirements. Also, the validation of lived experience is included in the Code of Ethics.
11	Rick Gilbert	MPNN CSB	He is pleased that the date deadline portion was removed from the regulation, and that this topic area is being addressed and made permanent. There are two larger issues to qualify peers in the state to do this valuable work: 1) The barrier crime aspect of disqualification. Many of us have come to a better way of life in recovery, as a result of consequences from actions we took. I'm fortunate that my consequences and jail time were only for misdemeanors. Concerned we won't have enough people to qualify. More specifically, DBHDS needs to understand the likelihood of some of us having such consequences in our history, including jail time. 2) Also, address the 500 hour requirement. That is daunting for a number of people. Helping with a small department grant, group working with are daunted by the requirement as it is more than they can do in a year, for the most part, and should be something that is doable on a part-time basis.	DBHDS appreciates the concern described; however, this does not pertain to the proposed regulation. A legislative change would have to occur to address concerns about current barrier crime restrictions. Examples of how the 500 hours of peer support experience can be acquired are: • in three months at 40 hours per week, or • six months at 20 hours per week or • 50 weeks at 10 hours per week. Also, other states require as many as 1,000 hours. The 500 hour requirement was recommended in the December 2013 report of the DBHDS Creating Opportunities Peer Support Planning Committee, which was developed by the members listed below and vetted by other interested stakeholders. Excerpt from the committee's report listing participants: *The Creating Opportunities Team…was co-chaired by Becky Sterling of MPNN CSB and Susan Pauley of DBHDS Central Office. Upon learning that leaders in the peer and advocacy SA and MH communities had begun conversations about certification, the Creating Opportunities Team formed a sub-committee to focus specifically on certification. Becky Sterling, Susan*

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				Pauley, Mark Blackwell (from SAARA) and Bonnie Neighbour (from VOCAL) were Creating Opportunities team members who joined with Heather Peck (from VOCAL), Jan Brown (from SpiritWorks), Mike Newcomb (then Chair of the Virginia Peer Support Coalition), Rose Farber (from On Our Own in Charlottesville), Dee Jacobson (member of VOCAL, and of Virginia Peer Support Coalition, and Marjorie Yates (from SAARA) to research, debate, discuss, and develop the recommendations for standards and for administration of a certification process. Other members of the peer and advocacy community attended some meetings, were consulted with, and shared information with us they believed could inform the work. Staff in DBHDS Central Office (Michael Shank, Rhonda Thissen, Jim Martinez and Mellie Randall) who have worked with recovery oriented services and other peer support initiatives over the years also provided input and information that assisted the committee in their decisions.

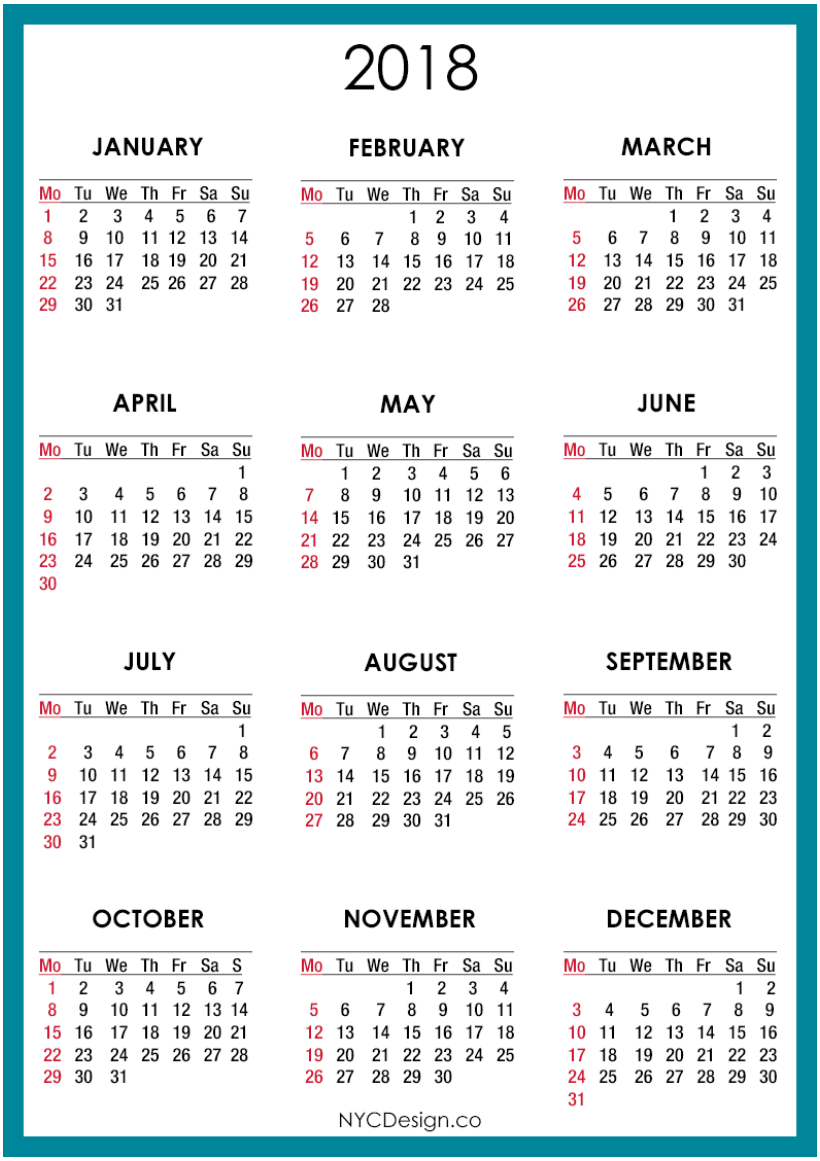
2017-2019 Proposed Topics for Upcoming Meetings

Meeting Date	Suggested Topics
July 2017	Biennial Retreat Peer Certification Program Update Progress on Multi- lingual and multi-cultural initiative
October 3 & 4, 2017 Williamsburg	Hospital Census/ EBL Workforce Issues and Workforce Development Possible Discussion on ARTS/Peers
December 4 & 5, 2017 Richmond	Review of Public Education Efforts Pres-Session Update Housing Presentation
April 2018 Hampton Roads (Virginia Beach) Proposed Date: April 10-11, 2018	DOJ Update Post-Session Update Budget Update Early Intervention Presentation Possible Jail Discussion
July 2018 Richmond Proposed Date: July 10-11, 2018	MHFA Training Overview Peer Services Update STEP-VA-SDA Update Possible REVIVE Training
October 2018 Roanoke Proposed Date: October 2-3, 2018	CIT Training Presentation Opioid Presentation Geriatric Services Presentation
December 2018 Richmond Proposed Date: December 4-5, 2018	Pre-Session Update Children's Services Presentation
April 2019	To Be Determined
July 2019	To Be Determined Biennial Retreat

2018 Meeting Schedule

2018 Schedule

- Wednesday, April 10-11, 2018, Virginia Beach
- Wednesday, July 10-11, 2018, Richmond
- Wednesday, October 2-3, 2018, Roanoke
- Thursday, December 4-5, 2018, Richmond



Event Schedule

Tuesday, December 4 & Wednesday December 5, 2018

Tuesday, **December 4, 2018**	
3:00pm-4:30pm	**Planning Committee Meeting** DBHDS Central State Office, 13th Floor Main Conference Room, Jefferson Building 1220 Bank Street, Richmond, VA
5:00pm-6:30pm	**Dinner & Tour** Richmond Behavioral Health Authority 107 S 5th St, Richmond, VA 23219

Wednesday, **December 5, 2018**	
9:00 a.m. - 12:00 p.m.	**DBHDS Strategic Planning Regional Meeting** *(This meeting is not part of the State Board Meeting. Board members are invited to attend. RSVP Required)* Virginia Tech Richmond Center 2810 N Parham Rd, Richmond, VA 23294 *Board Members are asked to pick up lunch on their own and bring to regular meeting site.*
12:45 p.m. - 3:30 p.m.	**Regular Meeting** Virginia Department of Aging and Rehabilitation Services 1610 Forest Avenue, Suite 100, Henrico, VA 23229

Directions to the Commonwealth Park Suites
901 Bank Street, Richmond, VA 23219

http://www.commonwealthparksuites.com/

From the West: I-64 East to I-95 South. I-95 South to 3rd Street Exit. 3rd Street to Franklin Street. Left on Franklin Street to 9th Street, Right on 9th Street, immediate left on Bank Street to Commonwealth Park Suites Hotel.

From the North: I-95 South to 3rd Street Exit. 3rd Street to Franklin Street, Left on to Franklin Street to 9th Street, Right on 9th Street immediate left on Bank Street to Commonwealth Park Suites Hotel.

From the South: I-95 North to I-195 Downtown Expressway. Exit Canal Street, make right on 9th Street, Right on Bank Street to Commonwealth Park Suites Hotel.

From the East: I-64 West, take the 5th Street Exit, 5th Street to Franklin Street. Left onto Franklin Street, Right on to 9th Street, immediate left onto Bank Street to Commonwealth Park Suites Hotel