COMMONWEALTH of VIRGINIA

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Office of Licensing
Licensing Regulations Overhaul (12VAC35-105)
REGULATORY ADVISORY PANEL
DRAFT MINUTES

Tuesday, October 22, 2019
Tuckahoe Library
Henrico, VA 23229
10:00 A.M. – 2:00 P.M.

TIME	ITEM
10:00 AM - 10:15 AM	**I. Welcome** – *Jae Benz* **II. Review of Minutes and Agenda** At 10 a.m. Jae Benz welcomed members, reviewed the agenda, and asked for introductions. Christy Evanko asked for two amendments to the minutes for the September 26, 2019, meeting to reflect that she was not representing VCARD, and that she had asked if could add back into the draft the licensure for ABA clinics. John Cimino asked for a correction to reflect his presence in September rather than Heidi Lawyer. With those corrections the minutes were accepted.
10:15 AM – 11:30 AM	**III. Further Clarification of Certain Identified Issues** Sections 180, 190, 200 Emergency preparedness **Emergency Preparedness** At 10:08, Ms. Benz turned the discussion over to Craig Camidge, Director, DBHDS Office of Emergency Management, to address some questions from the last meeting about the draft language for emergency preparedness. Mr. Camidge welcomed feedback from the RAP members and highlighted a couple related issues. He stated that emergency management has moved forward in health care only in the past several years, largely due to a significant CMS regulatory rewrite that affected not only hospitals and trauma centers but also ICF/DD, dialysis centers, home health, etc.[1]

[1] On September 8, 2016 CMS published in the Federal Register the *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule*. The regulation became effective November 16, 2016. Health care providers and suppliers affected by this rule were to be compliant and implement all regulations one year after the effective date,

He did a crosswalk of the current regulations to the draft and found 37 substantive changes including 10 changes to remove redundant or incorrect language. Some things were reordered and restated with standard emergency management industry language, with the overall goal to make it possible for providers to conduct business while facilitating structures to be in place to support each individual to survive an emergency.

Mr. Camidge stated his review of the RAP comments from September indicated most of the changes were seen as overly prescriptive, which is not his goal; rather, the goal is to set the standard and then leave room for providers to be creative on how that is met. He opened the floor for discussion. Issues raised included:

1. Language regarding the use of landline telephones and the associated cost with multiple locations. Mr. Camidge stated having a 'redundant ability' to communicate is the critical issue when primary means fail.
2. Clarity with the use of 'policy' versus 'procedure.'
3. Need to define 'personally identifiably information' and 'protected health information.'
4. Request for samples of MOUs. Any emergency plan should be reviewed at least annually. Whether an MOU or an internal policy or procedure, the important issue is to put thought into the steps to take, and it is documented to carry out those decisions. It is also important to state the risks for each individual and scenario.
5. Consider the possibility of less prescriptive language that talks about the development of a conceptual framework to outline the process, similar to hospital discharge protocols; that the department and CSBs will have coordinated response plans which includes certain elements.
6. Remove the language on communication with the media from the emergency response section.
7. Succession planning is a term used in emergency management and is closely related to delegation of authority. It includes mission essential functions to keep people alive and some responsibilities cannot be delegated. The succession plan template is a simple table, and ideally is three people deep. There will need to be good guidance of how to meet these standards. When the department provides the template, it becomes easy. Also, delegation of authority involves a vulnerability analysis that is a critical part. There is a template that allows a simple way to conduct the analysis in 90 minutes. It needs to be appropriate to the setting. Consider if such language should be in disability-specific chapters.
8. Clarification on current language that states: 'This section doesn't apply to home and noncenter based services.' A group home is not a center based service, but it is referring to a service that is provided in the home like intensive in-home.

on November 15, 2017. On September 30, 2019 CMS published in the Federal Register the *Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care Final Rule* which revised some of the emergency preparedness requirements for providers and suppliers. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html#main_content.

Sections 180, 190, 200

Ms. Benz reported that the Office of Licensing had received some comments to date through the public comment forum on Town Hall, but asked members to please remember that this is the initial draft. She wanted it distributed this early in the development process because the comments are helpful; there will be a number of other opportunities for comment. [Ms. Benz also reminded members that the regulatory action related to compliance with the US DOJ Settlement Agreement with Virginia is in the proposed stage of the standard adoption process and the required 60 day public comment period will be open from November 11, 2019 – January 10, 2020. Emily Bowles noted that a lot of changes were made from the language in the emergency regulation to this proposed stage language based on comments provided.]

Ms. Bowles reviewed some of the issues that, from comments received at the first RAP meeting, needed more research in these sections. The Office of Licensing will first decide on the outcomes the office is looking for and edit the language based on that research. The goal is to 'raise the bar' but not be overly burdensome.

Susan Puglisi explained where language came from in the draft development. During the last meeting, members expressed concerns and had questions about where language within these sections came from. Two handouts were distributed: one with substance abuse regulation from Massachusetts, and the other from the DBHDS Childrens Residential Regulation (12VAC35-46). Section 180-190 were modeled from Massachusetts, but modified for a general chapter and for Virginia, as staff felt they expressed best practices. But, Ms. Puglisi reiterated that this was a first draft, and staff are more than willing to hear feedback and concerns, and expertise in regard to the best way to edit the draft regulations to make them less burdensome but move towards best practices.

Members made suggestions and continued the discussion:

- Perhaps staff could amend the draft in regard to the executive director/administrator that articulates that the staff person knows what they are doing and have the regulations be focused on competencies (rather than how a provider needs to be structured).
- Possibly edit around how to demonstrate, and continue as, a high quality agency.
- Demonstrating experience and whether to provide official transcripts.

Ms. Bowles concurred with the members comments that comments about competencies makes a lot of sense. The concern is that the Office of Licensing sees instances of some providers that hire consultants on the front end to develop policies and leave after the business is established. In these circumstances providers can be left vulnerable when they do not understand what the policies are based on or require when the consultant is no longer in the process.

- Management/administrative expertise versus clinical expertise.

Ms. Bowles stated that a takeaway from the last meeting were two big sticking points: having a title, and having the education requirements. She asked members whether, if it were amended, would there still be concerns of having someone tasked with and having something other than an executive director.

- Members made the point that it was important not to have language that would disallow CSB executive directors around certain portions of the performance contract with DBHDS.

- Using the same language across all disabilities could cause liabilities for certain providers.
- Concern about any assumption that a provider needs to be more than one person.
- Important to consider if the regulations will support provider development and growth in underserved areas. Consult other offices within the department on the drafts.
- Define 'premises' if fulltime executive director is to be on premises.

Discussion continued.

11:30 AM - 12:00 PM	**IV.**	*BREAK to collect lunch*
12:00 PM – 1:30 PM	**V.**	**Discussion of Planned Disability-Specific Chapters** Developmental Disability, Mental Health, Substance Abuse, and possibly Dual-Diagnosis (DD and MH)

Ms. Benz provided a handout, explaining that staff wanted to focus on what members concerns would be about dividing the regulation by disability and how to ensure that no one would be excluded from needed services. Ms. Walker reiterated that the discussion was very preliminary as no draft had been initiated yet.

Members provided expert feedback on the topic and reviewed the handout. The result was that most members felt the chapters needed to be organized based on level of care and service, with subsections that repeat across those levels – definitions, staff, client records, etc. Ms. Puglisi stated feedback on what kind of subsections would occur would be appreciated.

- Individuals do not operate in a vacuum, concern on how to address those with dual diagnosis.
- Whether to have a chapter for co-occurring. There are services that overlap across disability categories. 65% of individuals with a DD diagnosis have a mental health diagnosis.
- There are some important differences per population. There is a history and philosophy behind those services and populations.
- How to address staff-specific sections if organized by service (repetition). Perhaps have a general section for the service and then disability-specific sections following.
- The goal is to define what a provider needs to do to be licensed for a particular service.

Dev Nair explained that there is also a push to align with the ARTS Waiver, to follow ASAM level of criteria, and staff are looking to see if the Licensing Regulations can align with those care criteria. The question is how to build in level of care criteria for substance abuse criteria when mixed in with MH and DD; it got a little confusing to do in one section. That is not the only reason, but that was another reason why it felt difficult to do in single chapter.

- CSBs have all statutes in one place, making it clear what had to be done to be a CSB, and all funds were tied to specifics. It isn't clear what would be gained by separating out by disability in the regulations.

Jae Benz gave an example: If a provider has in home, for DD the service would look a certain way; but BH in home has to be based on two evidenced-based models.

- Organizing by service makes sense because the service is the service, but if it is organized differently because it is provided for a particular population, then it is a different service.
- Sometimes a service description is the same, but with a new name it is possible to charge more (rate structure issue). Providers know what it is and know what it isn't; it can be called anything you want.
- It is more common in other states that have regulations comparable to service-specific rather than population specific.

Susan Puglisi stated that in her research, the chapters in other states seemed to be organized based on disability as staff have initially proposed, and then subdivided by service. That is why it is what we suggested because it is so common.

- Virginia is one of few states left that has all disabilities in one agency.
- It is more likely that the skill set that the provider brings to the table is one that is more easily translated to a different population.
- Perhaps add 'settings;' or 'duration' or 'intent' of a service.

Discussion continued.

1:30 – 1:45 p.m. **VI. Review: Prioritized Issues**

Attendees were asked if there was anything last thought about the initial draft general chapter.

- Any recognition of CARF, or perhaps different standards if a provider has a certain accreditation.

Dev Nair stated some states have 'deemed accreditation.'

- Jennifer Fidura gave Jae Benz a short draft of potential language for succession planning (not emergency management-related), that could be an expectation in the regulations.
- Clarity around 'comprehensive' in regard to initial assessments. Changes in 'licensing' notifications to 'licensure' notifications, and response times. Also, on p.22, that providers receive something back.

- VACBP providers asked for some time between when the regulations are officially adopted and the effective date.
- Clarity of language of 'onboarding' versus 'orientation,' as some agencies orient employees and onboard individuals.

VII. Adjournment

Ms. Benz thanked the members for all of the helpful discussion. There being no further business, the meeting was adjourned at 1:30.

(same) **Attachment 1:**	Tracking Chart Initial Draft: Response to Periodic Review ('Overhaul')

- **NOTICE: A 30-day public comment period on the draft opened September 30, 2019 until 11:59 p.m. on October 31, 2019.** Online comments on the initial draft may be viewed at https://townhall.virginia.gov/L/ViewNotice.cfm?GNid=1027). Comments were also received via email, fax, or hard copy mail to the Office of Licensing.

Regulatory Advisory Panel Membership and Staff (updated 10/22)

TYPE	Region	First Name	Last Name
CSB Exec	1	**1. Jane**	**Yaun**
Service-Group Home	1	**2. Tina**	**Martina**
Service-MH	1	**3. Mark**	**Gleason**
CM	2	**4. Phil**	**Caldwell**
Service-ICF	2	**5. Julie**	**Dwyer-Allen**
Peer	3	**6. Robin**	**Hubert**
Service-Day Support	3	**7. Leslie**	**Ewald**
Service-DD	3	**8. Kim**	**Taylor**
Indl	4	**9. Mary**	**McAdam**
Indl-AR	4	**10. Nickie**	**Brandenburger**
Prof-LBA	4	**11. Christy**	**Evanko**
Service-SA	4	**12. Candace**	**Roney**
Prof-LMHP	5	**13. James**	**Strickland**
Prof-QI/RM specialist	5	**14. Melissa**	**Constantine**
Agency Partner-VBPD	Statewide	**15. John**	**Cimino**
Agency-Partner-DHP	Statewide	**16. Elaine**	**Yeatts**
Agency-Partner-DMAS	Statewide	**17. Sue**	**Klaas**
Agency-Partner-DMAS	Statewide	**18. Teri**	**Morgan**
Association	Statewide	**19. Mindy**	**Carlin**
Association	Statewide	**20. Jennifer**	**Faison**
Association	Statewide	**21. Jennifer**	**Fidura**
Service-Sponsored Res.	Statewide	**22. John**	**Weatherspoon**
Behavioral Health and Private Hospitals	Statewide	**23. Jim**	**Newton**
DBHDS Staff	CLRA	**24. Dev**	**Nair**
DBHDS Staff	OL	**25. Jae**	**Benz**
DBHDS Staff	OL	**26. Emily**	**Bowles**
DBHDS Staff	OL	**27. Mackenzie**	**Glassco**
DBHDS Staff	ORA	**28. Ruth Anne**	**Walker**
DBHDS Staff	ORA	**29. Susan**	**Puglisi**
DBHDS Staff	OHR	**30. Deb**	**Lochart**
DBHDS Staff	OHR	**31. Taneika**	**Goldman**