# COMMONWEALTH of VIRGINIA

## *STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES*

**REGULAR MEETING**
**9:00 a.m., Wednesday, July 15, 2020**

NOTE LOCATION: **James Monroe Building**
**Conference Rooms C-D-E**
**101 N. 14th Street**
**Richmond, VA 23219**

- The meeting will be held electronically, in accordance with language in Item 4-0.01 g. of Chapter 1283 of the Acts of Assembly, 2020 Virginia General Assembly, Article 5 the Bylaws of the State Board, and the Virginia Freedom of Information Act (FOIA).
- To observe and listen to the meeting: **See full instructions below the agenda on the last two pages**. It is possible to listen only using a phone, or listen and view online via a computer.

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*Standing committee meetings are deferred until a later date.*

**DRAFT AGENDA**
via Google Meets or phone only, at 9:00 a.m.

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| **1.** | 9:00 | **Call to Order and Introductions** | Elizabeth Hilscher<br>*Vice Chair* | |
| **2.** | 9:05 | **Approval of July 15, 2020 Agenda**<br>➢ *Action Required* | | |
| **3.** | 9:10 | **Office Elections (per Article 4, Bylaws)**<br>**A. Temporary Passing of the Gavel**<br>**B. Report of the Nominating Committee**<br>**C. Election of Officers**<br>➢ *Action Required*<br>**D. Passing of the Gavel to New Chair** | Sandra Price-Stroble<br>*Nominating Committee Chair* | |
| **4.** | 9:25 | **Approval of Draft Minutes**<br>**A. Regular Meeting, December 11, 2019**<br>➢ *Action Required*<br>**B. Emergency Meeting, April 2, 2020**<br>➢ *Action Required*<br>**C. Nominating Committee, June 3, 2020**<br>➢ *Action Required: Committee Members only* | *Chair* | **p.3**<br>**p.14**<br>**p.22** |
| **5.** | 9:35 | **Public Comment** (*3 minute limit per speaker*) | | |
| **6.** | 9:55 | **Commissioner's Report** | Alison Land, FACHE<br>*Commissioner*<br>Heidi Dix<br>*Deputy Commissioner* | |

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| | | | *Quality Assurance, Government, and Regulatory Affairs* | |
| **6.** | 9:55 | **Regulations**<br><br>**A. Initiate Final Stage (Action 5091): Allowing a grace period for documentation of ISPs, to Amend Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services [12 VAC 35-105]**<br>➢ *Action Required: Initiate Final Stage*<br><br>**B. Response to Periodic Review: Requirements for Virginia's Early Intervention System [12 VAC 35□225]**<br>➢ *Action Required: Initiate Fast Track Action*<br><br>**C. Emergency Actions (per Item 318.B. of the 2020 Appropriation Act) to Amend**<br>○ **Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services [12 VAC 35 □ 105] and**<br>○ **Regulations for Children's Residential Facilities [12 VAC 35 □ 46]**<br>➢ *Action Required: Adopt emergency/NOIRA actions*<br>**1. Emergency Action: Addition of ASAM Criteria [12 VAC 35 □ 105]**<br>**2. Emergency Action: Addition of ASAM Criteria [12 VAC 35 □ 46]**<br>**3. Emergency Action: Amendments for Enhanced Behavioral Health Services**<br><br>**D. General Update – Regulatory Matrix and Workplan** | Ruth Anne Walker<br>*Director, Office of Regulatory Affairs*<br><br>Emily Bowles<br>*Assistant Director for Licensing, Quality, Regulatory Compliance, and Training*<br><br>Catherine Hancock<br>*Part C Administrator*<br><br>Emily Bowles<br><br>*(handouts)* | **p.23** |
| **6.** | 11:45 | **BREAK** to collect lunch | | |
| **7.** | 12:15 | **DBHDS Updates** | *Select DBHDS Staff* | |
| **8.** | 1:30 | **Update on the Virginia Association of Community Services Boards (VACSB)** | Jennifer Faison<br>*Executive Director* | |
| **9.** | 2:00 | **Miscellaneous**<br>**A. Board Liaison Reports**<br>**B. Quarterly Budget Report** | *(handouts)* | |
| **13.** | 2:15 | **Other Business** | | |
| **14.** | 2:30 | **Adjournment** | Chair | |

**NEXT MEETING: The next meeting of the State Board will be on Wednesday, October 14, 2020, at a location to be decided. The last meeting of 2020 will be on December 2nd.**

**STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES**

***DRAFT MEETING MINUTES***

**REGULAR MEETING**

**Wednesday, December 11, 2019**

**9:30 a.m. – 2:00 p.m.**

DBHDS Central Office, 1220 Bank Street, 13th Floor Conference Room,
Richmond Virginia 23219

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| **Members Present** | Paula Mitchell, **Chair**; Elizabeth Hilscher, Vice Chair; Rebecca Graser; Jerome Hughes; Moira Mazzi. |
| **Members Present via Telecom** | Djuna Osborne. |
| **Members Absent** | Jack Bruggeman; Varun Choudhary; Sandra Price-Stroble. |
| **Staff Present** | Alexis Aplasca, MD, Chief Clinical Officer<br>Heidi Dix, Deputy Commissioner, Division of Compliance, Legislative, and Regulatory Affairs (CLRA)<br>Tiffany Ford, Director, Office of Management Services<br>Lisa Jobe-Shields, Assistant Commissioner, Division of Community Behavioral Health<br>Emily Lowrie, Senior Policy Analyst, CLRA<br>Josie Mace, Financial and Policy Analyst, Office of Budget Development, Finance Division<br>Susan Puglisi, Regulatory Research Specialist, Office of Regulatory Affairs<br>Ruth Anne Walker, Director of Regulatory Affairs and State Board Liaison |
| **Guests Present** | Deirdre Johnson, Director, VOCAL Virginia; Elizabeth Bouldin-Cloptin; Heather Orrock. |
| **Call to Order and Introductions** | At 9:31 a.m., Paula Mitchell, Chair, called the meeting to order and welcomed everyone. Ms. Mitchell reported that the board's thoughts were with two board members who are not able to be here as planned, Sandra Price-Stroble and Jack Bruggeman. |
| **Approval of Agenda** | *At 9:33 a.m. the Board voted to adopt the October 9, 2019 agenda, including an amendment requested by Ms. Mitchell to move Items A, B, and C of #13 under Miscellaneous to be before the Legislative and Budget update in order to allow the quorum to be maintained for action items before the Vice Chair had to leave at 1:30 p.m. On a motion by Jerome Hughes and a second by Moira Mazzi, the agenda with amendment was approved unanimously.* |
| **Approval of Draft Minutes** | **Regular Meeting, October 9, 2019**<br>*At 9:35 a.m. on a motion from Beth Hilscher and a second by Becky Graser, the Board approved the minutes of the October 9 minutes.* |

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| | Ms. Mitchell requested members make note of questions during presentations until the speakers are finished and then ask questions, with the exception being if a clarifying answer is needed in order to continue to understand what is being presented. |
| **Quarterly Budget Report** | At 9:36 a.m., members reviewed the quarterly budget report. |
| **Public Comment** | At 9:43 a.m., Ms. Mitchell welcomed Ms. Deirdre Johnson, Director, VOCAL Virginia. Ms. Johnson provided perspective on the status of the Behavioral Health Redesign initiative. She stated that while she was very excited about Behavioral Health Redesign, she also had a lot of concern. Peers are supposed to be embedded in 60% of service design, but they can't be if services aren't working as intended or funded as needed. Other issues of concern are barrier crimes for peer recovery specialists (PRS), and understanding of the role of PRS versus other professional clinical services.<br><br>Virginia cannot have successful Behavioral Health Redesign if peer and family support are embedded throughout the service array, yet we have not made the effort to ensure the service is working as it should be, as well as being properly funded.<br>• Peer services are not currently working as intended due to burdensome documentation and supervision requirements, peers having lived experience and neglecting the fact that this often comes with criminal justice involvement in the form of barrier crime convictions, lack of understanding of the CPRS role, and inappropriate reimbursement rates.<br><br>Virginia needs a robust system of peer professionals to address the Extraordinary Barriers List, provide appropriate resources in discharge planning, and assist peers transitioning back to their communities. For this to happen, Virginia must:<br>1. Address the issue of barrier crimes.<br>2. Amend regulations to align with other credentialed providers.<br>3. Raise the reimbursement rate.<br><br>Additionally, peer respites are a wonderful alternative to hospitalization and would also provide a large cost savings for Virginia, as well as higher percentages of Emergency Department diversions.<br><br>A robust rate is needed, but in the Mercer presentation the week before, there was not information on the peer rate; yet a reimbursable rate of $26/hour is unacceptable. Ms. Johnson also mentioned a DHHS case study from 2014 regarding peer services within the service array, which speaks to the General Assembly's focus on 'low hanging fruit' for cost savings as the use of peers in the system result in savings. Ms. Graser asked what an appropriate rate would be. Discussion continued by Ms. Graser, Ms. Hilscher, and Ms. Mitchell.<br><br>Ms. Graser asked if peer respite was discussed in the Behavioral Health Redesign meetings. Ms. Johnson stated she had requested it multiple times, |

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| | but it is not yet an evidenced base practice (EBP). However, she wondered why not peer respite, if they are looking at intensive outpatient.<br><br>Ms. Mitchell asked staff if there would be a way of keeping track of the bills and budget amendments related to Behavioral Health Redesign and peer recovery issues. Staff confirmed the board would receive regular updates.<br><br>Ms. Mitchell thanked Ms. Johnson for taking time to come to the meeting and expressed appreciation for her perspective. |
| **Resolution Presentation** | At 9:53 a.m. on behalf of the State Board, Ms. Mitchell presented a resolution of appreciation to former board liaison Will Frank for his five years of services as the commissioner's designee as State Board Liaison in addition to serving as the Director of Legislative Affairs. |
| **Annual Executive Summary** | *At 10:10 a.m. after review by the members, the chair approved for submission to the Governor and the General Assembly the draft annual executive summary, with one correction of the December meeting dates as noted by Ms. Hilscher.* |
| **State Human Rights Committee** | At 10:11 a.m., Deb Lochart presented the recommendation of the State Human Rights Committee to reappoint Timothy M. Russell. *On a motion by Mr. Hughes and a second by Ms. Hilscher, Mr. Russell was appointed unanimously.* |
| **Commissioner's Report** | At 10:13 a.m., Ms. Mitchell welcomed Heidi Dix, Deputy Commissioner for Compliance, Legislative, and Regulatory Affairs (CLRA) to present the report for Acting Commissioner Mira Signer who was unable to attend as expected due to illness. Ms. Mitchell expressed regret that Ms. Signer was not present as this would have been the board's last time seeing her as Acting Commissioner before the new commissioner starts on Monday, and the board wanted to express on behalf of the board sincere appreciation for all she handled during this interim period. Ms. Dix was asked to convey those sentiments to Ms. Signer.<br><br>Ms. Dix presented a range of updates from the department as follows:<br><br>**Leadership changes**<br>• New CIO Robert Hobbleman started on December 9, 2019; he comes to DBHDS after 25 years at VDSS.<br>• Two deputies, Daniel Herr and Laura Nuss, were departing on December 13, 2019. Acting deputy commissioners have been identified as Dr. Michael Schaefer and Heather Norton, respectively.<br>• New Commissioner Alison Land was starting on December 16, 2019.<br><br>**DOJ Settlement Agreement with Virginia**<br>Four main areas of the Settlement Agreement |

1. Serving individuals with DD in the most integrated setting and building quality community-based alternatives for individuals, particularly individuals with complex needs.
2. Quality and risk management system, including monitoring and evaluating services, and implementing quality improvement processes at an individual, provider, and state-wide level.
3. Transitions from training centers/enhancement of community services.
4. Supporting independent housing and employment options for individuals with DD.

Timeline

- Per the Agreement, the Commonwealth must demonstrate compliance with all provisions no later than June 30, 2020.
- And for each provision, compliance is then maintained for a period of not less than 12 months.
- The Agreement contemplated to conclude no later than June 30, 2021.

What remains to be done

- Expand provider capacity.
- Improve provider competency in the short-term and have personnel capacity for on-going remediation needs.
- Stand up missing elements of the home and community-based services (HCBS) quality assurance and improvement system.
- Manage performance to achieve performance metrics for the Quality Assistance/Quality Improvement system.
- Establish authority and methods to collect outcome data.
- Procure information management tools, and capacity to store, manage, analyze, and report data.

In terms of meeting specific provisions, Virginia has met approximately 65% of provisions to date. Of the remaining provisions to meet:

- Section III – Integrated Settings (21 provisions).
- Section IV – Training Center Discharge Planning and Transition (on hold – 6 provisions).
- Section V – Risk Management, Quality and Improvement (26 provisions).
- Section IX – Document Library.

Where we are now:
In order to determine whether we are meeting the remaining provisions, the judge ordered the parties to determine specific indicators and then those indicators will be the basis for determining compliance. Virginia has been negotiating with DOJ, as ordered by Judge Gibney, to develop compliance indicators for the provisions of the Settlement Agreement with which the Commonwealth has not yet found to be in compliance. The compliance indicators are not a renegotiation of the agreement but rather are steps and metrics the parties agree the Commonwealth must take to reach compliance.

Judge Gibney directed the parties to file on December 9, 2019, a list of provisions that we have agreed upon. For the provisions upon which we are unable to agree, a hearing will be held on January 7, 2020, and the Court will establish compliance indicators. To date, Virginia has agreed with DOJ on compliance indicators for 30 provisions and 13 that we are still negotiating.

Ms. Hilscher asked if the Settlement Agreement dictated the elimination of the waiting list. She also commented on how at the annual budget hearings individuals and families pleased to get on the waiver, which should be a finite funding number that could be reached. Ms. Dix responded that the Settlement Agreement has numbers of slots per year in certain categories. However, the waiting list continues to evolve and grow. The waivers were transformed with levels of priority. Also, the cost of slots has to be balanced with the cost to raise rates periodically.

Ms. Mitchell asked if the document library would be on the agency website. Ms. Dix confirmed that it would be eventually. Ms. Graser asked if additional staff would be added to create the library, to which Ms. Dix replied that there would not be additional staff.

Ms. Mitchell asked if, for those items without agreement by the parties, could the judge arbitrarily set decisions about metrics, etc. Ms. Dix responded that he could do as he deems necessary.

**STEP VA**

Crisis Services – Mobile Crisis

DBHDS has steadily worked with CSBs to ensure sufficient planning and funding allocation plans for the $7.8 million in crisis services funding. Projected allocations for the distribution of the FY20 crisis funding was based on current crisis utilization rates for the five DBHDS regions. Budgets based on these projected allocations and plans were requested from the five regions. Two regions have plans that are in the final stages of approval, and three regions are in the process of revising their plans. Performance measures have been adopted. Upon DBHDS' approval of the regions' plans, funding will be disbursed.

Outpatient Services

The majority of funds ($7.9M) were distributed on an equal basis to all CSBs. Roughly $5M was distributed on the basis of need. A needs-based funding formula was developed based on population, outpatient FTEs, size of catchment area, treatment units provided, and overall CSB budget. CSBs were grouped into five categories ranging from low needs to very high needs; funds were distributed according to need. The five regions received $1.5M in funding for training and capacity building.

**STEP-VA Projected Activities December 2019-June 2020**

- Monitor and support implementation of Same Day Access and Primary Care Screening.
- Support CSBs in installation of Outpatient and Crisis Services.
- Utilize results of Comprehensive Needs Assessment and gather additional feedback from STAC and VACSB to improve implementation process.
- Collaborate with the Executive and Legislative branches to acquire funding for STEP VA implementation, infrastructure and oversight resources at DBHDS Central Office and infrastructure at CSBs.

Ms. Mitchell mentioned the report from CSBs in October about the impact of Medicaid expansion and asked if DBHDS had identified the most needy CSBs in that regard. Ms. Dix responded that for FY19, the agency distributed $7M to plug holes. For FY20, the amount is down such that it is basically zero, but it varies by CSB.

**Hospitals**

The average census for all state hospitals (excluding the Commonwealth Center for Children and Adolescents (CCCA) and maximum security at Central State Hospital) for the week of October 21, 2019, was 96%. Three hospitals were at 100% or above capacity by the end of the week to include Piedmont Geriatric Hospital (PGH) (102.4%), Eastern State Hospital (ESH) (100.3%), and CCCA (102.1%). Census increases at CCCA are particularly challenging due to the high pressure placement needs for this special population.

DBHDS continues to work with CSB emergency services, private hospitals, law enforcement and other partners to facilitate the best possible outcomes given the situation. There is ongoing work to support the facility directors and identify short- and long- term solutions.

**Western State Addition**

Ms Dix reported that a detailed timeline regarding Western State Hospital (WSH) and the delay in construction of 56 beds would be forwarded after the meeting (addendum: see below). Based on this timeline DBHDS is taking the following actions:

1. Procurement review of the contract, terms and agreements, and associated documents to identify missed opportunities for mitigation and dispute resolution.
2. External consultation request for DBHDS Office of Architecture and Engineering (OAE) departmental oversight and management of capital projects.
3. DBHDS review of all capital projects awarded to the identified OAE Firm.
4. DBHDS review of internal and external communication processes related to capital projects progress and outcomes.

**WSH Lessons Learned**

1. Maintain familiarity with the schedule as shown in the contract documents:
   a. Document discussions on the schedule.
   b. Clearly document reasons for changes to the schedule.
   c. Schedule changes to be formally incorporated into the contract by change order.
2. Formalize any issues or changes by keeping a written record.
3. Any changes to the contract should be documented through a change order or formal correspondence.
4. Communicate issues that may impact project delivery, budget to the appropriate agency and facility personnel, as well as to leadership and above. Include steps taken to remediate the problem/issue.

| | 2016 Planning Schedule | Actual Schedule | Comments |
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| Award A/E Contract | 1/26/2017 | 4/13/2017 | 1. The 2016 planning schedule was based on two assumptions:<br>o The existing patient wings could be replicated without the submission of new calculations and existing waivers would cover the new work.<br>o A single submission to DEB for each phase of the design would be sufficient, subject to the current code.<br>2. Once DGS clarified expectations with the A/E Firm in April 2017, the planning schedule was rendered invalid. |
| DEB Approval of Schematic Drawings | 4/27/2017 | 8/03/2017 | Schematic Drawings were submitted within reasonable timeframe given the April 2017 A/E Contract award. |
| DEB Approval of Preliminary Drawings | 8/3/2017 | 7/10/2018 | 1. Preliminary Drawings were submitted multiple times for DEB review to accommodate requests for new calculations related to occupancy load, mechanical and physical plant systems, as well as waivers and cost estimates by owner.<br>2. DBHDS requested a new A/E Firm Project Manager due to timeliness and submission concerns. |
| DEB Approval of Working Drawings | 2/9/2018 | 10/15/2019 | Working Drawings required additional effort including but not limited to:<br>1. Evaluation of cooling system and design of new cooling tower (7mos);<br>2. Design and approval of additional parking (2mos);<br>3. Submission of waivers and engineering judgements for fire alarm system, locking assemblies, etc… (5 mos). |
| Bid and Award Construction | 3/23/2018 | 12/15/2019 | DBHDS was given authority to solicit construction bids. Documents were distributed to five (5) pre-qualified bidders for pricing. Bids are were on |

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| Contract (30 days) | | | November 13, 2019. They are currently under evaluation. |
| Construction Complete | 4/29/2020 | 4/30/2021 | Based on a 437 day construction period, it is anticipated that the project will obtain substantial completion mid-April, 2021. Final completion is to be achieved 30 days later. |

Ms. Hilscher stated that the code change during that time made it difficult. She expressed sadness at the loss of time. Ms. Dix stated that there was one, then one right about the time of the approval, which made it really messy for a very step-wise process.

**Individual and Family Support Program (IFSP) Data Breach**

The IFSP Funding Program provides financial assistance to individuals and families awaiting services through one of Virginia's Developmental Disabilities waivers. Individuals on the waitlist may apply for financial assistance to cover eligible costs that support continued living in an independent setting.

- On October 1, 2019, personal information of some applicants for Individual and Family Support Program (IFSP) funding may have been seen by other applicants through the IFSP Funding Portal. Personal information of some applicants may have been visible to other applicants who were logged into the IFSP Funding Portal. The personal information that was visible to other applicants includes name, mailing address, email address, phone number, date of birth, or the last four digits of a social security number; full social security numbers, driver's license numbers, credit card numbers, health diagnoses, insurance information, and banking information were not visible to other applicants at any time.
- DBHDS discovered the breach within 16 minutes after the IFSP Funding Portal was opened to receive applications and immediately took the Portal offline. A number of steps have been taken to investigate this breach and prevent any potential harm to applicants. In addition to taking the IFSP website offline, DBHDS technical staff and the Virginia Information Technologies Agency have examined incident data to determine the cause of the data breach and correct identified issues and are implementing measures to restore the IFSP Portal to a secure, operational state.
- DBHDS has contacted all impacted individuals and provided additional information via postal mail.
- There were 1,439 total letters offering all affected individuals free credit monitoring services for up to two years.
- In addition, numerous updates were posted on the IFSP listserv to update all applicants on the situation and instruct on what steps applicants should take to continue the process of applying for IFSP funds.

Ms. Mitchell state that with all the leadership changes it might be helpful when everything had settled in to get a current organizational chart for the

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| | department. Ms. Dix mentioned there was also an organizational report to the General Assembly coming soon that could be provided.<br><br>Ms. Mitchell also inquired about the website as given the tasks the department has, to work around the issues with the website is an additional challenge. Ms. Dix concurred that it had been two years and needs to be fixed; efforts were underway to begin in the near future.<br><br>Ms. Mitchell thanked Ms. Dix for her time and stated the board really appreciated the presentation. |
| **Regulatory Actions and Updates** | **A. Authorization of Request for Emergency Extension (12VAC35-105): Compliance with Virginia's Settlement Agreement with US DOJ**<br>Ms. Mitchell asked for a motion to authorize the request to the Governor to extend the emergency regulation while the standard process is completed as the action for permanent adoption just finished the proposed stage 60-day public comment period and will not be completed in time (this is not unusual).<br><br>*On a motion by Ms. Hilscher and a second by Ms. Mazzi, the request was authorized.*<br><br>**B. Status Report on Families First**<br>Ms. Mitchell recalled to members that the Office of Licensing provided information previously on the changes coming as a result of the federal Family First Prevention Services Act (particularly in section Title IV–E) to begin certifying Children's Residential Facilities as Qualified Residential Treatment Programs (or, QRTPs). So with us again today is Emily Bowles, Assistant Director for Licensing, Quality, Regulatory Compliance, and Training.<br>C. General Update – Regulatory Matrix<br>Ms. Walker reviewed the regulatory matrix and the workplan handout. |
| **Performance Contract and Other OMS Updates** | At 11:19 a.m., Ms. Mitchell welcomed Tiffany Ford, Director, Office of Management Services.<br><br>Ms. Ford provided two handouts and gave an update on the recent reformation of the office and on the performance contract structure and process.<br><br>Ms. Mitchell asked Ms. Ford to give an example of how a project starts. Ms. Ford used the example of a federal grant. Her staff thinks of how the funds might be better utilized, they meet with the lead staff and find out what the lead office needs. Ms. Walker stated that the office provides a service that is much need to 'connects the dots' and does excellent work.<br><br>Regarding the performance contract, it is a working document based on a relationship with the community services boards. |

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| | Ms. Hilscher was grateful for the performance contract document for use when the Policy and Evaluation Committee reviews the related policy.<br><br>Ms. Mitchell thanked Ms. Ford behalf of the Board for being willing to put off the presentation from October to December to allow time for both Western and CCCA's presentations and tours. |
| **Committee Reports** | **A. Policy and Evaluation Committee**<br>At 11:40 a.m., Emily Lowrie, Senior Policy Analyst, reported that the Policy and Evaluation Committee was not able to have a quorum that morning but the committee submitted three policies in the packet for the Board's consideration:<br>• Policy 1016 (SYS) 86-23 Policy Goal of the Commonwealth for a Comprehensive, Community-Based System of Services<br>• Policy 1028 (SYS) 90-1 Human Resource Development<br>• Policy 1035 (SYS) 05-2 Single Point of Entry and Case Management Services<br>*On a motion from Mr. Hughes and a second from Ms. Graser, the revisions were approved.*<br><br>**B. Planning and Budget Committee**<br>Ms. Walker reported on the activity of the committee meeting on standing items including:<br>• Two staff from of the Office of Fiscal and Grants Management, Deputy Director Eric Billings, and Federal Grants Manager Ramona Howell, gave an overview of grants managed by DBHDS.<br>• Meghan McGuire, Senior Advisor for External Affairs, had reported in advance of the meeting on the status of DBHDS strategic planning efforts stating that work had been on hold so as not to get ahead of Commissioner Land. However, it is a five-year plan and the board is always welcome to choose something for elaboration by staff at any point.<br>• Ms. Walker reported confirming with leadership the primary contacts for the two prioritized updates in April (geriatrics and workforce).<br>• The state board quarterly budget report was included in the board meeting packet.<br>• The committee reviewed the budget priorities with the presentations planned for 2020 board meeting dates.<br>There was no request for action for the board from the committee. |
| **Lunch** | At 11:50 a.m., Ms. Mitchell suspended the meeting so that members could collect lunch. |
| **Behavioral Health Redesign** | At 12:09 p.m., Alexis Aplasca, MD, Chief Clinical Officer, presented on the Behavioral Health Redesign, and explained the differences between it and STEP-VA (population and services) and how the two initiatives complement each other. A seven-page handout was provided with details.<br><br>She stated that current services are not aligned with the most recent science. The vision is of a comprehensive evidence-based, trauma-informed, cost |

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| | effective system. Another trigger for the Behavioral Health Redesign initiative now is the impact of the bed of last resort legislation, which identified gaps in the system.<br><br>PACT service rates in Virginia are embarrassingly low.<br>Childrens services need to be expanded.<br>There are some standard services that are missing from the service array.<br>Regarding STEP-VA, the percentage of Medicaid members by CSBs varies across CSBs, but the average is 50%.<br>BH Redesign is very granular in comparison to STEP-VA.<br>Individuals with a voice and choice in services have better outcomes. |
| **Update on the Virginia Association of Community Services Boards (VACSB)** | At 12:45 p.m., Ms. Walker reported that the VACSB board meeting was concurrent with the state board, but Ms. Faison had provided a handout for the board. |
| **2020 General Assembly: Budget Review** | At 1:05 p.m., Josie Mace walked through the proposals included in the Governor's Budget Document. Staff would forward a more detailed report after the meeting. Many requested items were included for DBHDS. |
| **Bylaws** | At 1:15 p.m., Ms. Mitchell turned the members attention to the bylaws revisions needed due to a change in the Freedom of Information Act, explaining that the bylaws require review every four years or when there is a code change. *On a motion by Ms. Mazzi and a second by Ms. Hilscher, the amendments were approved.* |
| **Other Business** | There was no other business. |
| **Adjournment** | The meeting was adjourned at 1:42 p.m. |

**STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES**

***DRAFT* MEETING MINUTES**

**CALLED EMERGENCY MEETING**

*Electronic Meeting

**Thursday, April 2, 2020**

**9:30 a.m.**

**The board met electronically, without a quorum physically assembled, in accordance with Code of Virginia 2.2-3708.2.A.3. and Executive Order 51. Note: Audio record available upon request.*

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**EMERGENCY MEETING**

For minutes with comments received, see:
https://townhall.virginia.gov/L/GetFile.cfm?File=Meeting\65\30870\Minutes_DBHDS_30870_v1.pdf

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| **Members Present** | Paula Mitchell, **Chair**; Elizabeth Hilscher, Vice Chair; Varoun Chaudhary; Rebecca Graser; Jerome Hughes; Moira Mazzi; Djuna Osborne; Sandra Price-Stroble. |
| **Staff Present** | Jae Benz, Director of Licensing<br>Emily Bowles, Assistant Director for Licensing, Quality, Regulatory Compliance, and Training<br>Braden Curtis, Assistant Attorney General, Office of the Attorney General<br>Heidi Dix, Deputy Commissioner, Division of Compliance, Regulatory, and Legislative Affairs (CRLA)<br>Alison G. Land, FACHE, Commissioner<br>Dev Nair, Ph.D., Assistant Commissioner, CRLA<br>Ruth Anne Walker, Director of Regulatory Affairs and State Board Liaison |
| **Call to Order, Roll Call, and Introductions** | At 9:36 a.m., Paula Mitchell, Chair, called the meeting to order and welcomed everyone. Ms. Mitchell explained that the board was meeting electronically, without a quorum physically assembled, in accordance with Code of Virginia § 2.2-3708.2.A.3. and Executive Order 51. She directed anyone interested in a full explanation of the justification and parameters of this emergency meeting to review the cover memo of the meeting packet on page 1.<br><br>Ms. Mitchell explained that all board members and staff were unmuted to converse. All others on the call were muted with the ability to listen and view the screen. The meeting packet of information was located on Virginia's Town Hall, http://townhall.virginia.gov under 'Meetings.'<br><br>Ms. Mitchell then conducted a roll call of members (Hilscher, Graser, Price-Stroble, Mazzi, Osborne, Chaudhary, Hughes), after which she confirmed that a quorum was present on the call. |

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| | Ms. Mitchell also confirmed the DBHDS staff on the call: Heidi Dix, Dev Nair, Jae Benz, Emily Bowles, Ruth Anne Walker, and Alison Land. |
| **Approval of Agenda** | *At 9:40 a.m. o,n a motion by Sandra Price-Stroble and a second by Djuna Osborne the board voted unanimously to adopt the April 2, 2020, the agenda.* |
| **Public Comment** | At 9:41 a.m., Ms. Mitchell noted that in Article 5.h. of the State Board Bylaws, it states, 'The agenda for each meeting of the board shall indicate that public comment will be received at the beginning of the meeting.' She explained that for this meeting, receipt of public comment was handled differently, while still in accordance with the bylaws. Any person seeking to make comment to the state board was given the opportunity to submit comment in writing by 5 p.m. April 1, 2020, via email.<br><br>Ms. Mitchell announced that one comment was received on the draft from the Henrico Community Services Board and that staff from the Office of Licensing summarized the comments and provided a response to the comment. This information was visible on screen, while also emailed to the board just before the start of the meeting, and a revised meeting packet with the summary of comments and response attached was made available on Virginia's Town Hall. Ms. Mitchell allowed all on the call a moment to access that information.<br><br>Ms. Mitchell asked for a motion to receive the comments into the record to be part of the meeting record and to attach to the minutes. *At 9:43 a.m. on a motion by Elizabeth Hilscher and a second by Ms. Osborne, the board voted unanimously to adopt the April 2, 2020, comments into the record.* [Note: The excerpt of the comments and the response to comments from the revised meeting packet are attached to these minutes.]<br><br>Ms. Mitchell thanked the Licensing staff for compiling that information so quickly. |
| **Regulatory Actions and Updates** | **Amendments for Final Stage (12VAC35-105): Compliance with Virginia's Settlement Agreement with US DOJ**<br>At 9:44 a.m., Ms. Mitchell directed board members to turn to the action item for this emergency meeting on page 5 of the meeting packet. She noted that the amending language for the final stage was set out in [ square brackets ] to show edits to the language adopted in the proposed stage, and that it was only those bracketed edits under consideration.<br><br>Before asking for discussion or a vote, Ms. Mitchell recognized staff from the Office of Licensing present: Jae Benz, Director, and Emily Bowles, Assistant Director for Licensing, Quality, Regulatory Compliance, and Training. Also, Dr. Dev Nair, Assistant Commissioner for the Division of Compliance, Regulatory, and Legislative Affairs was available to possibly provide comment, if needed; and liaison to the board, Ruth Anne Walker, |

staffed the meeting. Ms. Mitchell asked Ms. Benz if she would give a brief overview for the board.

Ms. Benz stated she realized the turnaround time for review by the board was expedited (March 26, 2020), but explained that the office had been working diligently on the amendments, even before the close of the proposed stage public comment period on January 10, 2020. Staff had been on schedule to get revisions to the board no later than the usual two-week delivery when the COVID-19 crisis hit full force. The crisis then took top priority and consumed a large part of the day to day work of the office. Ms. Benz expressed appreciation to the board for taking time to review the amendments within the shortened timeframe.

The amendments were made in response to public comments and due to additional, more detailed requirements agreed upon by the parties in the negotiations on the Settlement Agreement. The more detailed requirements laid out how the Commonwealth would reach compliance with each of the provisions where there is a rating of noncompliance. Some of those indicators required changes to the regulations, so the amendments are critical components to reaching Virginia's goal of exiting the Settlement Agreement. Ms. Benz stated that in fact, if the regulations were not amended, the Commonwealth could be found in violation of a federal court order. So, the board's consideration of these amendments allows the Commonwealth to address those areas that required further changes. She expressed her appreciation to the board of their consideration of the final stage amendments and asked Ms. Bowles to explain in detail.

Ms. Bowles expressed the gratitude of the office to being nearing the end of a process started over two years ago. She proceeded to review and explain in detail all final stage amendments. The changes are delineated in the Town Hall agency background document.

The most significant changes have to do with the requirements for providers to conduct a root cause analysis, systemic risk assessments, clarification related to risks of harm, documentation of informed choice, and serious incident reporting. Amendments were also made to clarify the necessary qualifications of risk management staff. In response to comment, the changes between the proposed stage and final stage of these regulations will improve clarity and reduce provider burdens, while increasing risk management and quality improvement processes at every level of the service delivery system.

In addition, sections were rearranged and broken down largely to aid in readability and comprehension. Also, clarifying amendments were added for what providers should do if an approved corrective action was not successful in correcting systemic deficiencies, in order to facilitate quality improvement. Last, in response to significant public comment, language within the Emergency Regulations related to fire inspections was stricken, and the

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| | language reverted back to as it appeared before. Language related to fire safety was added below to 12VAC35-105-530 to accomplish the intent of the amendments, that is, to ensure that all providers adhere to a basic level of fire safety precautions for the health and safety of individuals.<br><br>Ms. Mitchell thanked Ms. Benz and Ms. Bowles. She then asked members if there were any questions for the Office of Licensing. Ms. Hilscher did not have a question but expressed approval and appreciation of the edits to break out text into clear lists and otherwise clarify the information and improve comprehension. Mr. Hughes concurred. Ms. Osborne expressed appreciation for all of the work by staff including the consideration of all the public comment, and she particularly appreciated the training that would be offered so that providers would be better equipped to implement the required policies, i.e. root cause analysis.<br><br>At 10:10 a.m., Ms. Mitchell asked for a motion to adopt the edits and initiate the final stage for the amendments to Chapter 105 to comply with the DOJ Settlement Agreement. *On a motion by Ms. Mazzi and a second by Ms. Osborne,* and after a roll call vote conducted by Ms. Mitchell *(Beth Hilscher; Becky Graser; Sandra Price-Stroble; Moira Mazzi; Djuna Osborne; Varoun Chaudhary; Jerome Hughes; and the chair), the board voted to adopt the edits as presented and the final stage was approved for initiation.*<br><br>Ms. Mitchell asked that staff file the final stage as appropriate. She made note to all listening on the call that there would be a final stage public comment period as part of the final stage process. |
| **Commissioner's Report** | At 10:14 a.m., Ms. Mitchell turned the meeting over to Commissioner Alison Land to give a presentation on the current state of emergency. She asked members to make note of their questions and hold them until after the commissioner's presentation.<br><br>Commissioner Land updated the board on the DBHDS and Commonwealth of Virginia COVID-19 response, stating that the department had never seen anything like COVID-19 before that disrupted personal and professional lives on such a large-scale for such a long duration. The department spent weeks preparing and building and planning, and had reached the implementation phase which was expected to be a marathon.<br><br>The leadership urged state hospitals and public and private community providers take all necessary precautions available to keep staff and service recipients healthy and safe, but to please stay in the fight to deliver services with as full capacities as they possibly could. Without their efforts, the wave of cases to private hospitals and state hospitals likely would be overwhelming for the medical system statewide.<br><br>Ms. Land stated that Virginia's response evolved rapidly over the past four weeks. The department was pushing forward in this unprecedented situation |

to tackle unforeseen circumstances and make key operational decisions as things proceeded. This involved a tremendous amount of effort.

Statewide, Governor Northam launched a COVID-19 Task Force in the last week of March. The task force has a healthcare coordination section that would enable better coordination and collaboration between the public and private systems.

Commissioner Land identified some key examples of implementation by the department:

I. For community services boards (CSBs) and private providers:

- Developed a new COVID-19 page on the DBHDS website for providers, healthcare workers, and individuals coping with COVID-19. This includes a comprehensive set of FAQs that are updated daily at www.dbhds.virginia.gov/covid19.
- Posted new operational and functional guidance on emergency prescreening, REACH, and permanent supportive housing. There was also new guidance from DMAS surrounding the expansion of telehealth and waiving certain program requirements.
- Worked closely with DMAS on many of these issues to ensure the guidance from both agencies aligns and both agencies were taking every advantage of federal resources or waivers where it would help the CSBs and other providers continue to operate, where appropriate.
- Established weekly calls with CSBs, providers, and their associations about the COVID-19 response.
- CSBs were asked to provide daily reports on their operational status, to include employees unable to work, lay-offs, program closures, and other critical information.
- Worked with the CSB executive directors and chief financial officers to monitor their financial situation as shut downs or reduction of some of their programs began. DBHDS was using the information the CSBs were providing to discuss how Governor Northam's Administration might provide either state or federal resources to support the CSBs during this time.

II. In regard to DBHDS overall:

- Updated and posted facility visitation policies on the COVID-19 page on the agency website mentioned above.
- Immediately established the Incident Management Team (IMT) that transitioned into an emergency operations center (EOC) staffed 12 hours a day during the week.
- Accelerated the launch of a new intranet as another communication tool for human resource guidance including teleworking information.
- Significantly ramped up resources posted to Facebook and Twitter.

III. DBHDS facilities:

Facility staff pushed forward during this extraordinarily challenging time that affected healthcare workers in such a disproportionate way. The DBHDS system has unique challenges in disaster preparedness including preparedness for COVID-19. Serving as the safety net and 'bed of last resort' for Virginia's behavioral health system results in the system operating dangerously close to maximum capacity even during non-disaster times. Since March 14, 2020, DBHDS facilities implemented strict visitation policies and began screening employees prior to each shift and monitoring for associated signs and symptoms of COVID-19 in individuals receiving services in facilities.

There were currently no individuals in state hospitals with major symptoms but given the rapid spread of the virus statewide, it was not expected to possibly stay the same at state hospitals for very long. As of April 1, 2020, two staff were confirmed positive at facilities. Department leadership was working closely with all DBHDS facilities to ensure when these situations arise precautions are taken to keep safe the individuals receiving services and staff in the facilities. Staff were working to prevent possible cases and planning for what to do should there be one within the patient population. This included following federal Centers for Disease Control (CDC) guidelines for health care organizations, restricted visitation policies, further increased infection control measures, and social distancing practices with staff and patients to minimize risk of exposure. Staff were preparing for how to isolate any individuals should there be positive COVID-19 cases. DBHDS was doing everything possible to procure additional personal protective equipment (PPE), such as masks, gloves, gowns, etc., which is an extreme challenge in the national shortage of PPE. Nationwide shortages of PPE were acutely felt at the state facilities. DBHDS was collaborating with state partners to benefit from the few distributions that were taking place and was also actively preparing for impending staffing shortages as more Virginians likely fall ill.

Notably, the census for Virginia's state psychiatric hospitals serving adults remained very high at 94.5%. Because living in a congregate setting increases risk, DBHDS was taking every opportunity to decompress the hospital census and rapidly arrange for community-based services for those who could be safely discharged. State facilities were working to minimize risk of exposure to both staff and patients, and also recognized the need to be flexible in this rapidly evolving environment.

IV. Coordination with the public and private community system included:

- Working to ensure DBHDS-funded assisted living facilities and transitional housing programs can continue taking admissions.
- Using telehealth platforms and virtual tours to enable community providers to interview potential clients, and for patients to be able to see the potential placement.
- Partnering with CSBs to increase usage of crisis stabilization units as temporary placements for individuals leaving state hospitals who may not

have a permanent placement or are waiting for their permanent placement to have an open bed.
- Discussing with some assisted living and nursing homes to implement emergency contracts to expedite discharges from the state facilities.

One of the system struggles that could significantly impact the department's ability to discharge patients who were well and clinically ready for discharge was that some mental health providers in the community had significantly decreasing service availability. But overall, the census decompression facilitated the ability of state hospitals to medically isolate or quarantine any person testing positive for COVID-19 and positioned the system as optimally as possible to care for individuals in need as the private hospital system likely becomes inundated by COVID-19 cases. The department was preliminarily successful in this decompression effort in all but the geriatric population. Unfortunately, this population appeared to be most vulnerable to the current pandemic.

Finally, Ms. Land stated how impressed she was with DBHDS, CSB, and provider staff. They were all pushing forward despite uncertainty and fears, and showed unyielding commitment to those served. She further stated that all Virginians truly owed them a debt of gratitude, and DBHDS was working hard to protect them and the individuals receiving services.

Ms. Graser asked for clarification of the number of approximately 200 individuals the department hoped to discharge from state hospitals. Ms. Land explained she had referred to those on the extraordinary barriers to discharge list (those ready to be discharged but for whom a community placement could not be found).

Mr. Hughes stated he runs five recovery centers in Northern Virginia that have gone to virtual services. He asked about funding that was already allocated but in limbo and stated his concern with contract funding related to keeping staff on. Ms. Land did not have updates on that but expected information in coming days.

Ms. Price-Stroble had a question and statement related to CSBs. As she realized services are not going to be exactly the same, she shared concerns of staff and individuals receiving services on the variation of person to person contact. For instance, at some CSBs staff come out to a car to get an individual for an appointment versus some using waiting rooms, or staff sharing a break room together in close proximity. Ms. Land stated she had received a number of contacts from others with these concerns. In some instances, it is not possible to do a virtual service. Some try to do in person at least six feet apart to keep the service going. Overall, she felt CSBs were trying to do the right thing. Ms. Price-Stroble asked if they are expected to do some things with consistency across CSBs, like with waiting rooms or bringing in a child; as in getting guidance from DBHDS. Ms. Land stated

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| | she did not know of any guidance on individuals coming in and out the front door, but that DBHDS could reach out to VACSB to share that idea.<br><br>Ms. Mitchell thanked and commended Ms. Land and the department for all the outstanding work done with these amendments even with the state of emergency and the work-life changes that had occurred as a result, and the work going on in a larger sense outside of the crisis. She asked the commissioner to pass those comments on to the other staff. |
| **Other Business** | At 10:40 a.m., Ms. Mitchell reminded board members to watch for an email from her announcing appointments to the Nominating Committee and the Grant Review Committee. She further reminded members and all on the call that the next regular meeting of the board is scheduled for July 15, 2020, in Richmond and that per the bylaws, officer elections will be held at that time.<br><br>Ms. Mitchell asked if there was any other business to come before the board.<br><br>On behalf of the board, Ms. Hilscher expressed regret that the board could not be with Ms. Mitchell for the meeting that day as it was Ms. Mitchell's last meeting before her term ended on June 30, 2020. Ms. Hilscher virtually presented the gift of a plaque recognizing Ms. Mitchell's eight years of outstanding service to transform behavioral health and developmental services in the Commonwealth of Virginia. For several of those years Ms. Mitchell was chair and has been a wonderful chair; a level, good, and calm leader who made sure everyone had a chance to be heard at meetings. Ms. Mitchell has been incredibly effective, always bringing good questions to the forefront; and has an incredible wealth of knowledge about the system. She has made Virginia a better place through her work on the board. Members concurred and offered personal comments of appreciation to Ms. Mitchell for her service as a member and as chair. Ms. Mitchell thanked the board and also expressed sadness at not being able to be together. |
| **Adjournment** | There being no further emergency business, Ms. Mitchell adjourned at 10:45 a.m. |

**STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES**

**Nominating Committee**

**DRAFT MINUTES**

**9:30 a.m., Wednesday, June 3, 2020**

**The board met electronically, without a quorum physically assembled, in accordance with language in Item 4-0.01 g. of Chapter 1283 of the Acts of Assembly, 2020 Virginia General Assembly, Article 5 the Bylaws of the State Board, and the Virginia Freedom of Information Act (FOIA). Note: Audio record available upon request.*

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| **I.** | 9:30 | **Call to Order**<br>Committee Chair Sandra Price Stroble called the meeting to order. Ms. Price-Stroble explained that the Nominating Committee was meeting electronically, without a quorum physically assembled, in accordance with language in Item 4-0.01 g. of Chapter 1283 of the Acts of Assembly, 2020 Virginia General Assembly, Article 5 the Bylaws of the State Board, and the Virginia Freedom of Information Act (FOIA). She further explained that while full board meetings must have a period for public comment, there is not a public comment period during this committee meeting.<br><br>**Roll Call**<br>As required for electronic meetings, Ms. Price-Stroble conducted a roll call of members (Jerome Hughes; Paula Mitchell) and announced that a quorum was present on the call.<br><br>Ms. Price-Stroble acknowledged DBHDS staff on the call (Board Liaison and Director of Regulatory Affairs, Ruth Anne Walker). |
| **II.** | 9:31 | **Approval of June 3, 2020, Agenda**<br>*On a motion by Mr. Hughes and a second by Ms. Mitchell, the agenda was adopted unanimously.* |
| **III.** | 9:32 | **Consideration of Nominees for Slate**<br>Ms. Price-Stroble referenced that the Bylaws of the Board lay out the timeframe for the nominations and elections of officers. She asked Ms. Mitchell, as the outgoing board chair, if Ms. Mitchell had a slate of nominees for the chair and vice chair positions. *Ms. Mitchell moved to nominate Elizabeth Hilscher for the chair position and Rebecca Graser for the vice chair position. Mr. Hughes seconded the motion.* Ms. Price-Stroble recorded in roll call fashion. *The vote was unanimous to adopt the slate as presented.* Ms. Price-Stroble announced that the report of the committee would be made to the full board at the July 15, 2020, regular meeting. |
| **IV.** | 9:35 | **Adjournment**<br>Ms. Price-Stroble thanked the committee members for their time for the ad hoc committee, and adjourned the meeting. |

**Regulatory Package: Five Action Items**

**A. Final Stage: ISP Initiate Final Stage (Action 5091): Allowing a grace period for documentation of ISPs, to Amend Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services [12 VAC 35-105]**

**Background:** Providers licensed by DBHDS are currently required to review the ISP at least every three months from the date of the implementation of the ISP or whenever there is a revised assessment based upon the individual's changing needs or goals. There is no allowance for additional administrative time to document the review, as is allowed in DMAS regulations. Such administrative 'grace periods' are not uncommon.

**Purpose:** The amendments would align DBHDS and DMAS regulations as to when a quarterly review or a revised assessment of the ISP must be documented, thus allowing practitioners to follow the same process rather than two different processes. This is intended to decrease administrative burdens and allow more time to provide services.

Seventeen comments were received during the 60-day public comment period held during the proposed stage (1/20/20 – 3/20/20). The comments are posted after the draft text below; there was overwhelming support for the action. The final stage must be filed by September 15, 2020.

**Action Requested:** Initiate the proposed stage of the standard process.

| 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 | Proposed | 07/18/2019 |

**Next Steps:**
If approved, staff initiates the final stage of the standard process.

**FINAL STAGE DRAFT: Chapter 105**

ALLOWING A GRACE PERIOD FOR DOCUMENTATION OF ISPS

**12VAC35-105-675. Reassessments and ISP reviews.**

A. Reassessments shall be completed at least annually and when there is a need based on the medical, psychiatric, or behavioral status of the individual.

B. The provider shall: (i) update the ISP at least annually~~. The provider shall~~ and (ii) complete quarterly ~~review~~ reviews of the ISP. The provider shall review the ISP at least every three months from the date of the implementation of the comprehensive ISP ~~or whenever there is a revised assessment based upon the individual's changing needs or goals~~. These reviews shall evaluate the individual's progress toward meeting the ~~plan's~~ ISP's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made. Documentation of the quarterly review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services. Case management quarterly reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due.

## Comments Received During the Proposed Stage

**Commenter:** Dr. Alexander Moore Kemetic Services LLC

**Reply to proposed update to quarterly review documentation**

I am in favor of an extension of the quarterly review
inorder to get three whole months documented and get signatures from parents , AR , guardians and get the documentation into a chart whether in electronic record keeping chart or the individual binder. I am not sure of how much time is being proposed but please allow for an extension of time that allows for the entire process to take place in
a manner that does not have conflicts in delivery of a
3 month time frame.

Dr. Alexander Moore
302-423-8870
CommentID: 78892

1/22/20 9:05 pm

**Commenter:** Susie Q

**BIG problems in CMHRS**

Over the last 5 -7 years there has been a shift in community mental health. Particularly in the last 6 months the shift for private providers dealing with not only DBHDS and DMAS regulations but also now MCO (managed care organizations) regulations has become the biggest administrative burden. While this town hall comment is not necessarily here for that topic it sets the stage for politicians to understand the climate of community behavioral health right now. The focus from true care to worrying about paperwork constantly for 3 (4 if you count human rights) different types of regulatory entities takes so much away from actually helping people. There should absolutely be regulations and rules to follow so that private providers like myself can follow ethical guidelines and demonstrate quality care. However, when the focus shifts from the client and what they need to meeting a deadline all the time it is very burdensome. ISP's should be revised. I tell my staff they are a working document. The burden of counting out exactly 90 days for a review and then ensure whether it snows, hails, sleets, etc we see them on the 90th day to get a signature and finalize review is really not therapeutic at all. If the focus was on the actual ISP and reviewing it as needs changed or even allowing for the administrative time to review it and obtain signatures around the 90 day period (maybe a 30 day grace period) then it may become a more useful document. There is no point in an ISP every 90 days when people are just doing it to do it and say it was done. If we had more flexibility as the provider to have more time to revise it, review it, and obtain signatures within a grace period than the quality of care I believe would increase.
Now the only downfall to all of those thoughts are that the MCO's now want the ISP to accompany the Service Authorization request. Those requests go in every 90 days so you may run into issues if the ISP has not been revised in time.
Overall, it sucks that all 4 entities plus MCO's are not on the same page at all about regulations that are in black and white and those that we are trying to serve are greatly affected by it. People being denied for services left and right because they have had them for "too long" or "the service failed"... after 18 months. I have so many "stories" that are real clients lives that are being affected by these ridiculous decisions. Big money companies are just trying to save the government money. I envision within a few years we will be back like the settlement days with mentally ill individuals walking the streets and homeless. That is the direction we are headed. So while I applaud the opportunity to correct an administrative time crunch there are some really big issues at stake in our community behavioral health world.
CommentID: 78894

1/23/20 8:21 am

**Commenter:** Sellati & Co., Inc

**Extension of time**

I am fully in agreement to allow a grace period for completing the quarterly review. Working in an OTP, the development of the treatment Plan (ISP) can be very time consuming, The process of reviewing the treatment plan with the patient, making changes to the treatment plan if necessary and obtaining signatures is not a simple

process. In our population patients can be seen any where from daily to monthly depending on how long they have been in treatment. It is impossible to ensure that the review is completed by the specific date, especially if the patient is not at the program on the deadline. Writing the treatment plan is also time consuming and counselors have often found there self writing the treatment plan with the patient in the office, which leaves the patients sitting there while the counselor is typing out the treatment plan and is not productive at all for the patient. What normally ends up happening is the treatment plan is brushed over and hurried. It is a constant juggle between meeting the patients needs and completing the paperwork that is required. Although not specifically addressed here, I feel compelled to address the DMAS requirement for an IPOC (ISP) on top of the required treatment plan that we currently are required to do, It is tedious and repetitive and adds an extra burden on both the counselor and the patient. Why are these patients required to have essentially two treatment plans (ISP) because they are on Medicaid.
CommentID: 78900

1/23/20 8:30 am

**Commenter:** John Malone HRCSB

**extension**

I am in favor of the proposed grace periods
CommentID: 78901

1/23/20 8:40 am

**Commenter:** Hanover Community Services

**Grace Period for Quarterlies**

Support Coordinators in Hanover are in agreement with the proposed changes. Many providers provide more than one service to an individual served (community engagement, day support, residential) and have to complete more than one quarterly per person every 90 days. This would allow the provider more time to complete the required documentation.
Keeping the grace period of 30 days for the Support Coordinator to complete the quarterly is much appreciated. We have a process to track down quarterlies from providers who don't send them in a timely manner and we inform DBHDS Community Resource Consultant of providers who don't send their quarterlies within the time period.
Our only concern would be that even with an extension from 10 to 15 days for the provider, there will continue to be providers who don't send their quarterlies to the Support Coordinator and there is little to no consequence for it.

CommentID: 78902

1/23/20 9:04 am

**Commenter:** Alleghany Highlands Community Services

**Quarterly Extension**

AHCS is in favor of the quarterly extensions.
CommentID: 78903

1/23/20 10:30 am

**Commenter:** Steve Stewart, Norfolk CSB

**Quarterly ISP Review Grace Periods**

We are in full agreement with the proposed changes and feel they will benefit CSB's and providers by allowing sufficient time to compile information and complete accurate and comprehensive reviews.
CommentID: 78907

1/23/20 7:08 pm

**Commenter:** Rinda Theibert

**it isnt rocket science and not a lot of work**

please just get the CSB case workers/ support coordinators to do their jobs in a timely manner and stop delaying everything for no reason... their jobs are not difficult and the amount of paperwork they have to do is min. (special education teachers for example have much more paperwork in a similar type of job) … I wish these gatekeepers weren't even part of the process to access services for people with DD... how much time do they really need to type a few paragraphs into a program ?
CommentID: 78912

1/23/20 7:11 pm

**Commenter:** Rinda Theibert

**I totally agree with Suzie Q**

there is no reason to burden private providers with CSB case workers and MCO program... it was so much easier and therapy whatever so much more effective when people could just help the person seeking treatment and not jump through all these unneeded extra hoops... things were so much better before Medicaid was taken over by all these MCO programs
CommentID: 78913

1/27/20 12:02 pm

**Commenter:** Ken Crum, ServiceSource

**Comment in support of the proposed changes**

We are in agreement with the proposed changes and feel they will benefit CSB's and providers by allowing sufficient time to compile information and complete accurate and comprehensive reviews.
As a provider, we appreciate this action by DBHDS to ease one of the required documentation processes.
CommentID: 78947

/27/20 8:24 pm

**Commenter:** concerned citizen

**the first commnet**

I know one of their group homes run by kemetic behavioral health norfolk va clients is a ward of Jewish Family Services. they only have one small group home. It would be interesting to know if Jewish Family Services is doing a poor job of acting as client and not signing documents in timely manner. It is very sad the way the system works and takes loved ones away from family and friends then takes the consumers small SSI check to pay for guardianship services (at least the rep payee part) From our understanding a local city is paying them for the rest of the guardianship part. It is even more upsetting a paid agency is doing a poorer job then a private guardian would be allowed to do. Maybe that is more of a problem. Maybe giving agencies more time to deal with government paid guardians isn't the answer; maybe letting people have people who give a crap control their lives would be a better idea. Isn't that what the Olmstead Settlement was supposed to be about?
CommentID: 78948

1/28/20 3:19 am

**Commenter:** Circle of Friends, LLC

**Allowing a grace period for documentation on ISP**

I agree that the grace period should be extended. With the new CMS requirements, that require time to address, it would be beneficial if providers were afforded the opportunity to have an extended period of time to document reviews or any other regulatory requirement.
CommentID: 78950
**ommenter:** Kimberly Jones / SOAR365

**Grace Period**

We agree with this extension of the grace period. We provide services to many individuals that require quarterlies, sometimes one person is working on up to 25 a month on top of other job duties. Having that extra time will also really help when the 10 days is also decreased by weekend and some holidays.
CommentID: 78971

2/12/20 10:38 am

**Commenter:** Tamara Starnes, Blue Ridge Behavioral Healthcare

**in support**

Supportive and appreciative of the proposed grace period for quartiles.
CommentID: 79047

2/26/20 12:30 pm

**Commenter:** Carol McCarthy

**Grace period for quarterly reviews**

I am in support of the grace period for quarterly reviews and the alignment of DBHDS/DMAS Regulations.
CommentID: 79300

2/26/20 12:34 pm

**Commenter:** Keonna Mack, H-NN CSB

**Quarterly/Person Centered Reviews.**

In agreement with adding a grace period for Quarterly/Person Centered Reviews.
CommentID: 79301

3/9/20 12:15 pm

**Commenter:** Hope House Foundation

**Grace period for ISP quarterly reviews**

We are in favor of the proposed grace period for the submission of quarterly reviews. This will allow for easier scheduling, review of plans and to make any requested changes with regard to the individuals, case management and guardians/family members. This also provides a cushion in case of an emergency situation due to injury, illness, weather or natural disaster.
CommentID: 79654

## B. Required Periodic Reviews: Response to Periodic Review: Requirements for Virginia's Early Intervention System [12 VAC 35-225]

**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.

**Purpose:** A periodic review as conducted from 11/11/19 – 12/02/19. Two comments were received and are posted below the draft text.

**Action Requested:** Initiate a fast track action.

| VAC Citation | Title | Last Activity | Date |
|---|---|---|---|
| 12 VAC 35-225 | Requirements for Virginia's Early Intervention System (Part C) | Periodic Review Closed | 12/02/19 |

**Next Steps:**

- If approved, staff initiates the fast track. (periodic review process chart)

The current Part C regulations may be viewed on Town Hall.


townhall.virginia.gov

## Fast-Track Regulation
## Agency Background Document

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|---|---|
| **Agency name** | Department of Behavioral Health and Developmental Services |
| **Virginia Administrative Code (VAC) citation(s)** | 12 VAC35-225 |
| **Regulation title(s)** | Requirements for Virginia's Early Intervention System |
| **Action title** | Response to Periodic Review |
| **Date this document prepared** | 12/03/2019 |

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1 VAC7-10), and the *Virginia Register Form, Style, and Procedure Manual for Publication of Virginia Regulations.*

## Brief Summary

*Please 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.*

This action is the result of a periodic review. The proposed amendments are not substantive and clarify the current Medicaid appeals process (Section 420) and the current requirements for obtaining parental consent to bill Medicaid managed care organizations (Sections 240, 250and 280) for Early Intervention Part C services and supports. Language in Section 420 is deleted and replaced with a description of the Early Intervention Dispute Resolution process and the Medicaid appeals process.

## Acronyms and Definitions

*Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.*

No acronyms are used in the updated language.

## Statement of Final Agency Action

*Please 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.*

The State Board of the Department of Behavioral Health and Developmental Services approved the promulgation of the Early Intervention Part C regulations. They were effective February 27, 2016.

## Mandate and Impetus

*Please 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, board decision, etc.). For purposes of executive branch review, "mandate" has the same meaning as defined in Executive Order 14 (as amended, July 16, 2018), "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."*

*As required by Virginia Code § 2.2-4012.1, please also explain why this rulemaking is expected to be noncontroversial and therefore appropriate for the fast-track process.*

This action is part of the regular review cycle. Since the regulations were initially promulgated, it was determined that further clarity was needed to specify that the Medicaid appeals process is different from the Early Intervention Part C dispute resolution process. Additionally, since the Department of Medical Assistance Services recently included Early Intervention Part C services in managed care; the updated process for Medicaid provider enrollment and obtaining parental consent for billing Medicaid and the managed care entities was added.

These are not expected to be controversial changes as the new language clarifies procedures currently in place. Beyond the new language these regulations, in large part, implement federal code and regulations so there is limited ability to make amendments to the Virginia regulations. Federal code is found at Part C

of the Individuals with Disabilities Education Act at 20 U.S.C. § 1435(a) and federal regulations are found at 34 CFR 303.1 et. seq.

## Legal Basis

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

The Department promulgated the regulations (12 VAC35-225) under Emergency Regulatory Authority. The Department has the legal authority to promulgate these regulations under Virginia Code § 2.2-5304 and in the Item 315 H.4 of Chapter 806 of the 2013 Virginia Acts of Assembly. This action is part of the triennial review process.

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

## Purpose

*Please 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's intended to solve.*

This action is part of the regular review cycle. Since the regulations were initially promulgated, it was determined that further clarity was needed to specify that the Medicaid appeals process is different from the Early Intervention Part C dispute resolution process. Additionally, since the Department of Medical Assistance Services included Early Intervention Part C services within managed care, procedures for provider enrollment with Medicaid and obtaining parental consent for billing Medicaid and the managed care entities was added.

The intent of the regulatory revisions is to clarify processes and inform stakeholders of information necessary to provide services to infants, toddlers, and their families.

## Substance

Please 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.

Section 240 – Use of Public Benefits or Public Insurance- adds language to state that consent from the parent must be obtained for the Medicaid managed care entity in order to bill for services.

Section 260 – Written Notification- adds language that the parent has the right to withdraw consent to disclose the infant or toddler's personally identifiable information to Medicaid and the Medicaid managed care entity

Section 280 – Provider Billing for Early Intervention Services- clarifies that providers must enroll with the Medicaid managed care entity.

Section 420 – Appeal to the Department of Medical Assistance Services- adds language that differentiates between the Medicaid appeals process and the Early Intervention Part C dispute resolution process.

## Issues

Please 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 of the changes are that families and stakeholders will be clear about current procedures.

## Requirements More Restrictive than Federal

Please 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.

These revisions are not more restrictive than federal regulations.

## Agencies, Localities, and Other Entities Particularly Affected

Please identify any other state agencies, localities, or other entities particularly affected by the regulatory change. "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
These regulatory revisions will assist the Department of Medical Assistance Services in clarifying correct procedures for obtaining consent and becoming a Medicaid provider.

Other Entities Particularly Affected
Local Early Intervention lead agencies and Early Intervention Part C providers will be impacted by these regulations.

## Economic Impact

*Pursuant to § 2.2-4007.04 of the Code of Virginia, please 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. Please keep in mind that this is change versus the status quo.*

**Impact on State Agencies**

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| *For your agency*: projected costs, savings, fees or revenues resulting from the regulatory change, including:<br>a) fund source / fund detail;<br>b) delineation of one-time versus on-going expenditures; and | There are no new costs associated with these revisions. |

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| c) whether any costs or revenue loss can be absorbed within existing resources | |
| *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 are no new costs associated with these revisions. |
| *For all agencies:* Benefits the regulatory change is designed to produce. | These revisions will clarify the process for obtaining consent and will differentiate between the Medicaid appeals process and the Early Intervention Part C Dispute Resolution process. |

**Impact on Localities**

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| Projected costs, savings, fees or revenues resulting from the regulatory change. | No fiscal impact unless it saves the provider time due to having specific information. |
| Benefits the regulatory change is designed to produce. | Provide clarity on obtaining consent and how to distinguish between the Medicaid appeals process and the Early Intervention Part C Dispute Resolution process |

**Impact on Other Entities**

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| 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. | These clarifications will provide information to Early Intervention Part C families and providers of services. |
| Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that:<br>a) is independently owned and operated and;<br>b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million. | These changes will impact the 40 Early Intervention systems and their employees and contractors.<br>While all families are informed about the Dispute Resolution process, very few choose this route. All parents in Early Intervention will have access to the information. |
| All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Please be specific and include all costs including, but not limited to:<br>a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses;<br>b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change;<br>c) fees;<br>d) purchases of equipment or services; and<br>e) time required to comply with the requirements. | No fiscal impact is expected for these clarifications. |
| Benefits the regulatory change is designed to produce. | |

## Alternatives

*Please 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 current regulations could remain as is. If the regulations are left as is, it could lead to more questions from providers and families about the differences between Early Intervention Part C dispute resolution and the Medicaid appeals process.

## Regulatory Flexibility Analysis

*Pursuant to § 2.2-4007.1B of the Code of Virginia, please 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.*

This regulatory action clarifies currently existing regulations related to the Early Intervention Part C program. It clarifies that consent must be obtained for the Medicaid managed care entity but does not add other requirements.

## Public Participation

*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.*

## Detail of Changes

*Please 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.*

*If the regulatory change will be a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory change. Delete inapplicable tables.*

*If the regulatory change is intended to replace an emergency regulation, please follow the instructions in the text following the three chart templates below. Please include citations to the specific section(s) of the regulation that are changing.*

For changes to existing regulation(s), please use the following chart:

| Current section number | New section number, if applicable | Current requirement | Change, intent, rationale, and likely impact of new requirements |
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| 12VAC35-240 | | B. Parental consent shall be obtained before the local lead agency or the early intervention service provider discloses, for billing purposes, a child's personally identifiable information to the Department of Medical Assistance Services.<br><br>E. If the parent does not provide the consent to use or enroll in public benefits or public insurance or to disclose information to the the Department of Medical Assistance Services for billing purposes, the local lead agency must still make available the early intervention services on the IFSP to which the parent has provided consent. | B. Parental consent shall be obtained before the local lead agency or the early intervention service provider discloses, for billing purposes, a child's personally identifiable information to the child's assigned Managed Care Organization or, if the child is not enrolled in managed care, to the Department of Medical Assistance Services.<br><br>E. If the parent does not provide the consent to use or enroll in public benefits or public insurance or to disclose information to the child's assigned Managed Care Organization or, if the child is not enrolled in managed care, to the Department of Medical Assistance Services for billing purposes, the local lead agency must still make available the early intervention services on the IFSP to which the parent has provided consent.<br><br>This clarifies the requirement to document the specific managed care entity |
| 12VAC35-260 | | 1.d. The parent's right to withdraw consent for disclosure, for billing purposes, of a child's personally identifiable information to the Department of Medical Assistance Services at any time; and | 1.d. The parent's right to withdraw consent for disclosure, for billing purposes, of a child's personally identifiable information to the child's assigned Managed Care Organization or, if the child is not enrolled in managed care, to the Department of Medical Assistance Services at any time; and<br><br>This clarifies the requirement to document the specific managed care entity |
| 12 VAC35-280 | | C.2. Enroll with the Department of Medical Assistance Services as an early intervention provider;<br><br>D.2. Enroll with the Department of Medical Assistance Services as an early intervention provider | C.2. Enroll with the Department of Medical Assistance Services and Medicaid contracted Managed Care Organizations as an early intervention provider;<br><br>D.2. Enroll with the Department of Medical Assistance Services and Medicaid contracted Managed Care Organizations as an early intervention provider<br><br>This language clarifies the enrollment process. |
| 12VAC35-420 | | | ~~A. In addition to the dispute resolution options described in this chapter, Medicaid or FAMIS recipients shall have~~ |

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| | | | ~~the right to file an appeal with the Department of Medical Assistance Services when they disagree with certain actions. Actions that may be appealed include:~~<br>~~1. Disagreement about the child's eligibility for services;~~<br>~~2. The provision of early intervention services, including those listed on the IFSP; and~~<br>~~3. The frequency, length, and intensity of services in the IFSP.~~<br>~~B. To ensure this right to appeal, the service coordinator shall provide the family with written information on the appeals process, regardless of whether or not the family expresses agreement or disagreement, if the child is found ineligible; the local system is refusing to initiate a service the family is requesting or is refusing to provide a service at the frequency or length desired by the family; or a service is decreased or ended, unless the family requested the service be decreased or ended.~~<br><br>Medicaid appeals are separate from and shall not affect a parent's right to request any of the dispute resolution options under 12VAC35-225-390, 12VAC35-225-400 and 12VAC35-225-410.<br><br>This clarifies the appeals process available to Medicaid members and the dispute resolution process available through Early Intervention Part C. The current language was confusing to some stakeholders. |
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## DRAFT TEXT: Establish Early Intervention Services System Regulations

CHAPTER 225

REQUIREMENTS FOR VIRGINIA EARLY INTERVENTIION SYSTEM

**12VAC35-225-10. Authority.**

A. Pursuant to § 2.2-5304 of the Code of Virginia, the Governor has designated the Department of Behavioral Health and Developmental Services as the state lead agency responsible for implementing the Virginia early intervention services system and ensuring compliance with federal requirements.

B. The Code of Virginia in §§ 2.2-2664, 5301, 5303, 5304, 5305, and 5306 establishes the structure of Virginia's early intervention system, including the duties and responsibilities of the state lead agency, coordinating council, and participating agencies.

C. Virginia's early intervention system, Infant & Toddler Connection of Virginia, must include, at a minimum, the components required by Part C of the Individuals with Disabilities Education Act at 20 U.S.C. § 1435(a) and at 34 C.F.R. Part 303.

**12VAC35-225-20. Definitions.**

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

"Ability to pay" means the amount a family is able to contribute toward the cost of early intervention services, based on family size, income, and expenses.

"Adjusted age" means an adjustment that is made for premature birth (gestation<37 weeks) used to determine developmental status until the child is 18 months old.

"Administrative complaint" means a written, signed complaint by an individual or organization alleging that the department, local lead agency, or early intervention service provider violated a requirement of Part C or 12VAC35-225.

"Assessment" means the ongoing procedures used by qualified early intervention service providers to identify (i) the child's unique strengths and needs and the concerns of the family; (ii) the early intervention services appropriate to meet those needs throughout the period of the child's eligibility under Part C; and (iii) the resources, priorities, and supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

"Assistive technology device" means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, fabricated or customized, that is used to increase, maintain, or improve functional capabilities of a child. The term does not include a medical device that is surgically implanted, such as a cochlear implant, or the optimization (e.g., mapping), maintenance, or replacement of that device.

"Assistive technology service" means any service that directly assists in the selection, acquisition, or use of an assistive technology device. Assistive technology services include: (i) evaluating the needs of the child, including a functional evaluation in the child's customary environment; (ii) purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices; (iii) selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; (iv) coordinating and using other therapies, interventions or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs; (v) providing training or technical assistance to a child, or, if appropriate, that child's family; and (vi) providing training or technical assistance to professionals (including individuals providing education or rehabilitation services) or other individuals who provide services to or are otherwise substantially involved in the major life functions of the child.

"Atypical development" means one or more of the following conditions or responses: (i) atypical or questionable sensory-motor responses; (ii) atypical or questionable social-emotional development; (iii) atypical or questionable behaviors that interfere with the acquisition of developmental skills; or (iv) impaired social interaction and communication skills with restricted and repetitive behaviors.

"Audiology" means services that include (i) identifying children with auditory impairments, using at risk criteria and appropriate audiologic screening techniques; (ii) determining the range,

nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures; (iii) referring children with auditory impairment for medical or other services necessary for habilitation or rehabilitation; (iv) providing auditory training, aural rehabilitation, speech reading and listening devices, orientation and training, and other services; (v) providing services for prevention of hearing loss; and (vi) determining the child's individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices.

"Child with a disability" or "infant or toddler with a disability" means an individual who is under three years of age and who needs early intervention services because he is experiencing a developmental delay in one or more areas of development or atypical development or has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

"Child find" means a comprehensive and coordinated system to locate, identify, refer, and evaluate all children with disabilities in Virginia who may be eligible for early intervention services under Part C.

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

"Counseling services" means the assessment and treatment of mental, emotional, or behavioral disorders and associated distresses that interfere with mental health, including (i) individual and/or family group counseling with the parent or parents and other family members; (ii) collaborating with the family, service coordinator and other early intervention service providers identified on an infant's or toddler's Individualized Family Service Plan (IFSP); and (iii) family training, education and support provided to assist the family of an infant or toddler with a disability in understanding his or her needs related to development, behavior or social-emotional functioning and to enhance his development.

"Day" means calendar day, unless clearly specified otherwise.

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

"Developmental delay" means a level of functioning that (i) is at least 25 percent below the child's chronological or adjusted age in cognitive, physical, communication, social or emotional, or adaptive development; or (ii) demonstrates atypical development or behavior even in the absence of a 25 percent delay. Developmental delay is measured using the evaluation and assessment procedures described in 12VAC35-225-90.

"Developmental services" means services provided to a child with a disability that include (i) designing learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction; (ii) curriculum planning, including the planned interaction of personnel, materials, time, and space, that leads to achieving the outcomes in the child's IFSP; (iii) providing families with information, skills, and support related to enhancing the skill development of the child; and (iv) working with the child to enhance his development.

"Discipline" or "profession" means a specific occupational category that may provide early intervention supports and services to eligible children under Part C and their families.

"Due process complaint" means a complaint filed by a parent requesting a due process hearing to resolve a disagreement with an early intervention service provider's proposal or refusal to initiate or change identification, eligibility determination, or placement of their child or the provision of early intervention services to the child or family.

"Duration" means the projection of when a given early intervention service will no longer be provided (such as when the child is expected to achieve the results or outcomes in his or her IFSP).

"Early intervention practitioner" means a person who is qualified to apply for or who holds certification as an early intervention professional, specialist, or case manager. An early intervention practitioner may be employed as an early intervention service provider under Part C.

"Early intervention service provider" means a provider agency (whether public, private or non-profit) or an early intervention practitioner that provides early intervention services under Part C, whether or not the agency or individual receives federal Part C funds.

"Early intervention records" means all records regarding a child that are required to be collected, maintained, or used under Part C.

"Early intervention services" means services provided through Part C designed to meet the developmental needs of children and families and to enhance the development of children from birth to age three who have (i) a 25 percent developmental delay in one or more areas of development, or (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. Early intervention services provided in the child's home and in accordance with this chapter shall not be construed to be home health services as referenced in § 32.1-162.7.

"Eligibility determination" means the evaluation procedures used by qualified early intervention service providers to determine a child's initial and continuing eligibility under Part C.

"Family fee" means the amount based on the accrued charges and co-payments that may be charged to families for services that an infant or toddler with a disability and family receive each month. The family fee may not exceed the monthly cap.

"Frequency" means the number of days or sessions a service will be provided.

"Health services" means services necessary to enable a child receiving services under Part C to benefit from other early intervention supports and services he receives and includes: (i) providing clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy collection bags, and other health services; and (ii) arranging consultation by physicians with other service providers concerning the special health care needs of the child that will need to be addressed in the course of providing other early intervention services. The term does not include services that are surgical in nature (such as cleft palate surgery, surgery for club foot, or the shunting of hydrocephalus); purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose); or related to the implementation, optimization (e.g., mapping), maintenance, or replacement of a medical device that is surgically implanted, including a cochlear implant; devices (such as heart monitors, respirators and oxygen, and gastrointestinal feeding tubes and pumps) necessary to control or treat a medical condition; or medical health services (such as immunizations and regular "well-baby” care) that are routinely recommended for all children.

"Homeless children" means children who meet the definition given the term homeless children and youths in Section 752 (42 U.S.C. § 11434a) of the McKinney-Vento Homeless Assistance Act, as amended, 42 U.S.C. § 11434a et seq.

"Inability to pay" means the amount a family is able to contribute toward the cost of early intervention services is zero, resulting in the family's receiving all early intervention services at no cost to the family

"Indian" means an individual who is a member of an Indian tribe.

"Indian tribe" means any federal or state Indian tribe, band, rancheria, pueblo, colony, or community, including any Alaska native village or regional village corporation.

"Individualized Family Service Plan" or "IFSP" means a written plan for providing early intervention supports and services to a child with a disability or his family that (i) is based on the evaluation for eligibility determination and assessment for service planning; (ii) includes information based on the child's evaluation and assessments; family information; results or outcomes; and supports and services, based on peer-reviewed research (to the extent practicable), that are necessary to meet the unique needs of the child and the family and to achieve the results or outcomes; and (iii) is implemented as soon as possible once parental consent is obtained.

"Informed clinical opinion" means the use of professional expertise and experience in combination with information gathered through eligibility determination or assessment for service planning, or both, to determine the child's developmental status and eligibility under Part C.

"Initial early intervention service coordination plan" means a written plan that specifies the activities that will be completed by the service coordinator prior to completion of the Individualized Family Service Plan.

"Intensity" means whether a service will be provided on an individual or group basis.

"Length of service" means the amount of time the service will be provided during each session (such as an hour or other specified timeframe).

"Local lead agency" means an entity that, under contract with the department, administers a local early intervention system.

"Location of service" means the actual place or places where the early intervention service will be provided.

"Medical services" means services provided by a licensed physician for diagnostic or eligibility determination purposes to determine a child's developmental status and need for early intervention supports and services.

"Monthly cap" means the maximum amount that a family will be required to pay per month for early intervention services regardless of the charge or charges or number of different types, frequency or length of services a child and family receive.

"Multidisciplinary" means the involvement of two or more separate disciplines or professions.

"Native language" means the language or mode of communication (such as sign language, Braille, or oral communication for persons with no written language) that is normally used by the child or his parents.

"Natural environments" means settings that are natural or typical for a same-aged child without a disability and may include the home or community settings.

"Nursing services" means services that include (i) conducting assessments of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems; (ii) providing nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development; and (iii) administering medications, treatment, and regimens prescribed by a licensed physician.

"Nutrition services" means services that include (i) individual assessments in nutritional history and dietary intake; anthropometric, biochemical, and clinical variables; feeding skills and feeding problems; and food habits and food preferences; (ii) developing and monitoring appropriate plans to address the nutritional needs of children eligible for early intervention supports and services, based on the findings of individual assessments; and (iii) making referrals to appropriate community resources to carry out nutritional goals.

"Occupational therapy" means services that are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include: (i) identifying and assessing the child’s functional needs and providing interventions related to adaptive development, adaptive behavior, play, and sensory, motor, and postural development; (ii) adapting the environment, and selecting, designing, and fabricating assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and (iii) preventing or minimizing the impact of initial or future impairment, delay in development, or loss of functional ability.

"Parent" means (i) a biological or adoptive parent or parents of a child; (ii) a foster parent, unless state law, regulations, or contractual obligations with a state or local entity prohibit a foster parent from acting as a parent; (iii) a guardian generally authorized to act as the child's parent, or authorized to make early intervention, educational, health or developmental decisions for the child (but not the state if the child is a ward of the state); (iv) an individual acting in the place of a biological or adoptive parent (including a grandparent, stepparent, or other relative) with whom the child lives, or an individual who is legally responsible for the child's welfare; or (v) a surrogate parent, when determined necessary in accordance with and assigned pursuant to these regulations. The term "parent" does not include any local or state agency, or their agents, if the child is in the custody of said agency.

"Participating agencies" means the Departments of Health, of Education, of Medical Assistance Services, of Behavioral Health and Developmental Services, and of Social Services; the Departments for the Deaf and Hard-of-Hearing and for the Blind and Vision Impaired; and the Bureau of Insurance within the State Corporation Commission.

"Payor of last resort" means a funding source that may be used only after all other available public and private funding sources have been accessed.

"Personally identifiable information" means the name of the child, the child's parent, or other family members; the address of the child or the child's family; a personal identifier, such as the child's or parent's social security number; or a list of personal characteristics or other information

that, alone or in combination, could be used to identify the child or the child's parents or other family members.

"Physical therapy" means services that promote the child’s sensory or motor function and enhance his musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include (i) screening, evaluation for eligibility determination and assessment of children to identify movement dysfunction; (ii) obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; (iii) adapting the environment and selecting, designing, and fabricating assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and (iv) providing individual or group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

"Primary referral sources" means those agencies, providers, entities, and persons who refer children and their families to the early intervention system and include (i) hospitals, including prenatal and postnatal care facilities; (ii) physicians; (iii) parents; (iv) child care programs and early learning programs; (v) local school divisions; (vi) public health facilities; (vii) other public health or social service agencies; (viii) other clinics and health care providers; (ix) public agencies and staff in the child welfare system, including child protective services and foster care; (x) homeless family shelters; and (xi) domestic violence shelters and agencies.

"Psychological services" means services that include (i) administering psychological and developmental tests and other assessment procedures; (ii) interpreting assessment results; (iii) obtaining, integrating, and interpreting information about child behavior and child and family conditions related to learning, mental health, and development; and (iv) planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs.

"Service coordinator" means a person who holds a certification as an early intervention case manager and is responsible for assisting and enabling children with disabilities and their families to receive the services and rights, including procedural safeguards, that are authorized to be provided under Virginia's early intervention program.

"Sign language and cued language services" means (i) teaching sign language, cued language, and auditory or oral language; (ii) providing oral transliteration services (such as amplification); and (iii) providing sign and cued language interpretation.

"Single point of entry" means the single entity designated by the local lead agency in each local early intervention system where families and primary referral sources make initial contact with the local early intervention system.

"Social work services" means services that include (i) making home visits to evaluate a child's living conditions and patterns of parent-child interaction; (ii) preparing a social or emotional developmental assessment of the child within the family context; (iii) providing individual and family-group counseling with parents and other family members, including appropriate social skill-building activities with the child and parents; (iv) working with identified problems in the living situation (home, community, and any center where early intervention supports and services are provided) that affect the child's use of early intervention supports and services; and (v) identifying, mobilizing, and coordinating community resources and services to enable the child with a disability and his family to receive maximum benefit from early intervention services.

"Speech-language pathology services" means services that include (i) identifying children with communication or language disorders and delays in development of communication skills and identifying and appraising specific disorders and delays in those skills; (ii) referring children with communication or language disorders and delays in development of communication skills for medical or other professional services necessary for the habilitation or rehabilitation; and (iii) providing services for the habilitation, rehabilitation, or prevention of communication or language disorders and delays in development of communication skills.

"State lead agency" means the agency designated by the Governor to receive funds to administer the state's responsibilities under Part C.

"Surrogate parent" means a person assigned by the local lead agency or its designee to ensure that the rights of a child are protected when no parent can be identified; the lead agency or other public agency, after reasonable efforts, cannot locate a parent; or the child is a ward of the state.

"Transportation and related costs" means the cost of travel and other costs that are necessary to enable a child with a disability and his family to receive early intervention supports and services.

"Virginia Interagency Coordinating Council" or "VICC" means the advisory council, established pursuant to § 2.2-2664 of the Code of Virginia, to promote and coordinate Virginia's system of early intervention services.

"Vision services" means services that include (i) evaluating and assessing visual functioning, including the diagnosis and appraisal of specific visual disorders, delays, and abilities that affect early childhood development; (ii) referring for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both; and (iii) providing communication skills training, orientation and mobility training for all environments, visual training, and additional training necessary to activate visual motor abilities.

"Visit" means a face-to-face encounter with the child with a disability or his parent, another family member, or caregiver, or both, for the purpose of providing early intervention supports and services.

"Ward of the state" means a child who, as determined by Virginia, is a foster child or is in the custody of a public children's residential facility. The term does not include a foster child who has a foster parent who meets the definition of "parent."

## Part I
## Virginia Early Intervention Services System

### 12VAC35-225-30. Early intervention services applicability, availability, and coordination.

A. These regulations shall apply to the state and local lead agencies, early intervention practitioners, and provider agencies.

B. Appropriate early intervention services based on scientifically based research, to the extent practicable, shall be available to all children with disabilities who are eligible for early intervention services in Virginia and their families, including children and families who reside on an Indian reservation geographically located in Virginia, or who are homeless and children who are wards of the state.

C. The Virginia Interagency Coordinating Council (VICC) shall promote and coordinate early intervention services in the Commonwealth and shall advise and assist the department.

1. Non-state agency members of the VICC shall be appointed by the Governor. State agency representatives shall be appointed by their agency directors or commissioners.

2. The VICC membership shall reasonably represent the population and shall be composed as follows:

a. At least 20 percent shall be parents, including minority parents, of infants or toddlers with disabilities or children with disabilities aged 12 years or younger, with knowledge of, or experience with, programs for children with disabilities. At least one parent member shall be a parent of a child with a disability aged six years or younger;

b. At least 20 percent shall be public or private providers of early intervention services;

c. At least one member shall be from the Virginia General Assembly;

d. At least one member shall be involved in personnel preparation;

e. At least one member shall be from each of the participating agencies involved in the provision of or payment for early intervention services to children with disabilities and their families. These members shall have sufficient authority to engage in policy planning and implementation on behalf of the participating agency and shall include:

(1) At least one member from the Department of Education, the state educational agency responsible for preschool services to children with disabilities. This member shall have sufficient authority to engage in policy planning and implementation on behalf of the Department of Education;

(2) At least one member from the Department of Medical Assistance Services, the agency responsible for the state Medicaid program;

(3) At least one member from the Department of Social Services, the agency responsible for child care and foster care;

(4) At least one member from the State Corporation Commission, Bureau of Insurance, the agency responsible for regulating private health insurance;

(5) At least one member designated by the Office of the Coordination of Education of Homeless Children and Youth;

(6) At least one member from the Department of Behavioral Health and Developmental Services, the agency responsible for children's mental health;

(7) At least one member from the Department for the Blind and Vision Impaired;

(8) At least one member from the Department for the Deaf and Hard of Hearing; and

(9) At least one member from the Department of Health.

f. At least one member shall be from CHIP of Virginia;

g. At least one member shall be from a Head Start or Early Head Start agency or program in Virginia; and

h. Other members selected by the Governor.

3. The VICC shall operate as follows:

a. The VICC shall have by-laws that outline nomination processes and roles of officers, committees, and other operational procedures;

b. No member of the VICC shall cast a vote on any matter that would provide direct financial benefit to that member or otherwise give the appearance of a conflict of interest under Virginia law;

c. The VICC shall meet, at a minimum, on a quarterly basis.

d. VICC meetings shall be announced in advance in the Commonwealth Calendar and through an announcement to local lead agencies;

e. VICC meetings shall be open and accessible to the public, and each meeting shall include a public comment period. Interpreters for persons who are deaf and other necessary services for both VICC members and participants shall be provided as necessary and upon request.

4. Subject to approval by the Governor, the VICC shall work with the department to develop an annual budget for VICC expenses that may include the use of Part C funds for the following:

a. Conducting hearings and forums;

b. Reimbursing members of the VICC for reasonable and necessary expenses for attending VICC meetings and performing VICC duties (including child care for parent representatives);

c. Compensating a member of the VICC if the member is not employed or must forfeit wages from other employment when performing official VICC business;

d. Hiring staff; and

e. Obtaining the services of professional, technical, and clerical personnel as may be necessary to carry out its functions under Part C.

5. Except as provided in subdivision 4 e of this subsection, VICC members shall serve without compensation from funds available under Part C.

Part II
Referrals for Early Intervention Services and Supports

**12VAC35-225-40. Public awareness and child identification and referral.**

A. The department shall develop and implement a public awareness program that focuses on the early identification of infants and toddlers with disabilities and provides information to parents of infants and toddlers through primary referral sources.

B. Local lead agencies and early intervention service providers shall collaborate with the department to prepare and disseminate information to all primary referral sources, including a description of the early intervention services available, a description of the child find system and how to refer a child under the age of three for eligibility determination or early intervention services, and a central directory.

C. The department, local lead agencies, and early intervention service providers shall collaborate with and assist primary referral sources in disseminating the information in 12VAC35-225-40 B. to parents of infants and toddlers, especially parents with premature infants or infants with other physical risk factors associated with learning or developmental complications.

D. Local lead agencies shall develop and implement local public awareness and child find procedures that include the methods to be used for planning and distributing public awareness materials and the roles of agencies and persons in the community involved in public awareness and child find activities.

E. The department shall maintain a central directory that shall be accessible to the general public through a toll-free number and the internet. The central directory shall include accurate and up-to-date information about:

1. Public and private early intervention services, resources, and experts available in Virginia;

2. Professional and other groups (including parent support, and training and information centers) that provide assistance to children with disabilities and their families; and

3. Research and demonstration projects being conducted in Virginia relating to children with disabilities.

F. The department shall implement a comprehensive child find system that is consistent with Part B of the Individuals with Disabilities Education Act, 20 U.S.C. § 1411 *et seq*. (Part B) and ensures that all children with disabilities who are eligible for early intervention services in Virginia are identified, located, and evaluated for eligibility determination, including:

1. Indian children with disabilities residing on a reservation geographically located in Virginia (including coordination, as necessary, with tribes, tribal organizations and consortia);

2. Children with disabilities who are homeless, in foster care, and wards of the state;

3. Children who are the subject of a substantiated case of child abuse or neglect; and

4. Children who are identified as directly affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.

G. The department shall ensure that the child find system is coordinated with all other major efforts to locate and identify children by other state agencies responsible for administering the various education, health, and social service programs relevant to children with disabilities and their families, including Indian tribes, and with the efforts of the:

1. Preschool special education program through the Department of Education;

2. Maternal and Child Health program, including the Maternal, Infant, and Early Childhood Home Visiting Program under Title V of the Social Security Act, as amended;

3. Early Periodic Screening, Diagnosis and Treatment (EPSDT) under Title XIX of the Social Security Act;

4. Programs under the Developmental Disabilities Assistance and Bill of Rights Act of 2000;

5. Head Start and Early Head Start;

6. Supplemental Security Income program under Title XVI of the Social Security Act;

7. Child protection and child welfare programs, including programs administered by, and services provided through, the Department of Social Services, as the foster care agency and as the State agency responsible for administering the Child Abuse Prevention and Treatment Act (CAPTA);

8. Child care programs in Virginia;

9. Programs that provide services under the Family Violence Prevention and Services Act;

10. Virginia's Early Hearing Detection and Intervention (EHDI) system;

11. Children's Health Insurance Program (CHIP) authorized under Title XXI of the Social Security Act;

12. Virginia Newborn Screening Program;

13. Virginia Congenital Anomalies Reporting Education System (VACARES); and

14. Care Connection of Virginia.

H. The department and local lead agencies shall use interagency agreements, memoranda of understanding, or other mechanisms, as needed, to minimize duplication of child find efforts among the programs listed in subdivision G of this subsection and that there will be effective use of the resources available through each public agency and early intervention service providers in Virginia to implement the child find system.

**12VAC35-225-50. Referrals to the single point of entry.**

A. All local lead agencies shall identify a single point of entry in their respective local early intervention systems to receive all referrals and inquiries from families and primary referral sources. This single point of entry shall be published in local public awareness and child find materials and communicated to potential referral sources.

B. Primary referral sources shall refer to the single point of entry any infant or toddler potentially eligible for early intervention services as soon as possible, but in no case more than seven days, after the child has been identified as potentially eligible.

C. The department shall require that local community services boards responsible for implementing and managing discharge plans required by § 32.1-127.B.6 of the Code of Virginia for substance-abusing postpartum women and their infants refer to the single point of entry any child under the age of three who is identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.

D. The Department of Social Services shall refer to the single point of entry any child under the age of three who is

1. identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or

2. the subject of a founded disposition of child abuse or neglect.

E. Early intervention service providers shall refer to the single point of entry any infant or toddler potentially eligible for early intervention services who becomes known to the provider through any source other than the early intervention system.

F. Parental consent shall not be required in order to make a referral to the local early intervention system and the local system shall accept a referral even if the referral source has not informed the family of the referral.

G. Referrals to the local single point of entry may be made by phone, fax, mail, e-mail, web-based system, in writing, or in person.

H. When making a referral, the referral source shall provide, at minimum, the child's or a family member's name and one method of contacting the family.

I. The date on which the local single point of entry receives a referral shall be counted as the first day of the 45-day timeline specified in 12VAC35-225-80.C within which eligibility determination, assessment for service planning, and the initial IFSP meeting shall be completed.

J. The single point of entry shall inform referred families whose children are close to the age of eligibility for early childhood special education services through the local school division under Part B that they have the option to be referred to the local school division instead of or simultaneously with referral to early intervention under Part C.

K. Upon referral, the single point of entry shall begin an early intervention record for the child and assign a service coordinator who will assist the family with intake, eligibility determination, assessment for service planning, and, if eligible, development of an IFSP.

**12VAC35-225-60. Intake.**

A. For purposes of the early intervention system, including determination of required parental consents or exercise of parental rights, a biological or adoptive parent, when more than one party is qualified under the definition of parent, the biological or adoptive parent must be presumed to be the parent unless that person does not have legal authority to make educational or early intervention decisions for the child. However, if a judicial decree or order identifies a specific person or persons to act as the parent of a child or to make educational or early intervention decisions on behalf of a child, then that person or persons shall be determined to be the parent.

B. The service coordinator shall conduct intake with the family in order to:

1. Inform the family about early intervention services and the IFSP process;

2. Provide the parent with a written notice and explanation of the family's rights and procedural safeguards under Part C, including:

a. A description of what personally identifiable information is maintained, the types of information sought, the methods used in gathering information (including the sources from whom information is gathered), and the uses to be made of the information;

b. The policies that early intervention service providers must follow regarding storage, disclosure to third parties, retention and destruction of personally identifiable information;

c. The rights of parents and children regarding the foregoing information, including their rights under the confidentiality provisions of Part C; and

d. A description of the languages in which this notice of rights and safeguards is available in Virginia.

3. With prior written notice and parent consent, gather information about the child's development and health history to assist in eligibility determination;

4. Facilitate identification of team members for and coordinate scheduling of eligibility determination;

5. Provide the schedule of sliding fees for early intervention services provided under Part C and other payment information.

C. Provide the schedule of sliding fees for early intervention services provided under Part C and other payment information; and

D. For children with Medicaid, ensure completion of the paperwork, including development of an Initial Early Intervention Service Coordination Plan, and data entry necessary to enroll the child in the Medicaid early intervention benefit. This plan shall end when the child is found ineligible for early intervention; the IFSP is signed; or 90 calendar days from the date of intake, whichever comes first.

**12VAC35-225-70. Eligibility criteria.**

A. The department shall identify physical and mental conditions with high probability of resulting in developmental delay.

B. A child shall be eligible for early intervention services under Part C if the child is under three years old and has:

1. A developmental delay as measured through the evaluation and assessment procedures described in this section; or

2. A diagnosed physical or mental condition with high probability of resulting in developmental delay.

**12VAC35-225-80. Evaluation for eligibility criteria.**

A. A child's medical and other records shall be used to establish initial eligibility (without conducting an evaluation for eligibility determination) if those records indicate that the child's level of functioning in one or more developmental areas constitutes a developmental delay or that the child otherwise meets the criteria for an infant or toddler with a disability.

1. If the records document a diagnosed physical or mental condition with a high probability of resulting in developmental delay, then a certified early intervention case manager or certified early intervention professional shall complete and sign the eligibility determination form to document review of the record.

2. If the records document a developmental delay, a certified early intervention professional shall review the record to determine whether it establishes eligibility, completing and signing the eligibility determination form if it does.

B. With prior written notice and parental consent, each child under the age of three who is referred to the early intervention system shall receive a timely, comprehensive multidisciplinary evaluation to determine eligibility unless eligibility is established under 12VAC35-225-80.A.

C. Except as provided in paragraph 12VAC35-225-80.A., the local lead agency shall ensure that, with parental consent, the evaluation for eligibility determination and, if the child is eligible, an assessment (of the child and family) and an initial IFSP meeting are completed within 45 days from the date of referral.

D. The 45-day timeline described in 12VAC35-225-80.C. shall not apply for any period when:

1. The child or parent is unavailable to complete the evaluation for eligibility determination, the assessments of the child and family, or the initial IFSP meeting due to exceptional family circumstances that are documented in the child's early intervention record; or

2. The parent has not provided consent for the evaluation for eligibility determination or the assessment of the child despite documented, repeated attempts by the service coordinator or other service provider, or both, to obtain parental consent.

E. In the event that circumstances described in 12VAC35-225-80.D delay the 45-day timeline, the service coordinator shall ensure:

1. The exceptional family circumstances, repeated attempts to obtain parental consent or other circumstances resulting in a delay are documented in the child's early intervention record;

2. The evaluation for eligibility determination, the assessments of the child and family, and the initial IFSP meeting are completed as soon as possible after the documented exceptional family circumstances no longer exist, parental consent is obtained, or other circumstances causing a delay no longer exist; and

3. Development of an interim IFSP, if appropriate for the child and family.

**12VAC35-225-90. Eligibility determination process.**

A. Eligibility determination shall be conducted by a multidisciplinary team of certified early intervention professionals, which may include one individual who is certified as an early intervention practitioner in more than one discipline or profession, and shall include the use of informed clinical opinion.

B. Eligibility determination shall be conducted in a non-discriminatory manner and with procedures selected that are not racially or culturally discriminatory.

C. Eligibility determination shall be conducted in the native language of the parent or other mode of communication used by the parent unless the early intervention service providers conducting the evaluation of the child determine that the language normally used by the child is developmentally appropriate for the child.

D. No single procedure shall be used as the sole criterion for determining a child's eligibility;

E. Eligibility determination shall include:

1. Use of an evaluation instrument;

2. Taking the child's history (including interviewing the parent);

3. Identifying the child's level of functioning in cognitive, physical, communication, social or emotional, and adaptive development;

4. Gathering information from other sources such as family members, other caregivers, medical providers, social workers, and educators, if necessary, to understand the full scope of the child's unique strengths and needs; and

5. Reviewing medical, educational, or other records.

F. Informed clinical opinion may be used as an independent basis to establish a child's eligibility even when other instruments do not establish eligibility; however, in no event may informed clinical opinion be used to negate the results of instruments used to establish eligibility;

G. The eligibility determination date, methods, participants and results shall be documented on the Eligibility Determination Form.

H. The service coordinator shall provide the family with a copy and explanation of the Eligibility Determination Form as soon as possible following eligibility determination at no cost to the family.

**12VAC35-225-100. Ineligibility for early intervention services.**

If, through the process of eligibility determination, a child is found to be not eligible for early intervention services, the service coordinator shall provide the parent with:

1. A prior written notice that the child has been determined to be not eligible, and

2. A copy and explanation of the notice of child and family rights and safeguards including the parent's right to dispute the eligibility determination by any combination of requesting mediation, making a due process complaint, or filing an administrative complaint.

Statutory Authority

**12VAC35-225-110. Assessment for service planning.**

A. With prior written notice and parental consent, each child found eligible for early intervention services shall receive:

1. A multidisciplinary assessment of the child's unique strengths and needs and the identification of services appropriate to meet those needs; and

2. A family-directed assessment of the resources, priorities, and concerns of the family and identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of that infant or toddler.

B. Assessments for service planning shall be conducted by a multidisciplinary team of certified early intervention professionals, which may include one individual who is certified as an early intervention practitioner in more than one discipline or profession, and shall include the use of informed clinical opinion.

C. Assessments shall be conducted in a non-discriminatory manner and with procedures selected that are not racially, culturally or linguistically discriminatory.

D. Assessments shall be conducted in the native language of the parent or other mode of communication used by the parent unless the early intervention service providers conducting the assessment of the child determine that the language normally used by the child is developmentally appropriate for the child.

E. The multidisciplinary assessment of the child shall include:

1. A review of the results of the eligibility determination;

2. Use of a comprehensive assessment tool;

3. Personal observations of the child;

4. Identification of the child's needs in cognitive, physical, communication, social or emotional, and adaptive development; and

5. If the child is new to Virginia's early intervention system, determination of entry ratings on the child outcome indicators required by the U.S. Department of Education, Office of Special Education Programs.

F. The initial family assessment shall be conducted within 45 days from the date of referral if the parent concurs, even if other family members are not available. The family-directed assessment shall:

1.Be voluntary on the part of each family member participating in the assessment;

2. Be based on information obtained through an assessment tool and through an interview with those family members who elect to participate in the assessment; and

3. Include the family's description of its resources, priorities and concerns related to enhancing their child's development.

4. Be conducted in the native language or other mode of communication used by the family member participating in the assessment, unless clearly not feasible to do so.

G. Early intervention service providers conducting assessments shall document the assessment results in the integrated, comprehensive assessment summary on the IFSP or in a separate written report that is then integrated into the comprehensive assessment summary on the IFSP.

## Part IV
## Service Planning, Delivery, Transition, and Discharge

### 12VAC35-225-120. Individualized Family Service Plan (ISFP) development.

A. A written IFSP shall be developed and implemented, with parent consent, for each eligible child.

B. The IFSP shall include:

1. The child's name, date of birth, gender, and city or county of residence; IFSP date and the dates the 6-month IFSP review is due and dates reviews are completed; child's and family's primary language or mode of communication; parents' and, if requested by the family, other family members' contact information; and the service coordinator's name and contact information;

2. Information about the child's and family's daily routines and activities;

3. The child's present levels of physical (including vision, hearing, motor and health status), cognitive, communication, social or emotional, and adaptive development based on the information from eligibility determination and assessment for service planning;

4. With the concurrence of the family, a statement of the family's resources, priorities, and concerns related to enhancing the development of the child;

5. The measurable outcomes to be achieved for the child (including pre-literacy and language skills, as developmentally appropriate for the child) and the criteria, procedures,

and timelines for determining the degree to which progress toward meeting the outcomes is being made and whether revisions to the outcomes or early intervention services identified in the IFSP are necessary;

6. The specific early intervention services, based on peer-reviewed research (to the extent practicable), that are needed to meet the unique needs of the child and family and to achieve the identified outcomes including:

a. Assistive technology devices and services;

b. Audiology services;

c. Developmental services;

d. Counseling services

e. Family training services;

f. Health services;

g. Medical services;

h. Nursing services;

i. Nutrition services;

j. Occupational therapy;

k. Physical therapy;

l. Psychological services;

m. Service coordination services;

n. Sign language and cued language;

o. Social work services;

p. Speech-language pathology services;

q. Transportation and related costs;

r. Vision services; or

s. Other services, as may be identified by the department.

7. The length, duration, frequency, intensity, method, and location for delivering each service;

8. A statement of the natural environment in which each early intervention service will be provided or a justification made by the IFSP team, including the parent, as to why, based on the child's outcomes, the service cannot be provided in the natural environment; and

9. Payment arrangements, if any.

10. To the extent appropriate, the medical and other services that the child or family needs or is receiving through other sources, but that are neither required nor funded under Part C and the steps the service coordinator or family may take to assist the child and family in securing those other services if those services are not currently being provided;

11. The projected date for the initiation of each early intervention service identified in the IFSP, which shall be as soon as possible but no more than 30 days from the date the parent signs the IFSP unless the IFSP team agrees on a later start date in order to meet the needs of the child or family;

12. The name of the service coordinator who will be responsible for implementing the early intervention services identified in the IFSP; and

13. The steps and services to be taken to support the smooth transition of the child from early intervention services to preschool services under Part B or other appropriate services, if any. The transition steps in the IFSP shall include, but are not limited to, the following:

a. Discussions with, and training of, parents, as appropriate, regarding future placements and other matters related to the child's transition;

b. Procedures to prepare the child for changes in service delivery, including steps to help the child adjust to, and function in, a new setting;

c. Confirmation that the required notification, unless the parent disagrees, and with parental consent additional information (such as copies of evaluations and assessments and the most recent IFSP) needed by the local school division to ensure continuity of services have been sent to the local school division; and

d. Identification of transition services and other activities that the IFSP team determines are necessary to support the transition of the child.

C. A meeting to develop the initial IFSP shall be held within 45 days from the date the referral is received.

D. Meetings of the multidisciplinary IFSP team, which must include two or more certified early intervention practitioners from separate disciplines or professions, shall include the following participants:

1. The parent or parents of the child;

2. Other family members, as requested by the parent, if feasible to do so;

3. An advocate or person outside of the family, if the parent requests that the person participate;

4. The service coordinator who will be responsible for implementing the IFSP;

5. A person or persons directly involved in conducting eligibility determination, assessment for service planning, or both; and

6. As appropriate, persons who will be providing early intervention services to the child or family.

E. Each meeting to develop an IFSP shall:

1. Take place in a setting and at a time that is convenient to the family; and

2. Be conducted in the native language of the family or other mode of communication used by the family, unless it is clearly not feasible to do so.

F. If an IFSP team member is unable to attend an IFSP meeting, the service coordinator shall make arrangements for the person's involvement through other means, which may include participating by telephone, having a knowledgeable authorized representative attend the meeting, or submitting a written report.

G. The service coordinator shall provide prior written notice of the date, time, and location of the IFSP meeting to the family and other participants early enough before the IFSP meeting date to ensure that they will be able to attend.

H. The service coordinator shall assist the parent in preparing for the IFSP meeting and shall ensure that the parent has the information needed in order to fully participate in the meeting.

I. With parental consent, an interim IFSP shall be developed and implemented when an eligible child or the child's family has an immediate need for early intervention services prior to completion of eligibility determination and assessment for service planning.

1. The interim IFSP shall include the name of the service coordinator who will be responsible for implementing the interim IFSP and coordinating with other agencies and persons; the early intervention services that have been determined to be needed immediately, including the frequency, intensity, length, location and methods of delivery; and the parent's signature indicating consent to implement the interim IFSP.

2. The development of an interim IFSP shall not negate the requirement to complete the eligibility determination and assessment for service planning and develop an initial IFSP within 45 calendar days of referral.

J. The service coordinator shall document in a contact note any circumstances that result in eligibility determination, assessment for service planning, or initial IFSP development occurring more than 45 calendar days after referral.

**12VAC35-225-130. IFSP approval and selection of service providers.**

A. The service coordinator shall explain the contents of the IFSP to the parent and informed written consent shall be obtained as indicated by the parent's signature and date of signature on the IFSP prior to the provision of early intervention services.

B. The service coordinator shall assist the family in selecting a service provider for each early intervention service listed on the IFSP from among those provider agencies (including independent providers) who are qualified to provide the services identified on the IFSP, who are in the parent's payor network, and who practice in the area where the child and family live. The parent's choice of service providers shall be documented on the IFSP Addendum page, which shall be signed and dated by the parent prior to service delivery.

1. If no early intervention service provider who can support and assist the family in accomplishing the IFSP outcomes is available within the family's Medicaid or private insurance network, then the parent shall be able to choose an early intervention service provider from outside their third party payor network.

2. If there is only one provider agency for the service needed by the child and family, then the parent shall be offered a choice of early intervention service providers from within that one provider agency for services other than service coordination. If the parent elects not to receive services from the one provider agency, then the local lead agency shall work to identify an alternative early intervention service provider.

3. The parent shall be offered the opportunity to select a provider agency any time a new service is added or when a change in provider agency is needed.

4. If the selected provider agency is unable to provide the service due to full provider caseloads or the requested early intervention service provider within that provider agency is unavailable, then the service coordinator shall explain to the parent the option to begin services right away with an available provider or to wait for his chosen provider to become available. If the parent chooses to wait, the service coordinator shall document the parent's decision in a contact note and the delay in start of services shall be considered a family scheduling preference.

5. The service coordinator shall inform the parent that he may request to change his service provider at any time by contacting the service coordinator.

C. The service coordinator shall retain a signed copy of the IFSP and, as soon as possible following development of the IFSP, shall provide a copy to the parent at no cost to the family and to all service providers who participated in assessment or development of the IFSP or will be implementing the IFSP.

**12VAC35-225-140. ISFP periodic review and updates.**

A. A periodic IFSP review shall be conducted every six months or any time the parent, service coordinator, or another member of the IFSP team identifies the potential need for revisions to the IFSP outcomes or services.

B. Each periodic IFSP review shall provide for the participation of the IFSP team members listed in 12VAC35-225-120.D. 1-4. If conditions warrant, provisions must be made for the participation of other representatives identified in 12VAC35-225-120.D.

C. Each periodic IFSP review shall include a determination of the degree to which progress has been made toward achieving the outcomes identified in the IFSP and the need for revisions of the outcomes or early intervention services identified in the IFSP.

**12VAC35-225-150. Annual ISFP review.**

A. An annual IFSP review shall be conducted to evaluate and revise, as appropriate, the IFSP for each child and the child's family.

B. The annual IFSP review shall include a determination of the child's continuing eligibility to receive early intervention services.

1. If the child's records document a diagnosed physical or mental condition with a high probability of resulting in developmental delay, then a service coordinator or certified early intervention professional shall complete and sign the eligibility determination form to document review of the record.

2. If the child's records document a developmental delay based on ongoing assessment, then a certified early intervention professional shall review the record to determine whether it establishes eligibility and shall complete and sign the eligibility determination form if it does.

3. In all other circumstances, a multidisciplinary team shall review existing health and developmental information gathered through records, parent input, observation, and an evaluation tool, if needed, to determine the child's continuing eligibility. The child's continuing eligibility determination date, methods, participants and results shall be documented on the Eligibility Determination Form.

4. The service coordinator shall provide the family, at no cost, with a copy and explanation of the Eligibility Determination Form as soon as possible following the eligibility determination.

C. Each annual IFSP review shall be conducted by the child's multidisciplinary team that includes the team members listed in 12VAC35-225-120.D.

D. During the annual IFSP review, the results of any current evaluations and assessments of the child and family shall be used in determining the early intervention services that are needed and will be provided.

**12VAC35-225-160. Physician certification.**

A. Physician certification shall be required regarding the medical necessity for services if the child is (i) covered by public health insurance (Medicaid, FAMIS or TRICARE) or by private health insurance that requires such certification and (ii) will receive services that can be reimbursed under that insurance plan. Certification shall be obtained at the initial and annual IFSP and any time a service is added or the frequency of a service is changed through a periodic IFSP review.

B. The service coordinator shall obtain a written certification of medical necessity from a physician (or physician assistant or nurse practitioner). A written certification requires:

1. A signature on the IFSP;

2. A signed letter referencing the IFSP; or

3. A completed and signed IFSP Summary Letter.

C. The service coordinator shall ensure that the certification required by this section certifies the IFSP as a whole. Early intervention service providers shall not be permitted to seek physician certification for individual services.

**12VAC35-225-170. Service delivery.**

A. Each early intervention service listed on a child's IFSP shall begin as soon as possible but no more than 30 days from the date the parent signs the IFSP unless the IFSP team decides on and documents the reasons for a later start date to meet the individual needs of the child and family. The 30-day timeline does not apply to delivery of an assistive technology device, which must be secured as soon as possible after the parent signs the IFSP.

B. Early intervention supports and services shall be provided only by certified early intervention service practitioners.

C. The service coordinator shall be responsible for the following:

1. Assisting parents of children with disabilities in obtaining access to needed early intervention services and other services identified in the IFSP, including making referrals to providers for needed services and scheduling appointments for children and their families;

2. Coordinating the provision of early intervention services and other services (such as educational, social, and medical services that are not provided for diagnostic or evaluative purposes) that the child needs or are being provided;

3. Conducting referral and other activities to assist families in identifying available early intervention service providers;

Coordinating, facilitating, and monitoring delivery of early intervention services required to ensure the services are provided in a timely manner;

4. Conducting follow-up activities to determine that appropriate early intervention services are being provided;

5. If the child has Medicaid or FAMIS, the service coordinator shall:

a. Document in a contact note the family's preferred method of contact (face-to-face, phone, email, or text) for the family contacts that are required every three months and any change in the family's preferred method of contact;

b. Make at least one direct contact with the family every three calendar months, beginning no later than the month after the initial IFSP is signed, with the method of contact determined by the family; and

c. Request completion of a health status report by the child's physician every six months.

D. Early intervention service providers shall deliver services in accordance with the IFSP and make a good faith effort to assist each eligible child in achieving the outcomes in the child's IFSP.

E. Early intervention sessions cancelled by the provider or missed due to a holiday shall be made up as quickly as possible unless the parent declines a make-up session.

F. Parents may request to change their early intervention service provider at any time by notifying their service coordinator.

**12VAC35-225-180. Service documentation.**

A. Early intervention service providers shall document all contacts made and all activities completed with or on behalf of families in a contact note within five business days of the contact. All contact notes shall include:

1. The child's first and last names;

2. Type of early intervention service provided;

3. Method of contact;

4. Date of the note and date of the contact, if the note is not written on the same date; and

5. The early intervention provider's signature, with a minimum of first initial and last name, discipline and credentials of the provider, and the date the note is signed by the provider.

B. Contact notes that document a service session also shall include:

1. A narrative description of what occurred during the session including what was done, what the family or other caregiver did during the session (including how they actively participated during the session), how the child responded during the session (including what the child was able to do in relation to outcomes and goals), and suggestions for follow-up;

2. Who was present;

3. Length of session (in minutes);

4. Location/setting in which service was provided;

5. Information from the family about what has happened since the last session; and

6. Plan for the next contact.

C. Contact notes that document a service coordination contact or activity also shall include the length of the contact or activity (in minutes), the service coordination short-term goal that the contact activity is addressing, and progress toward achieving the service coordination goal.

**12VAC35-225-190. Transition.**

A. A child shall be considered potentially eligible for preschool services under Part B unless there is a clear expectation that the child will no longer require services by the time he reaches age three. The determination of whether a particular child receiving early intervention services is

potentially eligible for Part B shall be made by that child's IFSP team as part of the transition process.

B. The department shall ensure the parent of a child with disabilities is informed of the availability of services under section 619 of the Individuals with Disabilities Education Act not fewer than 90 days prior to the toddler's third birthday.

C. For each child who is potentially eligible for preschool services under Part B, and unless the parent objects, the service coordinator shall ensure notification to the local school division and the Virginia Department of Education not fewer than 90 days before the child's third birthday or the anticipated date of transition if the child is age two by September 30 of a given school year.

1. The notification shall include the child's name, date of birth and parental contact information (including the parents' names, addresses, and telephone numbers).

2. The parent shall be informed in writing, on the IFSP, of the information that will be included in the notification, the earliest date on which the notification will be sent to the local school division and the Virginia Department of Education, and his right to opt out of the notification by initialing the opt out statement on the IFSP.

3. If the parent opts out of the notification, the notification shall not be sent.

D. If a child is potentially eligible for preschool services under Part B, the service coordinator shall, with the approval of the child's family, convene a transition conference among the local early intervention system, the family, and the local school division at least 90 days and (at the discretion of all parties) up to nine months before the child's third birthday, or anticipated date of transition if the child is age two by September 30 of a given school year, to discuss any services the child may receive under Part B.

E. If a child is not potentially eligible for preschool services under Part B, the service coordinator shall, with the approval of the family, make a reasonable effort to convene a transition conference among the local early intervention system, the family, and providers of other appropriate services, as available, to discuss appropriate services that the child may receive.

F. The service coordinator shall ensure development of a transition plan in the IFSP at least 90 days, and (at the discretion of all parties) up to nine months, before the child's third birthday, or anticipated date of transition if the child is age two by September 30 of a given school year, for all children exiting early intervention.

1. The family shall be included in the development of the transition plan.

2. The transition plan shall include steps for the child to exit the early intervention system and any transition services that the IFSP team identifies as needed by that child and family.

3. The service coordinator shall review with the parent the program options for a child with a disability for the period from his third birthday through the remainder of the school year.

G. The meeting to develop the transition plan and the transition conference may be combined.

H. The meeting to develop the transition plan and the transition conference, whether combined or held separately, shall meet the requirements of an IFSP meeting in 12VAC35-225-120.

**12VAC35-225-200. Referral and discharge.**

A. The service coordinator shall transmit, with parental permission, child-specific information (e.g. current IFSP), recent assessment findings, and other pertinent records to the appropriate school division in which the child resides as soon as possible after the notification to the local school division to ensure continuity of services.

B. If the child is found eligible for early intervention services more than 45 but less than 90 days before the child's third birthday, or before April 1 when the child will reach the age of eligibility for special education at the beginning of the upcoming school year, then as soon as possible after eligibility is determined, the service coordinator shall provide the notification required in 12VAC35-225-190.C unless the parent objects to such disclosure.

C. If a child is referred to the local early intervention system less than 45 days before the child's third birthday and that child may be eligible for preschool services under Part B, the service coordinator shall, with parental consent, refer the child to the local school division and Virginia Department of Education, but the local early intervention system shall not be required to conduct an eligibility determination, assessment for service planning, or hold an initial IFSP meeting under these circumstances.

D. The service coordinator shall ensure exit ratings on the child outcome indicators required by the U.S. Department of Education, Office of Special Education Programs are completed prior to discharge from Virginia's early intervention system for all children who had an entry rating and who have been in the early intervention system for six months or longer since their initial IFSP.

1. The exit rating shall be done no more than six months prior to the child's exit from Virginia's early intervention system.

2. Any circumstances that prevent completion of exit ratings shall be documented in a contact note.

E. The service coordinator shall ensure that no early intervention services are provided on or after the child's third birthday.

Part V:
Service Funding and Payment Systems

**12VAC35-225-210. Use of Part C funds.**

A. Funds available under Part C shall be used for the following activities:

1. To implement and maintain a statewide system of early intervention supports and services for children with disabilities and their families;

2. For direct early intervention supports and services for children with disabilities and their families that are not otherwise funded through other public or private sources; and

3. To expand and improve supports and services for children with disabilities and their families that are otherwise available.

B. Federal Part C funds and state general funds designated for early intervention services under Part C shall be used as the payor of last resort and shall not be used to satisfy a financial

commitment for supports and services that would otherwise have been paid for from another public or private source, including any medical program administered by the Department of Defense, but for the enactment of Part C of the Individuals with Disabilities Education Act.

C. The department and local lead agencies shall identify and coordinate all available resources to pay for early intervention services, including federal, state, local, and private sources.

D. The service coordinator shall coordinate the funding sources for early intervention services in each IFSP.

E. If necessary to prevent a delay in the timely provision of appropriate early intervention services to a child or the child's family, funds available under Part C may be used to pay the provider of early intervention supports and services (excluding medical services) and for functions associated with the child find system, eligibility determination, and assessment for service planning pending reimbursement from the agency or entity that has ultimate responsibility for the payment.

F. The department shall establish an interagency agreement with each participating state agency to ensure the provision of, and establish financial responsibility for, early intervention supports and services; to establish procedures for achieving a timely resolution of intra-agency and interagency disputes about payments for a given service or disputes about other matters related to Virginia's early intervention system; and to ensure that no early intervention supports and services to which a child is entitled are delayed or denied because of disputes between agencies regarding financial or other responsibilities.

G. Local lead agencies shall develop interagency agreements, contracts, or memoranda of agreement with as many early intervention service providers as possible to meet the needs of children with disabilities and their families and shall allow families to have access to any certified early intervention service provider in the family's payor network, who agrees to comply with all Part C requirements and is working in the local early intervention system area.

**12VAC35-225-220. Services provided at public expense.**

A. The following services shall be provided at public expense and at no cost to families:

1. Child find activities;

2. Eligibility determination and assessment for service planning;

3. Service coordination;

4. Administrative and coordinative activities related to the development, review, and evaluation of IFSPs and interim IFSPs; and

5. Administrative and coordinative activities related to implementation of procedural safeguards and other components of the statewide early intervention system related to child find, eligibility determination, assessment, and development of IFSPs.

B. Localities shall not be required to provide funding for any costs for early intervention services provided at public expense, either directly or through participating local public agencies.

**12VAC35-225-230. System of payments.**

A. The department shall establish and implement a system of payments, including a schedule of sliding family fees with monthly caps, for early intervention services provided under Part C. Under that system:

1. Fees shall not be charged to parents for the services a child is otherwise entitled to receive at no cost, including those listed in 12VAC35-225-220;

2. All early intervention services other than those listed in 12VAC35-225-220 shall be subject to family fees;

3. The inability of the parent of a child with a disability to pay for services shall not result in a delay or denial of services to the child or his family, such that if the family meets the criteria for inability to pay, the child shall receive all early intervention services at no cost to the family;

4. Parents shall not be charged any more than the actual cost of services, factoring in any amount received from other payment sources for that service;

5. Charges for early intervention supports and services shall be consistent regardless of the anticipated payment source, and parents with public insurance or benefits or private insurance shall not be charged disproportionately more than parents who do not have public insurance or benefits or private insurance;

6. All parents shall have the opportunity to submit information to establish ~~an~~ ability to pay and a monthly cap for family fees. Parents who choose not to provide the required income information shall be charged for all applicable co-payments, deductibles, and the full early intervention rate for services not covered by insurance;

7. The service coordinator shall ensure a family's ability to pay is established and consent for use of private insurance, public benefits, or public insurance is determined at intake for children who are covered by Medicaid or FAMIS and for all other children prior to delivering early intervention services other than those services that must be provided at no cost to the family; and

8. A family's ability to pay shall be reviewed at each annual IFSP and any time the family's financial circumstances change. If the family is unable to provide the required information, it shall be charged for all applicable co-payments and deductibles or the full early intervention rate for services not covered by insurance.

B. Family fees collected shall be retained by the local lead agency to support the local early intervention system.

C. Parents who wish to contest the imposition of a fee or the determination of the parents' ability to pay may contest such determinations in accordance with 12VAC35-225-380.A.

**12VAC35-225-240. Use of public benefits or public insurance.**

A. Parents shall not be required to enroll in public benefits or public insurance programs as a condition of receiving early intervention services, and parental consent shall be required prior to

using the public benefits and public insurance of a child or parent if that child or parent is not already enrolled in such a program.

B. Parental consent shall be obtained before the local lead agency or the early intervention service provider discloses, for billing purposes, a child's personally identifiable information to the child's assigned Managed Care Organization or, if the child is not enrolled in managed care, to the Department of Medical Assistance Services.

C. In Virginia, use of a child's or parent's public benefits or public insurance to pay for early intervention services shall not:

1. Decrease available lifetime coverage or any other insured benefit for that child or parent under that program;

2. Result in the child's parents paying for services that would otherwise be covered by the public benefits or public insurance program;

3. Result in any increase in premiums or discontinuation of public benefits or public insurance for that child or his parents; or

4. Risk loss of eligibility for the child or that child's parents for home and community-based waivers based on aggregate health-related expenditures.

D. If the parent gives consent for use of his private insurance to pay for early intervention services for a child who is covered by private insurance and by either public benefits or public insurance, the parent shall be responsible for the costs associated with use of the private insurance, as specified in 12VAC35-225-250.E.

E. If the parent does not provide the consent to use or enroll in public benefits or public insurance or to disclose information to the child's assigned Managed Care Organization or, if the child is not enrolled in managed care, to the Department of Medical Assistance Services for billing purposes, the local lead agency must still make available the early intervention services on the IFSP to which the parent has provided consent.

**12VAC35-225-250. Use of private insurance.**

A. The private insurance of a family may not be used to pay for early intervention services unless the parent has provided prior consent.

B. Parental consent to use of private insurance to pay for early intervention services shall be obtained when the local lead agency or early intervention service provider seeks to use the parent's private insurance or benefits to pay for the initial provision of early intervention services and each time there is an increase (in frequency, length, duration or intensity) in the provision of services in the child's IFSP.

C. The consent requirements in 12VAC35-225-250.A-B shall also apply when use of private insurance is required prior to use of public benefits or public insurance.

D. If a parent is determined to be unable to pay and does not provide consent for use of private insurance, the lack of consent shall not be used to delay or deny any early intervention services to the child or family.

E. If the parent provides consent for use of the family's private insurance to pay for early intervention services, Part C or other funds may be used to pay for co-payment or deductible amounts that exceed the family's monthly cap, unless the family has money in a flexible spending account that automatically pays the early intervention service provider or the family for these costs.

F. Families shall be responsible for paying their insurance premiums.

**12VAC35-225-260. Written notification.**

When obtaining parental consent for the provision of early intervention services or for use of public or private insurance or benefits, or both, the service coordinator shall ensure the parents receive written information on Virginia's system of payment policies, which includes the following:

1. Required notification to parents of children covered by Medicaid including:

a. Parental consent requirements in 12 VAC35-225-240 B;

b. The cost protections in 12VAC35-225-240 C;

c. The local lead agency responsibility to offer the early intervention services to which the parent has provided consent even if the parent does not provide consent for use of public benefits or public insurance as specified in 12VAC35-225-240 E;

d. The parent's right to withdraw consent for disclosure, for billing purposes, of a child's personally identifiable information to the child's assigned Managed Care Organization or, it the child is not enrolled in managed care, to the Department of Medical Assistance Services at any time; and

e. Categories of costs to parents as specified in 12VAC35-225-240 D.

2. Potential costs to the parent when their private insurance is used, which may include co-payments, deductibles, premiums or other long-term costs such as the loss of benefits because of annual or lifetime health insurance coverage caps under the insurance policy;

3. The payment system and schedule of sliding fees that may be charged to the parents for early intervention services;

4. The basis and amount of payments or fees;

5. Information on the determination of ability to pay and inability to pay, including when and how the determination is made;

6. Assurances regarding fees and service provision as specified in 12VAC35-225-230.A.1 and 12VAC35-225-230.A.3-5;

7. The policy on failure to provide the required income information as specified in 12VAC35-225-230.A.5;

8. Policies regarding use of federal or state Part C funds to pay for costs such as insurance co-payments or deductibles; and

9. Parent rights as specified in 12VAC35-225-230.C.

**12VAC35-225-270. Billing and collections of family fees, public benefits, and insurance.**

A. The local lead agency shall ensure billing for and collection of all family fees for the local early intervention system by:

1. Doing all billing and collection of family fees,

2. Contracting with a single entity to bill for and collect all family fees for the local early intervention system; or

3. Assigning the billing and collection of the family fee to a specific early intervention service provider for each child.

B. Early intervention service providers shall routinely, and no less than one time per month, confirm with families whether their insurance has changed and shall notify the local system manager immediately if a child who has or had Medicaid or FAMIS no longer has Medicaid or FAMIS or does not have the Medicaid Early Intervention benefit, and notify the service coordinator if the child had TRICARE or private insurance coverage and the child no longer has that coverage or the child has newly acquired Medicaid or FAMIS, TRICARE, or private insurance coverage.

C. The local system manager, or his designee, shall provide oversight to ensure Medicaid or FAMIS information is correctly entered into the department's early intervention management information system, ITOTS, to begin and maintain enrollment in the Medicaid early intervention benefit.

**12VAC35-225-280. Provider billing for early intervention services.**

A. In order to receive reimbursement from federal or state Part C funds as the payor of last resort, early intervention service providers shall:

1. Have a contractual relationship with the local early intervention system; and

2. Submit a contact log or contact notes to the local lead agency no later than the 21st of each month for all services provided in the previous month, including any service for which reimbursement is sought from Part C funds.

B. Early intervention service providers shall accept Medicaid reimbursement for medically necessary early intervention services as payment in full.

C. In order to bill Medicaid for early intervention services other than service coordination, the provider shall:

1. Be certified as an early intervention practitioner;

2. Enroll with the Department of Medical Assistance Services and Medicaid contracted Managed Care Organizations as an early intervention provider;

3. Provide services to children who are determined eligible for early intervention services under Part C;

4. Provide covered services as listed on the child's IFSP and, with the exception of the assessment for service planning and IFSP meetings, services that are approved by a physician, physician's assistant or nurse practitioner.

5. Comply with all other applicable DMAS requirements.

D. In order to bill Medicaid for service coordination, the provider shall:

1. Be certified as an early intervention case manager;

2. Enroll with the Department of Medical Assistance Services and Medicaid contracted Managed Care Organizations as an early intervention provider;

3. Deliver service coordination in accordance with a signed Initial Early Intervention Service Coordination Plan or a signed Individualized Family Service Plan (IFSP);

4. Provide at least one activity during the month being billed to the child, the family, service providers, or other organizations on behalf of the child or family in order to coordinate supports and services and assist the family in accessing needed resources and services;

5. Document the contact or communication completely and correctly in accordance with 12VAC35-225-180;

6. Make a phone, email, text, or face-to-face contact with the family at least one time every three calendar months, or document attempts of such contacts;

7. Ensure documented face-to-face interaction between the service coordinator and the family at the development of the initial IFSP and the annual IFSP along with documentation that the service coordinator observed the child during the calendar month that the IFSP meeting was held;

8. Submit the health status indicator questions to the child's physician every six months; and

9. Comply with all other applicable DMAS requirements.

E. Children who are dually enrolled in Virginia's early intervention system and in Medicaid or FAMIS shall receive service coordination under the early intervention targeted case management program.

## Part VI
## Procedural Safeguards

### 12VAC35-225-290. Notice of rights and procedural protections.

A. The service coordinator shall provide a written copy and explanation of the child's and family's rights and procedural safeguards at the intake visit and shall provide ongoing information and assistance to the family regarding their rights and procedural safeguards throughout the period of the child's eligibility for early intervention services.

B. The notice and explanation provided at the intake visit shall fully inform parents about the confidentiality requirements under Part C.

**12VAC35-225-300. Surrogate parent selection.**

A. A surrogate parent shall be assigned to a child if no parent of the child can be identified, the local system cannot after reasonable efforts locate a parent, or the child is a ward of the state. The service coordinator shall make reasonable efforts to ensure that a surrogate parent is assigned to the child within 30 days after determining the child needs a surrogate parent. In implementing the surrogate parent requirements, if the child is in foster care or a ward of the state, the service coordinator shall consult with the public agency that has been assigned care of the child.

B. The person selected as a surrogate parent shall:

1. Not be an employee of any public agency or early intervention service provider that provides early intervention services, education, care or other services to the child or any member of the child's family;

2. Have no personal or professional interest that conflicts with the interest of the child he or she represents; and

3. Have knowledge and skills that ensure adequate representation of the child.

C. A surrogate parent assigned to a child pursuant to this section shall have the same rights as a parent for all purposes in the early intervention system.

**12VAC35-225-310. Prior written notice.**

A. Prior written notice shall be given to the parent at least five days before an early intervention provider proposes or refuses to initiate or change identification, eligibility determination, or placement of the child or the provision of early intervention services to the child or family.

B. The prior written notice shall be in sufficient detail to inform the parent of the action being proposed or refused, the reasons for taking the action; and available procedural safeguards, including dispute resolution options.

C. The prior written notice shall be written in language understandable to the general public and shall be provided in the native language of the parent or other mode of communication used by the parent, unless it is clearly not feasible to do so. If the parent does not use a written language, documentation of the procedures used to provide prior notice shall be included in a contact note.

**12VAC35-225-320. Parental consents.**

A. Written parental consent shall be obtained prior to all eligibility determinations and assessments; providing early intervention services; disclosing personally identifiable information to anyone other than authorized representatives, officials or employees of the department, local lead agency or early intervention service providers collecting, maintaining or using information under Part C; and using public or private insurance or benefits. When seeking parental consent, the service coordinator shall ensure the following:

1. The parent is fully informed of all information relevant to the activity for which consent is sought, in the parent's native language;

2. The parent understands and agrees in writing to the carrying out of the activity for which consent is sought;

3. The consent form describes that activity and lists the early intervention records (if any) that will be released and to whom they will be released; and

4. The parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time and that, if a parent revokes consent, that revocation is not retroactive.

B. The parent shall have the right to accept or decline specific early intervention services identified by the IFSP team and may decline a service after first accepting it without jeopardizing their right to obtain other early intervention services.

C. If a parent does not give consent for eligibility determination, assessment or provision of early intervention services, the service coordinator shall document reasonable efforts to ensure that the parent is fully aware of the nature of the eligibility determination, assessment, or the services that would be available and understands the child will not be able to receive the eligibility determination, assessment or services unless consent is given.

D. If a parent refuses to provide consent to disclose personally identifiable information, the service coordinator shall explain to the family the impact of their decision to refuse consent for the release of information, including why consent is needed, how the information will be used, and how the absence of that information might affect the ability of their child to receive early intervention services. The explanation provided and the parent's final decision regarding consent to disclose the information shall be documented in a contact note.

E. Due process hearing procedures shall not be used to challenge a parent's refusal to provide any consent required under this section.

**12VAC35-225-330. Early intervention records.**

A. The local lead agency shall maintain a central early intervention record for each child referred to the local early intervention system. The central early intervention record must include the following:

1. Accurate demographic and referral information;

2. Signed releases and consents;

3. Other completed procedural safeguards forms;

4. Completed and signed Initial Early Intervention Service Coordination Plan, if the child has Medicaid or FAMIS;

5. Assessment reports;

6. Medical reports;

7. All other documentation collected during eligibility determination and IFSP development, including reports from previous outside screenings and assessments;

8. Completed eligibility determination form or forms;

9. All IFSPs developed, including documentation of periodic reviews;

10. Contact logs or contact notes submitted by providers, including service coordinators;

11. Copies of all correspondence to and from the local lead agency or its providers with or on behalf of the family;

12. Court orders related to service provision, custody issues, or parental rights;

13. Documentation of the family's ability to pay, unless it is kept in a separate financial file; and

14. Record access log listing any individual, except parents and authorized employees, obtaining access to the early intervention record, including the individual's name, date of access and purpose of access.

B. Each early intervention service provider shall maintain a clinical working file that must include, at a minimum:

1. A copy of the IFSP (including annual and periodic reviews),

2. Contact notes, and

3. Any completed screening or assessment protocols if not housed in the early intervention record.

C. Early intervention service providers working in the provider agency where the central early intervention record is housed shall have the option to maintain the items listed above in the central early intervention record instead of in a separate clinical or working file.

**12VAC35-225-340. Confidentiality of personally identifiable information.**

A. The department, local lead agencies, and all early intervention service providers shall ensure the confidentiality of personally identifiable information collected, maintained or used under Part C from the point in time when the child is referred to the local early intervention system until the later of when the provider agency is no longer required to maintain or no longer maintains that information under applicable federal and Virginia laws. Confidentiality shall be maintained at the collection, maintenance, use, storage, disclosure, and destruction stages.

B. One official at each local lead agency and each early intervention service provider shall assume responsibility for ensuring confidentiality of any personally identifiable information.

C. The department, local lead agency, and all early intervention service providers shall train all persons collecting or using personally identifiable information regarding federal and Virginia requirements for safeguarding records and personally identifiable information.

D. Each local lead agency and early intervention service provider shall maintain, for public inspection, a current listing of the names and positions of those employees within the local lead agency and early intervention service provider who have access to personally identifiable information.

**12VAC35-225-350. Inspection and review of early intervention service records.**

A. Parents of infants and toddlers who are referred to, or receive early intervention services, shall have the right to inspect and review all early intervention records collected, maintained, or used by the local lead agency or early intervention service providers, including records related to eligibility determination, assessments for service planning, development and implementation of IFSPs, provision of early intervention services, individual complaints involving the child, or any other part of the child's early intervention record.

B. The local lead agency and early intervention service providers shall provide parents, upon request, a list of the types and locations of early intervention records collected, maintained, or used by the local lead agency and early intervention service providers.

C. If any early intervention record includes information on more than one child, the parent has the right to inspect and review only the information relating to his child or to be informed of that specific information.

D. The right to inspect and review records includes the right to:

1. A response from the local lead agency or early intervention service provider to reasonable requests for explanations and interpretations of the early intervention records;

2. Request that the local lead agency or early intervention service provider provide copies of the early intervention records if failure to provide those copies would effectively prevent the parent from exercising the right to inspect and review the records; and

3. Have a representative of their choice inspect and review the records.

E. The local lead agency and early intervention service providers shall comply with a parent's request to inspect and review records without unnecessary delay, before any meeting regarding an IFSP or a due process hearing, and in no case more than 10 days after the request is made.

F. Upon request, the parent shall receive one copy of his child's early intervention record at no cost to the parent. After the parent has received one copy of the child's early intervention record at no cost, the local lead agency or early intervention service provider may charge a fee for additional copies. However, the local lead agency or early intervention service provider shall not charge a fee for additional copies of the child’s records if the fee effectively prevents the parent from exercising his right to inspect and review those records. The local lead agency or early intervention service provider shall not charge a fee to search for or to retrieve information and shall provide at no cost to parents a copy of each eligibility determination, assessment and IFSP as soon as possible after each IFSP meeting.

G. The local lead agency and early intervention service providers shall presume the parent has authority to inspect and review records relating to his child unless the local lead agency or early intervention service provider has been provided documentation that the parent does not have that authority under applicable Virginia laws governing such matters as custody, foster care, guardianship, separation and divorce.

H. The local lead agency and early intervention service providers shall keep a record of parties obtaining access to early intervention records collected, maintained or used by the early intervention system unless such access is by the parent or parents or authorized representatives and employees of the participating agency. The record of access shall include the name of the party accessing the record, the date access was given, and the purpose for which the party is authorized to use the early intervention record.

Statutory Authority

**12VAC35-225-360. Request to amend information in the early intervention record.**

A. A parent who believes that information in the early intervention records collected, maintained, or used in the early intervention system is inaccurate, misleading, or violates the privacy or other rights of the child or parent shall have the right to request that the agency that maintains the information amend the information.

B. When a parent requests that information in a record be amended, the local lead agency or early intervention service provider shall decide whether to amend the information in accordance with the request within a reasonable period of time after the request is received.

C. If the local lead agency or early intervention service provider refuses to amend the information in accordance with the request, the local lead agency or early intervention service provider shall inform the parent of the refusal and advise the parent of the right to a local hearing to challenge the information in their child's early intervention record.

1. A hearing shall be held within 30 days after the request is received by the local lead agency or early intervention service provider from the parent.

2. The parent shall be given written notice of the date, place and time at least 15 days before the hearing.

3. The hearing may be conducted by any person, including an official of the local lead agency or early intervention service provider, who does not have a direct interest in the outcome of the hearing.

4. The local lead agency or early intervention service provider shall give the parent a full and fair opportunity to present evidence relevant to the issues raised. The parent may, at their own expense, be assisted or represented by persons of their own choice, including an attorney.

5. The local lead agency or early intervention service provider shall issue its decision in writing to the parent within five business days after the conclusion of the hearing.

6. The decision of the local lead agency or early intervention service provider shall be based solely on the evidence presented at the hearing and shall include a summary of the evidence and the reasons for the decision.

7. If the hearing determines that the information is inaccurate, misleading or in violation of the privacy or other rights of the child or parent, the local lead agency or early intervention service provider shall amend the information accordingly and inform the parents in writing.

8. If the hearing determines that the information is not inaccurate, misleading or in violation of the privacy or other rights of the child or parent, the local lead agency or early intervention service provider shall inform the parent of the right to place in the early intervention record a statement commenting on the information or setting forth any reasons for disagreeing with the decision of the local lead agency or early intervention service provider. Any such explanation placed in the early intervention record shall be maintained as part of the early intervention record as long as the record or contested portion is maintained by the agency. If the early intervention record or the contested portion of the record is disclosed by the local lead agency or early intervention service provider to any party, the explanation shall also be disclosed to the party.

D. If the parent is not satisfied with the local hearing determination, the local lead agency or early intervention service provider shall advise the parent of his right to file a due process complaint with the department.

**12VAC35-225-370. Maintenance of early intervention service records.**

A. The local lead agency and early intervention service providers shall inform the parent when personally identifiable information collected, maintained or used in the early intervention system is no longer needed to provide services to the child and shall destroy the information at the request of the parent.

B. A child's early intervention record shall be destroyed at the request of his parent. However, a permanent record of a child's name, date of birth, parent contact information (including address and phone number), names of service coordinator or coordinators, early intervention service provider or providers, and exit data (including year and age upon exit and any programs entered into upon exiting) may be maintained without time limitation.

C. The local lead agency and early intervention service providers shall ensure early intervention records are maintained for a minimum of three years following the child's discharge from the local early intervention system.

## Part VI
## Dispute Resolution

**12VAC35-225-380. Notification of complaint resolution options.**

A. The department shall ensure the availability of procedures for resolving complaints through mediation, an administrative complaint, or a due process hearing.

B. The service coordinator shall inform the child's parent of all options for resolving complaints by providing written and verbal information that explains the options and the procedures for each and shall provide the parent with a contact at the department who can assist the parent in filing a complaint.

**12VAC35-225-390. Mediation.**

A. Mediation shall be voluntary on the part of all parties; shall be available at any time to parties to disputes involving any matter under Part C, including matters arising prior to the filing of a due process complaint; and shall not be used to delay or deny a parent's right to a due process hearing.

B. The department shall maintain a list of individuals who are qualified mediators and knowledgeable in laws and regulations relating to the provision of early intervention services and shall select mediators on a random or rotational basis.

C. An individual who serves as a mediator shall not be an employee of the department, a local lead agency, or an early intervention service provider that is involved in the provision of early intervention services or other services to the child and shall not have a personal or professional interest that conflicts with the person's objectivity. A person who otherwise qualifies as a mediator shall not be considered an employee of the department, a local lead agency or an early intervention provider solely because he or she is paid by the agency to serve as a mediator.

D. The department shall appoint a trained and impartial mediator within five days of receiving the request for mediation.

E. Each session in mediation shall be scheduled in a timely manner and shall be held in a location that is convenient to the parties involved in the dispute.

F. Mediation, including a written mediation agreement reflecting agreements reached by the parties to the dispute, shall be completed within 15 calendar days of the receipt by the department of notice that both parties have agreed to mediation. If resolution is not reached within 15 days, the department shall inform the parents in writing that they may request a due process hearing.

G. Extensions of the 15-day timeline may be granted for good cause. If there is a simultaneous request for mediation and a due process hearing, an extension shall not result in a violation of the 30-day timeline for completion of the due process hearing.

H. If the parties resolve the dispute through the mediation process, the parties shall execute a legally binding agreement that sets forth the resolution, states that all discussions that occurred during the mediation process are confidential and may not be used as evidence in any subsequent due process or civil proceeding, and is signed by both the parent and a representative of the local lead agency or early intervention service provider who has the authority to bind that agency.

I. The department shall bear the full cost of the mediation process.

**12VAC35-225-400. Due process hearing.**

A. Due process hearings shall be available to the parent of any child referred to the local early intervention system to resolve complaints regarding an early intervention provider's proposal or refusal to initiate or change his child's identification, eligibility determination, or placement or to the provision of early intervention services to the child or family.

B. The department shall arrange for the appointment of an impartial hearing officer within five days following receipt of a request for a due process hearing. The due process hearing officer shall:

1. Not be an employee of the department, a local lead agency or an early intervention service provider involved in the provision of early intervention services or the care of the child. A person who is otherwise qualified shall not be considered an employee of the department, a local lead agency, or an early intervention provider solely because he is paid by the agency to implement the due process hearing procedures;

2. Not have a personal or professional interest that conflicts with his objectivity in implementing the process;

3. Have knowledge about the provisions under Part C and the needs of and early intervention services available for children with disabilities and their families;

4. Listen to the presentation of relevant viewpoints about the due process complaint;

5. Examine information relevant to the issues;

6. Seek to reach a timely resolution of the due process complaint; and

7. Provide a record of the proceedings, including a written decision.

C. The due process hearing shall be carried out at a time and place that is reasonably convenient for the parent.

D. Any parent involved in a due process hearing shall have the right to:

1. Be accompanied and advised by counsel and by individuals with special knowledge or training with respect to early intervention services for children with disabilities;

2. Present evidence, and confront, cross-examine, and compel the attendance of witnesses;

3. Prohibit the introduction of any evidence at the hearing that has not been disclosed to the parent at least five days before the hearing;

4. Obtain a written or electronic verbatim transcript of the hearing at no cost to the family; and

5. Receive a written copy of the findings of fact and decisions at no cost to the parent.

E. The due process hearing shall be conducted, and a written decision shall be mailed to all parties, within 30 days of receipt by the department of the parent's request for a due process hearing. The hearing officer may grant a specific extension of the timeline at the request of either party.

F. Any party aggrieved by the findings and decision issued pursuant to a due process hearing shall have the right to bring a civil action in Virginia or federal court.

G. During the pendency of any proceeding involving a due process complaint, unless the local lead agency and the parent of the child agree otherwise, the child shall continue to receive the appropriate early intervention services in the setting identified in the IFSP for which the parent has provided consent. If the due process complaint involves an application for initial services, the child shall receive those services that are not in dispute.

H. Costs for due process hearings shall be equally shared by the local lead agency and the department. The costs shared include expenses of the hearing officer (i.e., time, travel, secretarial, postal and telephone expenses), expenses incurred by order of the hearing officer

(i.e., independent educational evaluations, deposition or transcript), and expenses for making a record of a hearing (i.e., hearing tapes).

I. The department shall not be responsible for expenses incurred for witnesses (except where hearing officers subpoena witnesses on their own initiative) or for the parent's attorney's fees.

**12VAC35-225-410. Administrative complaint.**

A. An individual or organization (including those from another state) shall have the right to file an administrative complaint with the department alleging that the local lead agency, an early intervention service provider or participating agency has violated a requirement of Part C.

B. The department shall widely disseminate to parents and other interested individuals, including parent training and information centers, protection and advocacy agencies, and other appropriate entities the procedures for filing and resolving administrative complaints.

C. An administrative complaint shall be made in writing to the department, allege a violation that occurred not more than one year prior to the date the complaint is received by the department, and include the following:

1. A statement that the department, local lead agency or early intervention service provider has violated a requirement of Part C;

2. The facts on which the statement is based;

3. The signature and contact information for the complainant; and

4. If alleging violations with respect to a specific child, (i) the name and address of the child; (ii) the name of the early intervention service provider serving the child; (iii) a description of the problem, including facts related to the problem; and (iv) a proposed resolution to the problem to the extent known and available to the complainant if there is one at the time the complaint is filed.

D. The party filing the complaint shall forward a copy of the complaint to the local lead agency or the early intervention service provider serving the child at the same time the party files the complaint with the department.

E. Within 60 days after a complaint is received, the department shall:

1. Carry out an independent on-site investigation, if the department determines that an investigation is necessary;

2. Give the complainant the opportunity to submit additional information, either orally or in writing, about the allegations in the complaint;

3. Provide the local lead agency, other participating agency or early intervention service provider with an opportunity to respond to the complaint within 10 days by providing a proposal to resolve the complaint and an opportunity to voluntarily engage in mediation;

4. Review all relevant information and make an independent determination as to whether the local lead agency, other participating agency or early intervention service provider is violating a requirement of Part C;

5. Issue a written decision to the complainant that addresses each allegation in the complaint and contains findings of fact and conclusions and the reasons for the final decision.

6. The final decision may include recommendations for technical assistance, negotiations and corrective actions to achieve compliance, as well as timelines for completion

7. If, in resolving an administrative complaint, the department finds a failure to provide appropriate early intervention services then the final decision shall address the corrective actions appropriate to address the needs of the child who is the subject of the complaint and his family (such as compensatory services or monetary reimbursement) and appropriate future provision of services for all children with disabilities and their families.

F. The 60-day timeline for resolving an administrative complaint may be extended only if exceptional circumstances exist with respect to a particular complaint or the parent (or individual or organization) and the local lead agency, other participating agency or early intervention service provider involved in the complaint agree to extend the timeline to engage in mediation.

G. If the administrative complaint received by the department is also the subject of a due process hearing or contains multiple issues of which one or more are part of that due process hearing, the department shall set aside any part of the complaint that is being addressed in the due process hearing until the conclusion of the hearing. Any issue in the complaint that is not part of the due process hearing shall be resolved using the 60-day time limit and the administrative complaint procedures.

H. If an issue is raised in a complaint that has previously been decided in a due process hearing involving the same parties, the hearing decision shall be binding, and the department shall inform the complainant to that effect.

I. A complaint alleging the local lead agency, other participating agency or early intervention service provider's failure to implement a due process hearing decision shall be resolved by the department.

J. A final decision of the department pursuant to this section shall be a final case decision that may be appealed pursuant to the Virginia Administrative Process Act (Va. Code § 2.2-4000 et seq.).

**12VAC35-225-420. Appeal to the Department of Medical Assistance Services.**

A. In addition to the dispute resolution options described in this chapter, Medicaid or FAMIS recipients shall have the right to file an appeal with the Department of Medical Assistance Services (DMAS) pursuant to federal and state Medicaid law. Appeals to DMAS are separate from the dispute resolution options available under this chapter and shall comply with applicable DMAS regulations. ~~when they disagree with certain actions. Actions that may be appealed include:~~

~~1. Disagreement about the child's eligibility for services;~~

~~2. The provision of early intervention services, including those listed on the IFSP; and~~

~~3. The frequency and length of services in the IFSP.~~

~~B. To ensure this right to appeal, the service coordinator shall provide the family with written information on the appeals process, regardless of whether or not the family expresses agreement or disagreement, if the child is found ineligible; the local system is refusing to initiate a service the family is requesting or is refusing to provide a service at the frequency or length desired by the family; or a service is decreased or ended, unless the family requested the service be decreased or ended.~~

B~~C~~. Families shall follow all applicable Department of Medical Assistance Services requirements when filing an appeal.

Part VIII
Early Intervention Practitioner Certification Requirements

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

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

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

1. Counselors:

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

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

2. Behavior Analysts certified through the Behavior Analyst Certification Board as a Board Certified Behavior Analyst (BCBA);

3. Educators:

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

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

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

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

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

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

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

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

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

7. Nurses:

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

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

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

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

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

11. Psychologists:

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

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

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

12. Social workers:

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

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

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

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

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

1. Assistant Behavior Analysts certified through the Behavior Analyst Certification Board as a Board Certified Assistant Behavior Analyst (BCaBA);

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

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

4. Nurses:

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

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

5. Occupational therapy assistants licensed by the Virginia Board of Medicine; and

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

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

**12VAC35-225-440. Supervision requirements.**

A. Certified early intervention professionals providing supervision to other early intervention personnel shall complete the supervision training administered by the department. A score of at least 80 percent accuracy on the competency test shall be required for successful completion.

B. Certified early intervention specialists shall work under the supervision of a certified early intervention professional who has completed the required supervision training.

**12VAC35-225-450. Certification required for early intervention service coordinators.**

A. Individual practitioners who provide service coordination to children enrolled in early intervention services shall be certified by the department as early intervention case managers.

B. Certified early intervention case managers shall hold:

1. A minimum of an undergraduate degree in any of the following fields:

a. allied health, including rehabilitation counseling, recreation therapy, occupational therapy, physical therapy, or speech or language pathology;

b. child and family studies;

c. counseling;

d. early childhood;

e. early childhood growth and development;

f. early childhood special education;

g. human development;

h. human services;

i. nursing;

j. psychology;

k. public health;

l. social work;

m. special education – hearing impairments;

n. special education – visual impairments; or

o. other related field or interdisciplinary studies approved by the department; or

2. An associate degree in a related field such as occupational therapy assistant, physical therapy assistant, or nursing; or

3. A high school diploma or general equivalency diploma, or an undergraduate degree in an unrelated field, plus three years' full-time experience, at least 32 hours per week, coordinating direct services to children and families and implementing individual service plans. Direct services address issues related to developmental and physical disabilities, behavioral health or educational needs, or medical conditions. Experience may include supervised internships, practicums, or other field placements.

C. Qualified persons shall demonstrate:

1. Expertise in the provision of service coordination services, as evidenced by successful completion of case management training approved by the department. A score of at least 80% accuracy on the case management training competency test shall be required for successful completion.

2. Knowledge of early intervention principles and practices, including infant and toddler development, family-centered practice and multidisciplinary team practice, by successful completion of the early intervention principles and practices online training modules

administered by the department. A score of at least 80 percent accuracy on each module's competency test shall be required for successful completion.

**12VAC35-225-460. Initial certification and recertification processes.**

A. To apply for initial certification as an early intervention professional, early intervention specialist, or early intervention case manager, applicants shall:

1. Obtain the designated early intervention certification application package from the department; and

2. Submit a completed and signed application package to the department with:

a. A signed assurance that the applicant will comply with all federal and state early intervention requirements;

b. Documentation of the applicant's educational credentials, professional certification, licensing, endorsement, or other qualification for the practice of his discipline in the Commonwealth of Virginia; and

c. Documentation of the applicant's successful completion of the training required by the department.

B. Any initial certification granted to persons who have made application for state certification, licensure, endorsement, or other qualification in his discipline and are awaiting licensure shall be valid only as long as that person meets the requirements of their discipline to practice in Virginia.

C. Three-year recertification. At least 30 days prior to the expiration of the practitioner's certification period, the certified early intervention practitioner shall submit an application for recertification to the department. This application shall include:

1. Documentation of the practitioner's continuing professional certification, licensing, endorsement, or other qualification for the practice of his discipline in the Commonwealth of Virginia; and

2. Documentation that the practitioner has successfully completed at least 30 hours of continuing learning activities during the three-year certification period. The continuing learning activities shall address one or more of the following: (i) evidenced-based practices in early intervention services; (ii) changes in federal or state law, regulations, or practice requirements; (iii) topics identified on a personal development plan; (iv) training needed for new responsibilities relating to early intervention services; and (v) training required by the department. For each continuing learning activity, documentation shall include a description of the activity and sponsoring organization, if applicable; the date or dates of training; the number of hours; and a copy of a certificate or verification of attendance, if applicable.

**12VAC35-225-470. Notice of decision on application for certification or recertification.**

The department shall provide written notice of the decision on the application for certification or recertification within 30 days of the receipt of a completed application and required documentation.

**12VAC35-225-480. Early intervention practitioner database.**

Early intervention practitioners meeting the requirements for certification shall be included in the practitioner database maintained by the department. Early Intervention practitioners are responsible for notifying the department of any change that may affect their early intervention certification status or their participation in Virginia's early intervention services system.

**12VAC35-225-490. Restoration of expired certifications.**

A. The department shall notify practitioners in writing of the date their early intervention certification expired and that the early intervention practitioner has been placed on inactive status in the practitioner database maintained by the department.

B. Early intervention practitioners whose early intervention certification has expired may apply to the department for restoration of their certification.

C. The department may restore early intervention certification for early intervention practitioners under the following conditions:

1. The individual's early intervention certification has been lapsed for a period of less than one year; and

2. The early intervention certification:

a. Has lapsed because the early intervention practitioner failed to complete the three-year recertification requirements and the practitioner provides documentation to the department demonstrating (i) he is currently qualified for the practice of his discipline in the Commonwealth of Virginia, and (ii) he has completed at least 30 hours of training addressing one or more of the topics specified in 12VAC35-225-450.B.1 or

b. Has lapsed because the early intervention practitioner's discipline-specific qualification expired and the practitioner provides documentation to the department demonstrating that he now holds a current license, certification, endorsement, or other qualification for the practice of his discipline in the Commonwealth of Virginia.

D. The department shall provide written notice of its decision to approve or deny the early intervention practitioner's request for restoration of his early intervention certificate within 30 days after the department receives a completed request and all required documentation.

E. Upon restoration of the practitioner's early intervention certification, the department shall record the active status of the certification in the practitioner database maintained by the department.

**12VAC35-225-500. Termination of certification.**

A. The department shall terminate an early intervention practitioner's early intervention certification under the following circumstances:

1. The practitioner's discipline-specific license, certification, or endorsement has been suspended, revoked, or otherwise terminated by the appropriate Virginia health regulatory board or other Virginia entity exercising appropriate authority over the practitioner's discipline-specific license, certification, or endorsement;

2. The practitioner, after a year, fails to comply with the recertification requirements set forth in these regulations; or

3. The practitioner fails to comply with his signed assurance that he will comply with all federal and state early intervention requirements.

B. The department shall notify the early intervention practitioner in writing of the date of and reason for termination and that the practitioner has been removed from the practitioner database maintained by the department.

**12VAC35-225-510. Reconsideration of decision to deny or terminate certification.**

A. In the event that the early intervention practitioner disagrees with the determination to deny or terminate certification, he may request reconsideration from the commissioner. The request shall be made in writing within 30 days of the date of the written notice of denial or termination and may include relevant additional information or documentation to support the request.

B. The commissioner shall review the request for reconsideration and information presented and issue a decision in writing within 30 business days following receipt of the request. The decision of the commissioner shall be a final case decision that may be appealed under the Virginia Administrative Process Act.

## Part IX
## Comprehensive System of Personnel Development (CSPD)

**12VAC35-225-520. CSPD requirements.**

A. The department shall ensure a comprehensive system of personnel development that includes the following:

1. Training of paraprofessionals and the training of primary referral sources with respect to the basic components of early intervention services available in Virginia;

2. Training local lead agencies and early intervention service providers to implement innovative strategies and activities for the recruitment and retention of early intervention service practitioners and service providers;

3. Promoting the preparation of early intervention practitioners and service providers who are fully and appropriately qualified to provide early intervention services; and

4. Training local lead agencies and early intervention practitioners and service providers to coordinate transition services for children with disabilities who are transitioning from the early intervention system under Part C to a preschool program under Section 619 of the Act, Head Start, Early Head Start, or another appropriate program.

B. The department shall establish and maintain an Integrated Training Collaborative that includes university faculty, parents, early intervention service providers and state early intervention professional development specialists to develop and implement professional development opportunities, materials, and resources on evidence-based practices for early intervention practitioners and service providers, families, university students, paraprofessionals, and primary referral sources.

C. The department shall use a variety of mechanisms to ensure awareness about and access to professional development, support, and resources, including statewide conferences and meetings, regional and local training activities, web-based training modules and resources, a written monthly update listing available resources and training, and teleconference and webinar capabilities.

D. The department shall support recruiting and retaining early intervention practitioners and service providers.

## Part X
## Lead Agency Oversight Responsibilities

### 12VAC35-225-530. Lead agency monitoring and supervision.

A. The department shall monitor implementation of and enforce the requirements under Part C, make determinations annually about the performance of each local early intervention system; and report annually to the public on the performance of Virginia and of each local early intervention system within 120 days of submitting Virginia's annual performance report to the United States Department of Education.

B. The primary focus of monitoring activities shall be on improving early intervention results and functional outcomes for all children with disabilities and their families and ensuring that local early intervention systems meet the requirements under Part C.

C. The department shall use quantifiable indicators and, as needed, qualitative indicators, to measure performance in providing early intervention services in natural environments, child find, effective monitoring, the use of mediation, and transition services.

D. The local lead agency and early intervention service providers shall cooperate fully with the department and shall provide all information requested by the department or its designee to monitor local performance and compliance with applicable state and federal regulations.

E. The department shall ensure that when it identifies noncompliance, the noncompliance is corrected as soon as possible and in no case later than one year after the noncompliance was identified.

F. If a local early intervention system is determined to need assistance for two or more consecutive years, need intervention, or need substantial intervention in meeting the requirements under Part C or if the local early intervention system fails to correct noncompliance within one year of identification, then the department shall enforce the requirements under Part C using one or more enforcement actions that may included the following:

1. Technical assistance;

2. Imposing conditions on the local early intervention system's funding;

3. Requiring the development and implementation of an improvement plan; or

4. Withholding funds in whole or in part.

## 12VAC35-225-540. Data collection and reporting.

A. The department shall collect, compile, and report timely, accurate, valid, and reliable data as needed to meet the data collection requirements of the U.S. Department of Education and the Virginia General Assembly.

B. The department shall not report any data that would result in the disclosure of personally identifiable information about individual children.

## Comments Received During the Periodic Review

**Commenter:** We care

**Cost**

It would be nice if Virginia would stop charging for EI services

CommentID: 76913

12/2/19 3:23 pm

**DBHDS Response**
Thank you for your comment. Any fees paid are based on the individual family's ability to pay. No one is denied services based on inability to pay. By collecting family fees and billing insurance, both public and private, Virginia is able to serve more children with developmental needs.

**Commenter:** Christy Evanko, Virginia Association for Behavior Analysis

**ABA and Early Intervention**

The Virginia Association for Behavior Analysis Public Policy Committee suggests that the definition of Applied Behavior Analysis be added to these definitions of the Early Intervention regulations 12VAC35-225-20:

Applied Behavior Analysis (ABA) - The design, implementation, and evaluation of environmental modifications using the principles and methods of behavior analysis to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. This service is tiered in that unlicensed persons typically deliver the intervention under the supervision of a licensed assistant behavior analyst and/or licensed behavior analyst.

While Licensed Behavior Analysts can currently provide some services under the umbrella of early intervention in Virginia, allowing the full practice of ABA for children with developmental disabilities under the age of three. There is a large body of research showing the efficacy and ultimately money-saving (over the lifetime) effects of ABA when used in early intervention for children with autism and other developmental disabilities.
CommentID: 77000

**DBHDS Response**
Thank you. Applied Behavior Analysis (ABA) can be provided within the current regulatory category of Developmental Services. The Infant and Family Individualized Service Plan would include ABA as the modality for providing Developmental Services.

The list of definitions in 12 VAC 35-225-20 defines terms used in the current regulations. ABA is not included as it is not specifically mentioned in the regulations. ABA services can be provided when the treatment team identifies ABA as the modality of treatment. The service would be provided within the scope of the Early Intervention service of Developmental Services and as long as the service provided is consistent with the practices of natural environments and coaching.

**C. <u>Three Emergency Actions (per Item 318.B. of the 2020 Appropriation Act) to Amend:</u>**

- Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services [12 VAC 35 - 105] and
- Regulations for Children's Residential Facilities [12 VAC 35 - 46]

**<u>Action Required: Adopt emergency drafts through Emergency/NOIRA actions:</u>**

1. Emergency Action: Addition of ASAM Criteria [12 VAC 35 - 105]
2. Emergency Action: Addition of ASAM Criteria [12 VAC 35 - 46]
3. Emergency Action: Amendments for Enhanced Behavioral Health Services

**Background:** The 2020 Session of the General Assembly mandated these emergency regulations in Item 318.B. of the 2020 Appropriation Act:

> *B. The Department of Behavioral Health and Developmental Services shall have the authority to promulgate emergency regulations to: i) ensure that licensing regulations support high quality community-based mental health services and align with the changes being made to the Medicaid behavioral health regulations for the services funded in this Act that support evidence-based, trauma-informed, prevention-focused and cost-effective services for members across the lifespan* **[enhanced behavioral health]***; and ii) amend the licensing regulations to align with the American Society of Addiction Medicine Levels of Care Criteria* **[ASAM]** *or an equivalent set of criteria into substance use licensing regulations to ensure the provision of outcome-oriented and strengths-based care in the treatment of addiction. The department shall seek input from the Department of Medical Assistance Services and other stakeholders to align with the implementation plan for changes being made to the Medicaid behavioral health regulations. To implement these changes, the Department of Behavioral Health and Developmental Services shall promulgate emergency regulations to become effective within 280 days or less from the enactment of this Act*

**Explanation:**

**Action Requested:** Approve the drafts to comply with the General Assembly mandate, adopting as a two step action for each: Emergency/NOIRA so the permanent process can begin.

**Next Steps:** If approved, staff will initiate the three Emergency/NOIRA actions

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## 1. Emergency Action: Addition of ASAM Criteria [12 VAC 35 - 105]

townhall.virginia.gov

# Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

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|---|---|
| **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** | Amend the Licensing regulations to align with the ASAM Criteria |
| **Date this document prepared** | 6/30/20 |

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), 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 the subject matter, intent, and goals of this 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 or changes. If applicable, generally describe the existing regulation.*

The Department of Behavioral Health and Developmental Services (DBDHS) was directed by the 2020 General Assembly within the Appropriation Act to utilize emergency authority to promulgate licensing regulations that align with the American Society of Addiction Medicine Levels of Care Criteria (ASAM) or an equivalent set of criteria to ensure the provision of outcome-oriented and strengths-based care in the treatment of addiction. The goal of this regulatory action is to amend the licensing regulations, Rules and Regulations for Licensing Providers by the DBHDS 12VAC35-105, to align with the ASAM Levels of Care Criteria which ensures individualized, clinically driven, participant-directed and outcome-informed treatment.

## 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.*

ASAM- American Society of Addiction Medicine

DBHDS- Department of Behavioral Health and Developmental Services

State Board- State Board of Behavioral Health and Developmental Services

## Mandate and Impetus (Necessity for Emergency)

*Explain why this rulemaking is an emergency situation in accordance with § 2.2-4011 A and B of the Code of Virginia. In doing so, either:*

a) *Indicate whether the Governor's Office has already approved the use of emergency regulatory authority for this regulatory change.*
b) *Provide specific citations to Virginia statutory law, the appropriation act, federal law, or federal regulation that require that a regulation be effective in 280 days or less from its enactment.*

*As required by § 2.2-4011, also describe the nature of the emergency and of the necessity for this regulatory change. In addition, delineate any potential issues that may need to be addressed as part of this regulatory change*

The 2020 General Assembly directed DBDHS to promulgate emergency regulations to become effective within 280 days or less from the enactment of the Appropriation Act. In addition to the mandate from the General Assembly, this regulatory action is needed to incorporate best practices into the licensing regulations in order to promote recovery from the disease of addiction, because substance-related disorders affect individuals, their families, the workplace and the general community. In late 2016 the Governor and the State Health Commissioner declared the opioid addiction crisis a public health emergency. Since that time DBHDS and a number of sister agencies have been working to make policy changes to address the crisis. This regulatory action is another tool to address the crisis.

## 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 or Acts and 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.*

DBDHS was directed by the 2020 General Assembly within the Appropriation Act to utilize emergency authority to promulgate regulations which align with a set of criteria to ensure the provision of outcome-oriented and strengths-based care in the treatment of addiction. Item 318 of the 2020 Acts of Assembly Chapter 1289 charges the Department to make the changes within this regulatory action. Section 37.2-203 of the Code of Virginia gives the Board of Behavioral Health and Developmental Services the authority to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code and other laws of the Commonwealth administered by the DBHDS commissioner.

## Purpose

*Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.*

The purpose of this regulatory action is to align Virginia's licensing regulations with the ASAM levels of care criteria. This alignment is necessary to incorporate best practices into licensing regulations in order to promote remission and recovery from the disease of addiction. Regulations that promote remission and recovery from the disease of addiction are essential to protecting the health and welfare of citizens.

Substance related disorders affect the individual, their families, the workplace and the general community. An essential component of Virginia's efforts to address the opioid epidemic is ensuring that a range of quality, evidence-based substance use related services are available throughout the Commonwealth that span the spectrum of available levels of care. The alignment of Virginia's licensing regulations with the ASAM criteria will help advance that effort.

## 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.

This regulatory action amends the licensing regulations, Rules and Regulations for Licensing Providers by the DBHDS 12VAC35-105, to align with the ASAM Levels of Care Criteria which ensures individualized, clinically driven, participant-directed and outcome-informed treatment. The regulatory action provides the necessary definitions for the newly aligned services to be provided and creates staff, program admission, discharge and co-occurring enhanced program criteria for ASAM levels of care 4.0, 3.7, 3.5, 3.3, 3.1, 2.5, 2.1, 1.0 and OTS.

## 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 advantage of the regulatory change is Licensing Regulations that incorporate best practices related to treatment of substance related conditions, which in turn will result in citizens of the Commonwealth receiving more effective treatment of substance related conditions. This is an advantage to the public, the agency, and the Commonwealth. The primary disadvantage is that some providers may experience a financial burden in order to comply with the new regulations. There are no known disadvantages to the agency or the Commonwealth.

## 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.*

As this regulatory action is the result of a General Assembly mandate. There are no viable alternatives.

## Periodic Review and Small Business Impact Review Announcement

*This Emergency/NOIRA is not being used to announce a periodic review or a small business impact review.*

## 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. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

The Department of Behavioral Health and Developmental Services is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, and (iii) the potential impacts of the regulation.

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, 1220 Bank Street, Richmond Virginia 23219, Phone Number: 804-371-2709, 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.

A public hearing will not be held following the publication of the emergency stage of this regulatory action.

## 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 emergency 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 section number | New section number, if applicable | Current requirements in VAC | Change, intent, rationale, and likely impact of new requirements |
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| 12VAC35-105-20. Definitions. | | Provides current definitions for the Licensing Regulations.<br><br>The following term is being amended: "Medication assisted opioid treatment | Change: Adding the following definitions for terms utilized within the ASAM criteria:<br>• Allied health professionals;<br>• ASAM;<br>• Clinically managed high-intensity residential care; |

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| | | (Opioid treatment service)" means an intervention strategy that combines outpatient treatment with the administering or dispensing of synthetic narcotics, such as methadone or buprenorphine (suboxone), approved by the federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs. | • Clinically managed low-intensity residential care;<br>• Credentialed addiction treatment professional;<br>• Intensity of Service;<br>• Medically managed intensive inpatient service;<br>• Medically monitored intensive inpatient treatment;<br>• Medication assisted treatment;<br>• Mental health intensive outpatient services;<br>• Mental health outpatient service;<br>• Mental health partial hospitalization service;<br>• Motivational enhancement;<br>• Physician extenders;<br>• Specific high-intensity residential services;<br>• Substance abuse intensive outpatient service;<br>• Substance abuse outpatient service; and<br>• Substance abuse partial hospitalization services.<br><br>Removing the following terms which will no longer be used due to alignment with ASAM:<br>• Medically managed withdrawal services;<br>• Outpatient service;<br>• Partial hospitalization service;<br>• Social detoxification service; and<br>• Substance abuse intensive outpatient service.<br><br>The current term “medication assisted treatment” is being updated to “medication assisted opioid treatment.” The definition is unchanged and as follows: “means an intervention strategy that combines outpatient treatment with the administering or dispensing of synthetic narcotics, such as methadone or buprenorphine (suboxone), approved by the federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.” |

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| | | | In addition a new definition has been created for “Medication assisted treatment” as follows: “means the use of FDA-approved medications in combination with counseling and behavioral therapies to provide treatment of substance use disorders Medication assisted treatment includes but not limited to medication assisted opioid treatment..”<br><br>Impact: Clear regulations |
| 12VAC35-105-30. Licenses. | | Provides the current list of specific services which require a license | Change: Adding the new ASAM license titles within the list of services which require a license including: Clinically-managed high-intensity residential care; clinically-managed low-intensity residential care; medically managed intensive inpatient service; medically monitored intensive inpatient treatment; medication assisted opioid treatment; mental health intensive outpatient; mental health outpatient; mental health partial hospitalization; specific high-intensity residential; substance abuse outpatient; and substance abuse partial hospitalization.<br><br>Removal of terms which will not be utilized due to ASAM alignment including:<br>• Managed withdrawal, including medical detoxification and social detoxification;<br>• Opioid treatment/medication assisted treatment;<br>• Outpatient; and<br>• Partial hospitalization.<br><br>Impact: Clear regulations, some providers may have their license type changed due to the new terminology |
| 12VAC35-105-925. Standards for the evaluation of new licenses for providers of services to individuals | | Provides the standards for providers of services to individuals with opioid addictions | Change: Updating the terminology within the section to reflect the ASAM terminology. Specifically updating the name of the Article from Medication Assisted Treatment to “Medication Assisted Opioid Treatment” and removal of the term “Opioid Treatment Services”<br><br>Impact: Clarity of the regulations |

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| with opioid addiction. | | | |
| 12VAC35-105-930. Registration, certification or accreditation | | Provides requirements for opioid treatment services with regarding to registration, certification or accreditation | Change: Updating the terminology within the section to reflect the ASAM terminology. Specifically replacing the term “opioid treatment service” with “medication assisted opioid treatment service.”<br><br>Impact: Clarity of the regulations |
| 12VAC35-105-960. Physical examinations. | | Provides requirements for the physical examination of individuals receiving opioid treatment services | Change: Updating the terminology within the section to reflect the ASAM terminology. Specifically replacing the term “opioid agonist service” with “medication assisted opioid treatment service.”<br><br>Impact: Clarity of the regulations |
| 12VAC35-105-1000. Preventing duplication of medication services. | | Requires opioid treatment service providers to take steps to prevent the duplication of opioid treatment services | Change: Updating the terminology within the section to reflect the ASAM terminology. Specifically replacing the terms “opioid medication services” and “opioid treatment service” to “medication assisted opioid treatment services.”<br><br>Impact: Clarity of the regulations |
| 12VAC35-105-1055. Description of level of care provided. | | Requires providers of medically managed withdrawal services to describe the level of their services and medical management provided | Change: Updating the terminology within the section to reflect the ASAM terminology. Specifically updating the name of the Article from Medically Managed Withdrawal Services to Medically Monitored Intensive Inpatient Services.<br><br>Impact: Clarity of the regulations |
| 12VAC35-105-1110. Admission assessments. | | Lists the requirements that medically managed withdrawal service providers must fulfill upon admission of an individual receiving their services. | Change: Updating the terminology within the section to reflect the ASAM terminology. Specifically updating the term “managed withdrawal services” to “medically monitored intensive inpatient services.”<br><br>Impact: Clarity of the regulations |
| | 12VAC35-105-1420. Addiction Medicine Service Requirements. | | Intent: Briefly describes the purpose of the Addiction Medicine Service criteria<br>Rationale: Explanation of the new Part of the Licensing Regulations.<br>Impact: Clearer regulations. |
| | 12VAC35-105-1430. Medically managed intensive inpatient (ASAM | | Intent: Provide clear staff requirements within medically managed intensive inpatient programs, which are programs provided within an acute care inpatient setting such as an acute care hospital. |

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| | LOC 4.0) staff criteria. | | Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1440. Medically managed intensive inpatient (ASAM 4.0) program criteria. | | Intent: Provide clear program requirements within medically managed intensive inpatient programs which are programs provided within an acute care inpatient setting such as an acute care hospital..<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1450. Medically managed intensive inpatient (ASAM 4.0) admission criteria. | | Intent: Provide clear admission requirements within medically managed intensive inpatient programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1460. Medically managed intensive inpatient (ASAM 4.0) discharge criteria. | | Intent: Provide clear discharge requirements within medically managed intensive inpatient programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1470. Medically managed intensive inpatient co-occurring enhanced programs. (ASAM 4.0) | | Intent: Provide additional licensing requirements for medically managed intensive inpatient programs which treat individuals with co-occurring disorders.<br><br>Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders. |
| | 12VAC35-105-1480. Medically monitored intensive inpatient services (ASAM LOC 3.7) staff criteria. | | Intent: Provide clear staff requirements within medically monitored intensive inpatient treatment programs, which provide 24 hour care in a facility under the supervision of medical personnel providing directed evaluation, observation, and medical monitoring.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1490. Medically monitored | | Intent: Provide clear program requirements within medically monitored intensive inpatient |

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| | intensive inpatient services (ASAM 3.7) program criteria. | | treatment programs, which provide 24 hour care in a facility under the supervision of medical personnel providing directed evaluation, observation, and medical monitoring. .<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1500. Medically monitored intensive inpatient (ASAM 3.7) admission criteria. | | Intent: Provide clear admission requirements within medically monitored intensive inpatient programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1510. Medically monitored intensive inpatient (ASAM 3.7) discharge criteria. | | Intent: Provide clear discharge requirements within medically monitored intensive inpatient programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1520. Medically monitored intensive inpatient co-occurring enhanced programs.(ASAM 3.7) | | Intent: Provide additional licensing requirements for medically monitored intensive inpatient programs which treat individuals with co-occurring disorders.<br><br>Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders. |
| | 12VAC35-105-1530. Clinically managed high-intensity residential services (ASAM LOC 3.5) staff criteria. | | Intent: Provide clear staff requirements within clinically managed high intensity residential care programs, which provide 24 hour supportive treatment. The individuals served by clinically managed high-intensity residential care are individuals who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1540. Clinically managed high-intensity residential | | Intent: Provide clear program requirements within clinically managed high intensity residential care programs, which provide 24 hour supportive treatment. The individuals |

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| | services (ASAM 3.5) program criteria. | | served by clinically managed high-intensity residential care are individuals who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1550. Clinically managed high-intensity residential services (ASAM 3.5) admission criteria. | | Intent: Provide clear admission requirements within clinically managed high-intensity residential service programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1560. Clinically managed high-intensity residential services (ASAM 3.5) discharge criteria. | | Intent: Provide clear discharge requirements within clinically managed high-intensity residential service programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1570. Clinically managed high-intensity residential services co-occurring enhanced programs. (ASAM 3.5) | | Intent: Provide additional licensing requirements for clinically managed high-intensity residential service programs which treat individuals with co-occurring disorders.<br><br>Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders. |
| | 12VAC35-105-1580. Clinically managed population - specific high-intensity residential services (ASAM LOC 3.3) staff criteria. | | Intent: Provide clear staff requirements within high intensity residential services programs, which provide a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of the individuals served.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1590. Clinically managed population-specific high-intensity | | Intent: Provide clear program requirements within high intensity residential services programs, which provide a structured recovery environment in combination with high-intensity clinical services provided in a |

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| | residential services (ASAM 3.3) program criteria. | | manner to meet the functional limitations of the individuals served.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1600. Clinically managed population-specific high-intensity residential services (ASAM 3.3) admission criteria. | | Intent: Provide clear admission requirements within high intensity residential services programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1610. Clinically managed population-specific high intensity residential services (ASAM 3.3) discharge criteria. | | Intent: Provide clear discharge requirements within high intensity residential services programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered |
| | 12VAC35-105-1620. Clinically managed population-specific high-intensity residential services co-occurring enhanced programs. (ASAM 3.3) | | Intent: Provide additional licensing requirements for high intensity residential services programs which treat individuals with co-occurring disorders.<br><br>Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders. |
| | 12VAC35-105-1630. Clinically managed low - intensity residential services (ASAM LOC 3.1) staff criteria. | | Intent: Provide clear staff requirements within clinically managed low-intensity residential service program, which provide ongoing therapeutic environment for individuals requiring some structured support.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1640. Clinically managed low-intensity residential services ( ASAM 3.1) program criteria. | | Intent: Provide clear program requirements within clinically managed low-intensity residential service programs, which provide ongoing therapeutic environment for individuals requiring some structured support. |

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| | | | Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1650. Clinically managed low-intensity residential services (ASAM 3.1) admission criteria. | | Intent: Provide clear admission requirements within clinically managed low-intensity residential service programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1660. Clinically managed low-intensity residential services (ASAM 3.1) discharge criteria. | | Intent: Provide clear discharge requirements within clinically managed low – intensity residential service programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1670. Clinically managed low-intensity residential services co-occurring enhanced programs.(ASAM 3.1) | | Intent: Provide additional licensing requirements for clinically managed low-intensity residential service programs which treat individuals with co-occurring disorders.<br><br>Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders. |
| | 12VAC35-105-1680. Substance abuse partial hospitalization services (ASAM LOC 2.5) staff criteria. | | Intent: Provide clear staff requirements within partial hospitalization programs, which provide services for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1690. Substance abuse partial hospitalization services (ASAM 2.5) program criteria. | | Intent: Provide clear program requirements within partial hospitalization programs which provide services for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |

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| | 12VAC35-105-1700. Substance abuse partial hospitalization (ASAM 2.5) admission criteria. | | Intent: Provide clear admission requirements within partial hospitalization programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1710. Substance abuse partial hospitalization (ASAM 2.5) discharge criteria. | | Intent: Provide clear discharge requirements within partial hospitalization programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1720. Substance abuse partial hospitalization co-occurring enhanced programs. (ASAM 2.5) | | Intent: Provide additional licensing requirements for partial hospitalization programs which treat individuals with co-occurring disorders.<br><br>Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders. |
| | 12VAC35-105-1730. Substance abuse intensive outpatient services (ASAM LOC 2.1) staff criteria. | | Intent: Provide clear staff requirements within intensive outpatient service programs, which provide between 9 and 19 hours of structured treatment consisting primarily of counseling and education. Within this level of care an individual's needs for psychiatric and medical services are generally addressed through referrals.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1740. Substance abuse intensive outpatient services (ASAM 2.1) program criteria. | | Intent: Provide clear program requirements within intensive outpatient programs, which provide between 9 and 19 hours of structured treatment consisting primarily of counseling and education.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1750. Substance abuse intensive outpatient services (ASAM 2.1) admission criteria. | | Intent: Provide clear admission requirements within intensive outpatient service programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |

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| | 12VAC35-105-1760. Substance abuse intensive outpatient services (ASAM 2.1) discharge criteria. | | Intent: Provide clear discharge requirements within intensive outpatient service programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1770. Substance abuse intensive outpatient services co-occurring enhanced programs. (ASAM 2.1) | | Intent: Provide additional licensing requirements for intensive outpatient service programs which treat individuals with co-occurring disorders.<br><br>Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders. |
| | 12VAC35-105-1780. Substance Abuse Outpatient Services (ASAM LOC 1.0) staff criteria. | | Intent: Provide clear staff requirements within outpatient service programs, which provide an organized nonresidential service for fewer than 9 contact hours a week.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1790. Substances abuse outpatient services (ASAM 1.0) program criteria. | | Intent: Provide clear program requirements within outpatient programs, which provide an organized nonresidential service for fewer than 9 contact hours a week.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1800. Substance abuse outpatient services (ASAM 1.0) admission criteria. | | Intent: Provide clear admission requirements within outpatient service programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1810. Substance abuse outpatient services (ASAM 1.0) discharge criteria. | | Intent: Provide clear discharge requirements within outpatient service programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1820. Substance abuse outpatient services co-occurring | | Intent: Provide additional licensing requirements for outpatient service programs which treat individuals with co-occurring disorders. |

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| | enhanced programs. (ASAM 1.0) | | Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders. |
| | 12VAC35-105-1830. Medication assisted opioid treatment (ASAM LOC OTS) staff criteria. | | Intent: Provide clear staff requirements within opioid treatment programs, which provide medications to treat opioid use disorders.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1840. Medication assisted opioid treatment (ASAM OTS) program criteria. | | Intent: Provide clear program requirements within opioid treatment programs, which provide medications to treat opioid use disorders.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-105-1850. Medication assisted opioid treatment (ASAM OTS) admission criteria. | | Intent: Provide clear admission requirements within opioid treatment programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-105-1860. Medication assisted opioid treatment (ASAM OTS) discharge criteria. | | Intent: Provide clear discharge requirements within opioid treatment programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |

**DRAFT TEXT: ASAM CHAPTER 105**

## ASAM Alignment

### 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" (§ 37.2-100 of the Code of Virginia) means 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 a person receiving care or treatment for mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders). 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 person;

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

5. Use of excessive force when placing a person in physical or mechanical restraint;

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

7. Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with the person'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.

"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.

"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 must 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.

"Brain injury" means any injury to the brain that occurs after birth, but before age 65, 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" or "treatment" 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" means services that can include assistance to individuals and their family members in assessing needed services that are responsive to the person's individual 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 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" 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" 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.

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

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

"Community intermediate care facility/mental retardation" or "ICF/MR" means a residential facility in which care is provided to individuals who have mental retardation (intellectual disability) or a developmental disability who need more intensive training and supervision than may be available in an assisted living facility or group home. Such facilities shall comply with Title XIX of the Social Security Act standards and federal certification requirements, provide health or rehabilitative services, and provide active treatment to individuals receiving services toward the achievement of a more independent level of functioning or an improved quality of life.

"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, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability.

"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. A corrective action plan must be completed within a specified time.

"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 psychiatric clinical nurse specialist; (viii) a licensed psychiatric nurse practitioner; (ix) a licensed marriage and family therapist; (x) a licensed substance abuse treatment practitioner; (xi) 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; (xii) 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); (xiii) 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 or any situation or circumstance in which the individual perceives or experiences a sudden loss of the individual's ability to use effective problem-solving and coping skills.

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

"Day support service" means structured programs of activity or training services for adults with an intellectual disability or a developmental disability, generally in clusters of two or more continuous hours per day 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 disabilities" means autism or a severe, chronic disability that meets all of the following conditions identified in 42 CFR 435.1009:

1. Attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, that is found to be closely related to mental retardation (intellectual disability) because this condition results in impairment of general intellectual functioning or adaptive behavior similar to behavior of individuals with mental retardation (intellectual disability) and requires treatment or services similar to those required for these individuals;

2. Manifested before the individual reaches age 18;

3. Likely to continue indefinitely; and

4. Results in substantial functional limitations in three or more of the following areas of major life activity:

a. Self-care;

b. Understanding and use of language;

c. Learning;

d. Mobility;

e. Self-direction; or

f. Capacity for independent living.

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

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

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

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

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

"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.

"IFDDS Waiver" means the Individual and Family Developmental Disabilities Support Waiver.

"Individual" or "individual receiving services" means a person receiving services that are licensed under this chapter whether that person is referred to as a patient, consumer, client, resident, student, individual, recipient, family member, relative, or other term. When the term is used, 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.

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

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

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

"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 community treatment service" or "ICT" means a self-contained interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a full-time psychiatrist that:

1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illness, especially those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services;

2. Minimally refers individuals to outside service providers;

3. Provides services on a long-term care basis with continuity of caregivers over time;

4. Delivers 75% or more of the services outside program offices; and

5. Emphasizes outreach, relationship building, and individualization of services.

"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 mental retardation (intellectual 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.

"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, or licensed behavior analyst.

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

"Medically managed intensive inpatient service" means an organized service delivered in an inpatient setting including an acute care general hospital, psychiatric unit in a general hospital, or a free-standing 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 managed withdrawal services" means detoxification services to eliminate or reduce the effects of alcohol or other drugs in the individual's body.~~

"Medically monitored intensive inpatient treatment" means a substance use treatment program that provides 24-hour care in a facility under the supervision of medical personnel. The care provided shall include 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, and 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.

"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 effects 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.

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

"Medication administration" means the direct application of medications 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 ~~(Opioid treatment service)~~" means an intervention strategy that combines outpatient treatment with the administering or dispensing of synthetic narcotics, such as methadone or buprenorphine (suboxone), approved by the federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.

"Medication assisted treatment" means the use of FDA-approved medications in combination with counseling and behavioral therapies to provide treatment of substance use disorders. Medication assisted treatment includes but not limited to medication assisted opioid treatment.

"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 (MHCSS)" 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 intensive outpatient services" means a structured program of skilled treatment in a non-residential setting that includes 9-19 hours of intervention a week (adult) or 6-19 (child) and programming that occurs across 3-4 days of services weekly. The service is provided over a period of time for individuals requiring more intensive services than an outpatient service can provide and less intensive than partial hospitalization, residential, or inpatient treatment.~~

"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 that 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 twenty hours per week of skilled treatment services focused on individuals who require intensive, highly coordinated,

structured and inter-disciplinary ambulatory treatment within a stable environment that is of greater intensity than intensive outpatient, but of lesser intensity than inpatient.

"Mental illness" means 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.

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

"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 the failure by an individual 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 a person receiving care or treatment for mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders).

"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.

~~"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. 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. "Outpatient service" specifically includes:~~

~~1. 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. 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. 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.~~

~~"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 focused on individuals with serious mental illness, substance abuse (substance use disorders), or co-occurring disorders at risk of hospitalization or who have been recently discharged from an inpatient setting.~~

"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.

"Program of assertive community treatment service" or "PACT" means a self-contained interdisciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a full- or part-time psychiatrist that:

1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses, including those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services;

2. Minimally refers individuals to outside service providers;

3. Provides services on a long-term care basis with continuity of caregivers over time;

4. Delivers 75% or more of the services outside program offices; and

5. Emphasizes outreach, relationship building, and individualization of services.

"Provider" means 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, mental retardation (intellectual disability), or substance abuse (substance use disorders), (ii) services to individuals who receive day support, in-home support, or crisis stabilization services funded through the IFDDS Waiver, or (iii) residential services for individuals with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601 and 54.1-3701 of the Code of Virginia.

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

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

"Qualified mental health professional" or "QMHP" means a person who by education and experience is professionally qualified and registered by the Board of Counseling in accordance with 18VAC115-80 to provide collaborative mental health services for adults or children. A QMHP

shall not engage in independent or autonomous practice. A QMHP shall provide such services as an employee or independent contractor of the department or a provider licensed by the department.

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

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

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

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

"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 mental retardation (intellectual disability), the concept of recovery does not apply in the sense that individuals with mental retardation (intellectual disability) will need supports throughout their entire lives although these may change over time. With supports, individuals with mental retardation (intellectual disability) are capable of living lives that are fulfilling and satisfying and that bring meaning to themselves and others whom they know.

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

"Residential crisis stabilization service" means (i) providing short-term, intensive treatment to nonhospitalized individuals who require multidisciplinary treatment in order to stabilize acute psychiatric symptoms and prevent admission to a psychiatric inpatient unit; (ii) providing normative environments with a high assurance of safety and security for crisis intervention; and

(iii) mobilizing the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

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

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

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

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

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

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

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

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

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

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

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

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

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

"Serious injury" means any injury resulting in bodily damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner while the individual is supervised by or involved in services, such as attempted suicides, medication overdoses, or reactions from medications administered or prescribed by the service.

"Service" means (i) planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), 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, mental retardation (intellectual disability), or substance abuse (substance use disorders). Services include outpatient services, intensive in-home services, 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, halfway house, and other residential services; (ii) day support, in-home support, and crisis stabilization services provided to individuals under the IFDDS Waiver; and (iii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports or 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.

"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.

~~"Social detoxification service" means providing nonmedical supervised care for the individual's natural process of withdrawal from use of alcohol or other drugs.~~

"Specific high-intensity residential services" 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.

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

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

"State methadone authority" means the Virginia Department of Behavioral Health and Developmental Services that is authorized by the federal Center for Substance Abuse Treatment

to exercise the responsibility and authority for governing the treatment of opiate addiction with an opioid drug.

"Substance abuse (substance use disorders)" means 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" means treatment provided in a concentrated manner for two or more consecutive hours per day to groups of individuals in a nonresidential setting. This service is provided over a period of time for individuals requiring more intensive services than an outpatient service can provide. Substance abuse intensive outpatient services include multiple group therapy sessions during the week, individual and family therapy, individual monitoring, and case management.~~

"Substance abuse intensive outpatient service" means structured treatment provided to individuals who require more intensive services than is normally provided in an outpatient service can provide but do not require inpatient services. Treatment consists primarily of counseling and education about addiction-related and mental health challenges delivered a minimum of 9 to 19 hours of services per week for adults or 6 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" means a center based substance abuse treatment delivered to individuals for less than 9 hours of service per week for adults, or less than 6 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 specifically 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.

4. 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 9 contact hours a week.

"Substance abuse partial hospitalization services" means a short-term, non-residential 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.

"Substance abuse residential treatment for women with children service" means a 24-hour residential service providing an intensive and highly structured substance abuse service for women with children who live in the same facility.

"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.

"Therapeutic day treatment for children and adolescents" means a treatment program that serves (i) children and adolescents from birth through age 17 and under certain circumstances up to 21 with serious emotional disturbances, substance use, or co-occurring disorders or (ii) children from birth through age seven 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.

**12VAC35-105-30. Licenses.**

A. Licenses are issued to providers who offer services to individuals who have mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); have developmental disability and are served under the IFDDS Waiver; 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. Case management;

2. Clinically managed high-intensity residential care;

3. Clinically managed low-intensity residential care;

4. Community gero-psychiatric residential;

~~3.~~5. Community intermediate care facility-MR;

~~4.~~6. Residential crisis stabilization;

~~5.~~7. Nonresidential crisis stabilization;

~~6.~~8. Day support;

~~7.~~9. Day treatment, includes therapeutic day treatment for children and adolescents;

~~8.~~10. Group home and community residential;

~~9.~~11. Inpatient psychiatric;

~~10.~~12. Intensive Community Treatment (ICT);

~~11.~~13. Intensive in-home;

~~12. Managed withdrawal, including medical detoxification and social detoxification;~~

~~13.~~14. Medically managed intensive inpatient service;

15. Medically monitored intensive inpatient treatment;

16. Medication assisted opioid treatment;

17. Mental health community support;

18. Mental health intensive outpatient;

19. Mental health outpatient;

20. Mental health partial hospitalization;

~~14. Opioid treatment/medication assisted treatment;~~

~~15.~~21. Emergency;

~~16. Outpatient;~~

~~17. Partial hospitalization;~~

~~18.~~22. Program of assertive community treatment (PACT);

~~19.~~23. Psychosocial rehabilitation;

~~20.~~24. Residential treatment;

~~21.~~25. Respite care;

26. Specific high-intensity residential;

~~22.~~27. Sponsored residential home;

~~23.~~28. Substance abuse residential treatment for women with children;

~~24.~~29. Substance abuse intensive outpatient;

30. Substance abuse outpatient;

31. Substance abuse partial hospitalization;

~~25.~~32. Supervised living residential; and

~~26.~~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.**

Article 1

Medication Assisted Opioid Treatment ~~(Opioid Treatment Services)~~

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 director shall be licensed or certified by the applicable Virginia health regulatory board or by a nationally recognized certification board or eligible for this license or certification with relevant training, experience, or both, in the treatment of individuals with opioid addiction;

2. 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;

3. A minimum of one pharmacist;

4. Nurses;

5. Counselors shall be licensed or certified by the applicable Virginia health regulatory board or by a nationally recognized certification board or eligible for this license or certification; and

6. Personnel to provide support services.

F. 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 on-site security; and

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

G. 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. Psychological services;

2. Social services;

3. Vocational services;

4. Educational services; and

5. Employment services.

H. 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.

I. Applicants shall provide policies and procedures that each individual served to be assessed every six months by the treatment team to determine if that individual is appropriate for safe and voluntary medically supervised withdrawal, alternative therapies including other medication assisted treatments, or continued federally approved pharmacotherapy treatment for opioid addiction.

J. Applicants shall submit policies and procedures describing services they will provide to individuals who wish to discontinue opioid treatment services.

K. 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.

L. 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 ~~opioid treatment service~~medication assisted opioid 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 ~~opioid treatment services~~medication assisted opioid treatment services shall maintain accreditation with an entity approved under federal regulations.

**12VAC35-105-960. Physical examinations.**

A. The individual shall have a complete physical examination prior to admission to the service unless the individual is transferring from another licensed ~~opioid agonist service~~medication assisted opioid treatment service. The results of serology and other tests shall be available within 14 days of admission.

B. Physical exams of each individual shall be completed annually or more frequently if there is a change in the individual's physical or mental condition.

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

D. On admission, all individuals shall be offered testing for AIDS/HIV. The individual may sign a notice of refusal without prejudice.

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

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

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

**12VAC35-105-1055. Description of level of care provided.**

Article 2

~~Medically Managed Withdrawal Services~~ Medically Monitored Intensive Inpatient Services

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

**12VAC35-105-1110. Admission assessments.**

During the admission process, providers of ~~managed withdrawal services~~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.

**12VAC35-105-1420. Addiction Medicine Service Requirements.**

12VAC35-105-1420- Part VII –Addiction Medicine Service Requirements

Article 1- ASAM

Addiction medicine service criteria facilitate outcome-oriented and strengths-based care in the treatment of addiction, including matching individuals to appropriate types and levels of care. Part VII contains requirements for staffing; programs, including co-occurring enhanced programs; admission; and discharge for addiction medicine services. In addition to these requirements, providers shall comply with American Society of Addiction Medicine (ASAM) level of care (LOC) criteria where indicated.

**12VAC35-105-1430. Medically managed intensive inpatient (ASAM LOC 4.0) staff criteria.**

Article 2 Medically Managed Intensive Inpatient

A medically managed intensive inpatient program shall meet the following staff requirements:

1. Have a team of appropriately trained and credentialed professionals who provide medical management by physicians 24 hours a day, primary nursing care and observation 24 hours a day, and professional counseling services 16 hours a day;

2. Have an interdisciplinary team of appropriately credentialed clinical staff, including addiction-credentialed physicians, nurse practitioners, physician assistants, nurses, counselors, psychologists, and social workers, who assess and treat individuals with severe substance use disorders, or addicted individuals with concomitant acute biomedical, emotional or behavioral disorders;

3. Have staff who are knowledgeable about the biopsychosocial dimensions of addiction as well as biomedical, emotional, behavioral and cognitive disorders;

4. Have facility-approved addiction counselors or licensed, certified, or registered addiction clinicians who administer planned interventions according to the assessed needs of the individual; and

5. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-105-1440. Medically managed intensive inpatient (ASAM LOC 4.0) program criteria.**

A medically managed intensive inpatient program shall meet the following programmatic requirements. The program shall:

1. Deliver services in a 24 hour medically managed, acute care setting and shall be available to all individuals within that setting;

2. Provide cognitive, behavioral, motivational, pharmacologic, and other therapies provided on an individual or group basis, depending on the individual's needs;

3. Provide, for the individual who has a severe biomedical disorder, physical health interventions to supplement addiction treatment;

4. Provide, for the individual who has stable psychiatric symptoms, individualized treatment activities designed to monitor the individual's mental health;

5. Provide planned clinical interventions that are designed to enhance the individual's understanding and acceptance of his addiction illness;

6. Provide family and caregiver treatment services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

7. Provide health education services;

8. Make Medication Assisted Treatment (MAT) available for all individuals admitted to the service. MAT may be provided by facility staff or coordinated through alternative resources; and

10. Comply with Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services 12VAC35-105-1055 through 12VAC35-105-1130.

**12VAC35-105-1450. Medically managed intensive inpatient (ASAM LOC 4.0) admission criteria.**

Before a medically managed intensive inpatient program 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:

1. Meet diagnostic criteria for a substance use disorder and/or addictive disorder of moderate to high severity as defined by the DSM; and

2. Meet the admission criteria of Level 4.0 of ASAM including the specific criteria for adult and adolescent populations.

**12VAC35-105-1460. Medically managed intensive inpatient (ASAM LOC 4.0) discharge criteria.**

Before a medically managed intensive inpatient program may discharge or transfer an individual, 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 ASAM 4.0 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.

**12VAC35-105-1470. Medically managed intensive inpatient (ASAM LOC 4.0) co-occurring enhanced programs.**

A. Staff: Medically managed intensive inpatient co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals, who assess and treat the individual's co-occurring mental disorders. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

B. Therapy: Medically managed intensive inpatient co-occurring enhanced programs shall offer individualized treatment activities designed to stabilize the individual's active psychiatric symptoms, including medication evaluation and management.

**12VAC35-105-1480. Medically monitored intensive inpatient services (ASAM LOC 3.7) staff criteria.**

Article 3 Medically Monitored Intensive Inpatient Services

A medically monitored intensive inpatient treatment program shall meet the following staff requirements. The program shall:

1. Have a licensed physician to oversee the treatment process and assure quality of care. A physician, a licensed nurse practitioner, or a licensed physician assistant shall be available 24 hours a day in person or by telephone. A physician shall assess the individual in person within 24 hours of admission;

2. Offer 24-hour nursing care, and shall conduct a nursing assessment on admission. The level of nursing care must be appropriate to the severity of needs of individuals admitted to the service;

3. Have interdisciplinary staff, including physicians, nurses, addiction counselors, and behavioral health specialists, who are able to assess and treat the individual and obtain and interpret information regarding the individual's psychiatric and substance use or addictive disorders;

4. Offer daily onsite counseling and clinical services. Clinical staff shall be knowledgeable about the biological and psychosocial dimensions of addiction and other behavioral health disorders with specialized training in behavior management techniques and evidence-based practices;

5. Have staff able to provide a planned regimen of 24 hour professionally directed evaluation, care and treatment services;

6. Make MAT available for all individuals. MAT may be provided by facility staff or coordinated through alternative resources; and

7. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-105-1490. Medically monitored intensive inpatient services (ASAM LOC 3.7) program criteria.**

A medically monitored intensive inpatient treatment program shall meet the following programmatic requirements. The program shall:

1. Be made available to all individuals within the inpatient setting;

2. Provide a combination of individual and group therapy as deemed appropriate by a licensed mental health professional and included in an assessment and treatment plan. Such therapy shall be adapted to the individual's level of comprehension;

3. Make available medical and nursing services onsite to provide ongoing assessment and care of addiction needs;

4. Provide direct affiliations with other easily accessible levels of care or close coordination through referral to more or less intensive levels of care and other services;

5. Provide family and caregiver treatment services as deemed appropriate by a licensed mental health professional and included in an assessment and treatment plan;

6. Provide educational and informational programming adapted to individual needs. The educational and informational programming shall include materials designed to enhance the individual's understanding of addiction and may include peer recovery support services as appropriate;

7. Utilize random drug screening to monitor drug use and reinforce treatment gains;

8. Regularly monitor the individual's adherence in taking any prescribed medications; and

9. Comply with Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services 12VAC35-105-1055 through 12VAC35-105-1130

**12VAC35-105-1500. Medically monitored intensive inpatient (ASAM LOC 3.7) admission criteria.**

Before a medically monitored intensive inpatient program 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:

1. Meet diagnostic criteria for a substance use disorder of the DSM or addictive disorder of moderate to high severity; and

2. Meet the admission criteria of Level 3.7 of ASAM including the specific criteria for adult and adolescent populations.

**12VAC35-105-1510. Medically monitored intensive inpatient (ASAM LOC 3.7) discharge criteria.**

A. Before a medically monitored intensive inpatient program may discharge or transfer an individual, 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 ASAM 3.7 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.

B. Discharge planning shall occur for individuals and include realistic plans for the continuity of MAT services as indicated.

**12VAC35-105-1520. Medically monitored intensive inpatient (ASAM LOC 3.7) co-occurring enhanced programs.**

A. Support systems: Medically monitored intensive inpatient co-occurring enhanced programs shall offer psychiatric services, medication evaluation, and laboratory services as indicated by the needs of individuals admitted to the service. A psychiatrist shall assess the individual by telephone within 4 hours of admission and in person with 24 hours following admission. A LMHP shall conduct a behavioral health-focused assessment at the time of admission. A RN shall monitor the individual's progress and administer, or monitor the individual's self-administration of, psychotropic medications.

B. Staff: Medically monitored intensive inpatient co-occurring enhanced programs shall be staffed by addiction psychiatrists and appropriately credentialed behavioral health professionals, who are able to assess and treat co-occurring psychiatric disorders and who have specialized training in behavior management techniques and evidence based practices. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Therapies: Medically monitored intensive inpatient co-occurring enhanced programs shall offer planned clinical activities designed to promote stabilization of the individual's behavioral health needs and psychiatric symptoms and to promote such stabilization, including medication education and management, and motivational and engagement strategies.

**12VAC35-105-1530. Clinically managed high-intensity residential services (ASAM LOC 3.5) staff criteria.**

Article 4- Clinically Managed High-Intensity Residential Services

A clinically managed high-intensity residential care program shall meet the following staff requirements. The program shall:

1. Offer telephone or in-person consultation with a physician, a licensed nurse practitioner, or a licensed physician assistant in case of emergency related to an individual's substance use disorder 24 hours a day 7 days a week;

2. Offer onsite 24-hour-a-day clinical staffing by credentialed addiction treatment professionals and other allied health professionals, such as peer recovery specialists, who work in an interdisciplinary team;

3. Have clinical staff knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Staff shall be able to identify the signs and symptoms of acute psychiatric conditions. Staff shall have specialized training in behavior management techniques; and

4. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-105-1540. Clinically managed high-intensity residential services (ASAM LOC 3.5) program criteria.**

A clinically managed high-intensity residential care program shall meet the following programmatic requirements. The program shall:

1. Provide daily clinical services including a range of cognitive, behavioral, and other therapies in individual or group therapy; programming; and psychoeducation as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

2. Provide counseling and clinical interventions to teach an individual the skills needed for daily productive activity, prosocial behavior, and reintegration into family and community;

3. Provide motivational enhancement and engagement strategies appropriate to an individual's stage of readiness to change and comprehension;

4. Have direct affiliations with other easily accessible levels of care or provide coordination through referral to more or less intensive levels of care and other services;

5. Provide family and caregiver treatment services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

6. Provide educational, vocational, and informational programming adaptive to individual needs;

7. Utilize random drug screening to monitor progress and reinforce treatment gains as appropriate to an individual treatment plan;

8. Ensure and document that the length of an individual’s stay shall be determined by the individual’s condition and functioning;

9. Make a substance use treatment program available for all individuals; and

10. Make MAT available for all individuals. Medication assisted treatment may be provided by facility staff, or coordinated through alternative resources.

**12VAC35-105-1550. Clinically managed high-intensity residential services (ASAM LOC 3.5) admission criteria.**

A. The individuals served by clinically managed high-intensity residential care are individuals who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service.

B. Before a clinically managed high-intensity residential service program 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:

1. Meet diagnostic criteria for a substance use disorder and/or addictive disorder of moderate to high severity as defined by the DSM; and

2. Meet the admission criteria of Level 3.5 of ASAM.

**12VAC35-105-1560. Clinically managed high-intensity residential services (ASAM LOC 3.5) discharge criteria.**

Before a clinically managed high-intensity residential service program may discharge or transfer an individual, 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 ASAM 3.5 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.

**12VAC35-105-1570. Clinically managed high-intensity residential services (ASAM LOC 3.5) co-occurring enhanced programs.**

A. Support Systems: Clinically managed high-intensity residential services co-occurring enhanced programs shall offer psychiatric services, medication evaluation, and laboratory services. Such services shall be available by telephone within 8 hours and on-site or closely coordinated off-site within 24 hours.

B. Staff: Clinically managed high-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals, including addiction psychiatrists who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Therapies: Clinically managed high-intensity residential services co-occurring enhanced programs shall offer planned clinical activities designed to stabilize the individual's mental health problems and psychiatric symptoms and to maintain such stabilization, including medication education and management, and motivational and engagement strategies. Goals of therapy shall apply to both the individual's substance use disorder and any co-occurring mental disorder

**12VAC35-105-1580. Clinically managed population - specific high-intensity residential services (ASAM LOC 3.3) staff criteria.**

Article 5- Clinically Managed Population- Specific High-Intensity Residential Services-

A high intensity residential services program shall meet the following staff requirements. The program shall:

1. Offer telephone or in-person consultation with a physician or, a licensed nurse practitioner, or a physician assistant in case of emergency related to an individual's substance use disorder 24 hours a day, 7 days a week;

2. Have allied health professional staff on-site 24 hours a day. At least one clinician with competence in the treatment of substance use disorder shall be available on-site or by telephone 24 hours a day;

3. Have clinical staff knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment, and able to identify the signs and symptoms of acute psychiatric conditions. Staff shall have specialized training in behavior management techniques; and

4. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-105-1590. Clinically managed population- specific high-intensity residential services (ASAM LOC 3.3) program criteria.**

A high-intensity residential services program shall meet the following programmatic requirements. The program shall:

1. Provide daily clinical services which shall include a range of cognitive, behavioral and other therapies administered on an individual and group basis, medication education and management, educational groups, and occupational or recreation activities as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

2. Provide daily professional addiction and mental health treatment services which may include relapse prevention, exploring interpersonal choices, peer recovery support and development of a social network;

3. Provide services to improve the individual's ability to structure and organize the tasks of daily living and recovery. Such services shall accommodate the cognitive limitations within this population;

4. Make available medical, psychiatric, psychological, laboratory and toxicology services through consultation or referral, as indicated by the individual's condition;

5. Provide case management including ongoing transition and continuing care planning;

6. Provide motivational interventions appropriate to the individual's stage of readiness to change, and designed to address the individual's functional limitations;

7. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;

8. Provide family and caregiver treatment services as deemed appropriate by an assessment and treatment plan;

9. Utilize random drug screening to monitor progress and reinforce treatment gains;

10. Regularly monitor the individual's adherence in taking prescribed medications;

11. Make the substance use treatment program available to all individuals served by the residential care service; and

12. Make MAT available for all individuals. Medication assisted treatment may be provided by facility staff, or coordinated through alternative resources.

**12VAC35-105-1600. Clinically managed population-specific high-intensity residential services (ASAM LOC 3.3) admission criteria.**

Before a clinically managed, population-specific, high-intensity residential service program 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:

1. Meet diagnostic criteria for a substance use disorder and/or addictive disorder of moderate to high severity as defined by the DSM; and

2. Meet the admission criteria of Level 3.3 of ASAM.

**12VAC35-105-1610. Clinically managed population-specific high intensity residential services (ASAM LOC 3.3) discharge criteria.**

A. Before a clinically managed, population-specific, high-intensity residential service program may discharge or transfer an individual; 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 ASAM 3.3 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.

B. Discharge planning shall occur for individuals and include realistic plans for the continuity of MAT services as indicated.

**12VAC35-105-1620. Clinically managed population-specific high-intensity residential services (ASAM LOC 3.3) co-occurring enhanced programs.**

A. Support Systems: Clinically managed population-specific high-intensity residential services co-occurring enhanced programs shall offer psychiatric services, medication evaluation, and laboratory services. Such services shall be available by telephone within 8 hours and on-site or closely coordinated off-site within 24 hours, as appropriate to the severity and urgency of the individual's mental condition.

B. Staff: Clinically managed population-specific high-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed psychiatrists and licensed mental health professionals who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Therapies: Clinically managed population-specific high-intensity residential services co-occurring enhanced programs shall offer planned clinical activities designed to stabilize the individual's mental health problems and psychiatric symptoms, and to maintain such stabilization, including medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental health disorder(s).

**12VAC35-105-1630. Clinically managed low - intensity residential services (ASAM LOC 3.1) staff criteria.**

Article 6- - Clinically Managed Low – Intensity Residential Services

A clinically-managed, low-intensity residential services program shall meet the following staff requirements. The program shall:

1. Offer telephone or in-person consultation with a physician in case of emergency related to an individual's substance use disorder, available 24 hours a day, 7 days a week. The program shall also provide allied health professional staff on-site 24 hours a day;

2. Have clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use disorder and their treatment, and are able to identify the signs and symptoms of acute psychiatric conditions;

3. Have a team comprised of appropriately trained and credentialed medical, addiction and mental health professionals; and

4. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-105-1640. Clinically managed low-intensity residential services (ASAM LOC 3.1) program criteria.**

A clinically-managed, low-intensity residential services program shall meet the following programmatic requirements. The program shall:

1. Offer a minimum of five hours a week of professionally directed treatment in addition to other treatment services offered to individuals such as partial hospitalization or intensive outpatient treatment the focus of which is stabilizing the individual's substance use disorder. Services shall be designed to improve the individual's ability to structure and organize the tasks of daily living and recovery;

2. Ensure collaboration with care providers to develop an individual treatment plan for each individual with time-specific goals and objectives;

3. Provide counseling and clinical monitoring to support successful initial involvement in regular, productive daily activity;

4. Provide case management services;

5. Provide motivational interventions appropriate to the individual's stage of readiness to change and comprehension;

6. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services. 7. Include the ability to arrange for needed procedures as appropriate to the severity and urgency of the individual's condition;

8. Provide family and caregiver treatment and peer recovery support services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

9. Provide addiction pharmacotherapy and the ability to arrange for pharmacotherapy for psychiatric medications;

10. Utilize fandom drug screening to monitor progress and reinforce treatment gains;

11. Make a substance abuse treatment program available to all individuals; and

12. Make MAT available for all individuals. Medication assisted treatment may be provided by facility staff, or coordinated through alternative resources.

**12VAC35-105-1650. Clinically managed low-intensity residential services (ASAM LOC 3.1) admission criteria.**

Before a clinically-managed, low-intensity residential service program 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:

1. Meet diagnostic criteria for a substance use disorder and/or addictive disorder of moderate to high severity as defined by the DSM; and

2. Meet the admission criteria of Level 3.1 of ASAM.

**12VAC35-105-1660. Clinically managed low-intensity residential services (ASAM LOC 3.1) discharge criteria.**

Before a clinically-managed, low-intensity residential service program may discharge or transfer an individual, 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 ASAM 3.1 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.

**12VAC35-105-1670. Clinically managed low-intensity residential services (ASAM 3.1) co-occurring enhanced programs.**

A. Support Systems: Clinically managed low-intensity residential services co-occurring enhanced programs shall offer psychiatric services, including medication evaluation and laboratory services. Such services shall be provided on-site or closely coordinated off-site, as appropriate to the severity and urgency of the individual's mental condition.

B. Staff: Clinically managed low-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed licensed mental health professionals, who are able to assess and treat co-occurring disorders with the capacity to involve addiction-trained psychiatrists. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Therapies: Clinically managed low-intensity residential services co-occurring enhanced programs shall offer planned clinical activities that are designed to stabilize the individual's mental health problems and psychiatric symptoms and to maintain such stabilization, including

medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental disorder.

**12VAC35-105-1680. Substance abuse partial hospitalization services (ASAM LOC 2.5) staff criteria.**

Article 7 Partial Hospitalization

A substance abuse partial hospitalization program shall meet the following staff requirements. The program shall:

1. Have an interdisciplinary team of addiction treatment professionals including counselors, psychologists, social works and addiction-credentialed physicians. Physicians treating individuals in this level shall have specialty training or experience in addiction medicine;

2. Have staff able to obtain and interpret information regarding the individual's biopsychosocial needs;

3. Have staff trained to understand the signs and symptoms of mental disorders, and to understand and be able to explain the uses of psychotropic medications and their interactions with substance-related disorders; and

4. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-105-1690. Substance abuse partial hospitalization services (ASAM LOC 2.5) program criteria.**

A substance abuse partial hospitalization program shall meet the following programmatic requirements. The program shall:

1. Offer no less than 20 hours of programming per week in a structured program. Services may include individual and group counseling, medication management, family therapy, peer recovery support services, educational groups, or occupational and recreational therapy;
2. Provide a combination of individual and group therapy as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
3. Provide medical and nursing services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
4. Provide motivational enhancement and engagement strategies appropriate to an individual's stage of readiness to change and comprehension;
5. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;
6. Provide family and caregiver treatment services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
7. Provide educational and informational programming adaptable to individual needs;
8. Ensure and document that the length of service shall be determined by the individual's condition and functioning;

9. Make emergency services available by telephone 24 hours a day 7 days a week when the program is not in session; and

10. Make MAT available for all individuals. MAT may be provided by facility staff, or coordinated through alternative resources.

**12VAC35-105-1700. Substance abuse partial hospitalization (ASAM LOC 2.5) admission criteria.**

Before a substance abuse partial hospitalization program 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:

1. Meet diagnostic criteria for a substance use disorder and/or addictive disorder as defined by the DSM; and

2. Meet the admission criteria of Level 2.5 of ASAM including the specific criteria for adult and adolescent populations.

**12VAC35-105-1710. Substance abuse partial hospitalization (ASAM LOC 2.5) discharge criteria.**

Before a substance abuse partial hospitalization program may discharge or transfer an individual, 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 ASAM 2.5 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.

**12VAC35-105-1720. Substance abuse partial hospitalization (ASAM LOC 2.5) co-occurring enhanced programs.**

A. Support Systems: Substance abuse partial hospitalization co-occurring enhanced programs shall offer psychiatric services appropriate to the individual's mental health condition. Such services shall be available by telephone and on site or closely coordinated off site, within a shorter time than in a co-occurring capable program.

B. Staff: Substance abuse partial hospitalization co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals, who assess and treat co-occurring mental disorders. Intensive case management shall be delivered by cross-trained, interdisciplinary staff through mobile outreach, and involves engagement-oriented addiction treatment and psychiatric programming. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Therapies: Substance abuse partial hospitalization co-occurring enhanced programs shall offer intensive case management, assertive community treatment, medication management and psychotherapy.

**12VAC35-105-1730. Substance abuse intensive outpatient services (ASAM LOC 2.1) staff criteria.**

Article 8 – Intensive Outpatient Services

A substance abuse intensive outpatient services program shall meet the following staff requirements. The program shall:

1. Be staffed by interdisciplinary team of appropriately credentialed addiction treatment professionals, including counselors, psychologists, social workers, and addiction-credentialed physicians. Physicians shall have specialty training or experience in addiction medicine or addiction psychiatry;
2. Have program staff that is able to obtain and interpret information regarding the individual's biopsychosocial needs;
3. Have program staff trained to understand the signs and symptoms of mental disorders, and to understand and be able to explain the uses of psychotropic medications and their interactions with substance use and other addictive disorders; and
4. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-105-1740. Substance abuse intensive outpatient services (ASAM LOC 2.1) program criteria.**

A substance abuse intensive outpatient program shall meet the following programmatic requirements. The program shall:

1. Offer a minimum of three service hours per service day to achieve no less than nine hours and no more than nineteen hours of programming per week in a structured environment;

2. Ensure Psychiatric and other medical consultation shall be available within 24 hours by telephone and within 72 hours in person;

3. Offer consultation in case of emergency related to an individual's substance use disorder by telephone 24 hours a day, 7 days a week, when the treatment program is not in session;

4. Provide a combination of individual and group therapy as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

5. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;

6. Provide family and caregiver treatment and peer recovery support services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

7. Provide education and informational programming adaptable to individual needs and developmental status;

8. Ensure and document that the length of service shall be determined by the individual's condition and functioning; and

9. Make MAT available for all individuals. MAT may be provided by facility staff, or coordinated through alternative resources.

**12VAC35-105-1750. Substance abuse intensive outpatient services (ASAM LOC 2.1) admission criteria.**

Before a substance abuse intensive outpatient service program 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:

1. Meet diagnostic criteria for a substance use disorder and/or addictive disorder as defined by the DSM; and

2. Meet the admission criteria of Level 2.1 of ASAM including the specific criteria for adult and adolescent populations.

**12VAC35-105-1760. Substance abuse intensive outpatient services (ASAM LOC 2.1) discharge criteria.**

Before a substance abuse intensive outpatient service program may discharge or transfer an individual, 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 ASAM 2.1 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.

**12VAC35-105-1770. Substance abuse intensive outpatient services (ASAM LOC 2.1) co-occurring enhanced programs.**

A. Support Systems: Substance abuse intensive outpatient services co-occurring enhanced programs shall offer psychiatric services appropriate to the individual's mental health condition. Such series shall be available by telephone and on site or closely coordinated off site, within a shorter time than in a co-occurring capable program.

B. Staff: Substance abuse intensive outpatient services co-occurring enhanced programs shall be staffed by appropriately credential mental health professionals, who assess and treat co-occurring mental disorders. Capacity to consult with an addiction psychiatrist shall be available. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Therapies: Substance abuse intensive outpatient services co-occurring enhanced programs shall offer intensive case management, assertive community treatment, medication management and psychotherapy.

**12VAC35-105-1780. Substance Abuse Outpatient Services (ASAM LOC 1.0) staff criteria.**

Article 9 – Substance Abuse Outpatient Services

Substance abuse outpatient service programs shall meet the following staff requirements. The program shall:

1. Have appropriately credentialed or licensed treatment professionals who assess and treat substance-related, mental and addictive disorders;
2. Have program staff who are capable of monitoring stabilized mental health problems and recognizing any instability of individuals with co-occurring mental health conditions;
3. Provide medication management services, by a licensed independent practitioner with prescribing authority; and
4. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-105-1790. Substances abuse outpatient services (ASAM LOC 1.0) program criteria.**

Substance abuse outpatient service programs shall meet the following programmatic requirements. The program shall:

1. Offer no more than nine hours of programming a week;
2. Ensure emergency services shall be available by telephone 24 hours a day, 7 days a week;
3. Provide individual or group counseling, motivational enhancement, family therapy, educational groups, occupational and recreational therapy, psychotherapy, addiction and pharmacotherapy shall be provided as indicated by each individual's needs;
4. For individuals with mental illness, ensure the use of psychotropic medication, mental health treatment and the individual's relationship to substance abuse disorders shall be addressed as the need arises;
5. Provide medical, psychiatric, psychological, laboratory, and toxicology services, on-site or through consultation or referral. Medical and psychiatric consultation shall be available within 24 hours by telephone, or if in person, within a time frame appropriate to the severity and urgency of the consultation requested;
6. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services; and
7. Ensure through documentation that the duration of treatment varies with the severity of the individual's illness and his response to treatment.

**12VAC35-105-1800. Substance abuse outpatient services (ASAM LOC 1.0) admission criteria.**

Before a substance abuse outpatient service program 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:

1. Meet diagnostic criteria for a substance use disorder and/or addictive disorder as defined by the DSM; and

2. Meet the admission criteria of Level 1.0 of ASAM including the specific criteria for adult and adolescent populations.

**12VAC35-105-1810. Substance abuse outpatient services (ASAM LOC 1.0) discharge criteria.**

Before a substance abuse outpatient service program may discharge or transfer an individual, 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 ASAM 1.0 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.

**12VAC35-105-1820. Substance abuse outpatient services (ASAM LOC 1.0) co-occurring enhanced programs.**

A. Support Systems: Substance abuse outpatient services co-occurring enhanced programs shall offer ongoing intensive case management for highly crisis-prone individuals with co-occurring disorders.

B. Staff: Substance abuse outpatient services co-occurring enhanced programs shall include credentialed mental health trained personnel who are able to assess, monitor, and manage the types of severe and chronic mental disorders seen in a level 1 setting as well as other psychiatric disorders that are mildly unstable. Staff shall be knowledgeable about management of co-occurring mental and substance-related disorders, including assessment of the individual's stage of readiness to change and engagement of individuals who have co-occurring mental disorders. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Therapies: Substance abuse outpatient services co-occurring enhanced programs shall offer therapies to actively address monitor and manage psychotropic medication, mental health treatment and the interaction with substance-related and addictive disorders.

**12VAC35-105-1830. Medication assisted opioid treatment (ASAM LOC OTS) staff criteria.**

Article 10 – Medication Assisted Opioid Treatment Program

Medication assisted opioid treatment programs shall meet the following staff requirements. The program shall:

1. Have linkage with or access to psychological, medical, and psychiatric consultation;
2. Have access to emergency medical and psychiatric care through affiliations with more intensive levels of care;
3. Have access to physical evaluations and ongoing primary medical care;
4. Have the ability to conduct or arrange for appropriate laboratory and toxicology tests; and
5. All clinical staff whether employed by the provider or available through consultation, contract, or other means shall be qualified by training and experience and appropriately

licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-105-1840. Medication assisted opioid treatment (ASAM LOC OTS) program criteria.**

Medication assisted opioid treatment programs shall meet the following programmatic requirements. The program shall:

1. Provide individualized, patient-centered assessment and treatment, which may include peer recovery support services;
2. Provide case management, including medical monitoring and coordination, with on and off-site treatment services provided as needed;
3. Provide psychoeducation, including HIV/AIDS education, and other health education services;
4. Assess, order, administer, reassess, and regulate medication and dose levels appropriate to the individual; supervise withdrawal management from opioid analgesics, including methadone or buprenorphine; and oversee and facilitate access to appropriate treatment;
5. Monitor drug testing that is to be done a minimum of 8 times per year; and
6. Comply with Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services 12VAC35-105-925 through 12VAC35-105-1050.

**12VAC35-105-1850. Medication assisted opioid treatment (ASAM LOC OTS) admission criteria.**

Before a medication assisted opioid treatment program 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:

1. Meet diagnostic criteria for severe opioid use disorder; and
2. Meet the admission criteria of Level 1.0 of ASAM.

**12VAC35-105-1860. Medication assisted opioid treatment (ASAM LOC OTS) discharge criteria.**

Before a medication assisted opioid treatment programs may discharge or transfer an individual, 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 ASAM OTS 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.

## 2. Emergency Action: Addition of ASAM Criteria [12 VAC 35 - 46]


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# Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

| | |
|---|---|
| **Agency name** | Department of Behavioral Health and Developmental Services (DBHDS) |
| **Virginia Administrative Code (VAC) Chapter citation(s)** | 12VAC35-46 |
| **VAC Chapter title(s)** | Regulations for Children's Residential Facilities |
| **Action title** | Amend the Children's Residential Licensing regulations to align with the ASAM Criteria |
| **Date this document prepared** | 6/30/2020 |

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), 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 the subject matter, intent, and goals of this 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 or changes. If applicable, generally describe the existing regulation.*

The Department of Behavioral Health and Developmental Services (DBDHS) was directed by the 2020 General Assembly within the Appropriation Act to utilize emergency authority to promulgate licensing regulations that align with the American Society of Addiction Medicine (ASAM) Levels of Care Criteria or an equivalent set of criteria to ensure the provision of outcome-oriented and strengths-based care in the treatment of addiction. The goal of this regulatory action is to amend the licensing regulations, Regulations for Children's Residential Facilities [12VAC35-46], to align with the ASAM Levels of Care Criteria, which ensure individualized, clinically driven, participant-directed and outcome-informed treatment.

## 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.*

ASAM- American Society of Addiction Medicine

DBHDS- Department of Behavioral Health and Developmental Services

State Board- State Board of Behavioral Health and Developmental Services

## Mandate and Impetus (Necessity for Emergency)

*Explain why this rulemaking is an emergency situation in accordance with § 2.2-4011 A and B of the Code of Virginia. In doing so, either:*

*c) Indicate whether the Governor's Office has already approved the use of emergency regulatory authority for this regulatory change.*

*d) Provide specific citations to Virginia statutory law, the appropriation act, federal law, or federal regulation that require that a regulation be effective in 280 days or less from its enactment.*

*As required by § 2.2-4011, also describe the nature of the emergency and of the necessity for this regulatory change. In addition, delineate any potential issues that may need to be addressed as part of this regulatory change*

The 2020 General Assembly directed DBDHS to promulgate emergency regulations to become effective within 280 days or less from the enactment of the Appropriation Act. In addition to being mandated by the General Assembly, the regulatory change is necessary as substance use disorders affect individuals, their families, the workplace, and the general community, therefore DBHDS must incorporate best practices within its licensing regulations in order to promote recovery from the disease of addiction. This is especially a concern with the increase of substance use in general. According to the Monitoring the Futures Survey of 2019, there has been an increase in adolescent marijuana vaping from 2018 to 2019. This increase ranked among the largest single-year increases ever observed by this survey in the past 45 years among all outcomes ever measured. In 2019 the percentage of adolescents who had vaped marijuana in the last 12 months was 21% in 12th grade, 19% in 10th grade, and 7% in 8th grade.

According to the Middle School Virginia Youth Survey conducted by the Virginia Department of Health (VDH), in 2017 approximately 3% of respondents indicated that they used marijuana before age 11 and almost 10% drank alcohol before age 11. That same VDH survey of high school students illustrated that over 30% of this population in 2017 reported using alcohol in the past 30 days. The survey also indicated that 25% of respondents binge drank, 20% reported using marijuana, and approximately 3% used heroin in a 30 day period.

## 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 or Acts and 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.*

DBDHS was directed by the 2020 General Assembly within the Appropriation Act to utilize emergency authority to promulgate regulations which align with a set of criteria to ensure the provision of outcome-oriented and strengths-based care in the treatment of addiction. Item 318 of the 2020 Acts of Assembly Chapter 1289 charges the Department to make the changes within this regulatory action. Section 37.2-203 of the Code of Virginia gives the Board of Behavioral Health and Developmental Services the authority to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code and other laws of the Commonwealth administered by the DBHDS commissioner.

## Purpose

*Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.*

Substance related disorders affect the individual, their families, the workplace and the general community, therefore the department must incorporate best practices in licensing regulations in order to promote remission and recovery from the disease of addiction. Regulations that promote remission and recovery from the disease of addiction are essential to protect the health and welfare of citizens.

Substance use disorders (SUDs) among children, adolescents, and their families pose particular challenges for the community. Given the differences in developmental and emotional growth between youth and adults, the complex needs of this population are remarkably different from those of the traditional adult treatment population, requiring different expertise and guidance. In addition, many adolescents who abuse drugs have a history of physical, emotional, and/or sexual abuse or other trauma.

Behavioral therapies, delivered by trained clinicians, help an adolescent stay off drugs by strengthening his or her motivation to change. The ASAM Criteria (American Society of Addiction Medicine) is designed to provide specific substance use disorder treatment guidance to counselors, clinicians, and case managers. Level 3.5 programming is specifically designed for youth and adults that require 24 hour care and treatment to begin and sustain a recovery process. This type of guidance can significantly improve the treatment outcomes of youth in need of residential services.

## 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.

This regulatory action amends the licensing regulations, Regulations for Children’s Residential Facilities [12VAC35-46], to align with the ASAM Levels of Care Criteria which ensures individualized, clinically driven, participant-directed and outcome-informed treatment. The regulatory action provides the necessary definitions for the newly aligned services to be provided and creates staff, program admission, discharge and co-occurring enhanced program criteria for ASAM levels of care 3.5 and 3.1.

## 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 advantage of the regulatory change is to have Children's Residential Licensing Regulations that incorporate best practices related to treatment of substance use disorders, which in turn will result in citizens of the Commonwealth receiving more effective treatment of substance use disorders. This is an advantage to the public, the agency, and the Commonwealth. The primary disadvantage is that some providers may experience a financial burden in order to comply with the new regulations. There are no known disadvantages to the agency or the Commonwealth.

## 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.*

As this regulatory action is the result of a General Assembly mandate. There are no viable alternatives.

## Periodic Review and Small Business Impact Review Announcement

*This Emergency/NOIRA is not being used to announce a periodic review or a small business impact review.*

## 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. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

The Department of Behavioral Health and Developmental Services is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, and (iii) the potential impacts of the regulation.

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, 1220 Bank Street, Richmond Virginia 23219, Phone Number: 804-371-2709, 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.

A public hearing will not be held following the publication of the emergency stage of this regulatory action.

## 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 emergency 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 section number | New section number, if applicable | Current requirement | Change, intent, rationale, and likely impact of new requirements |
|---|---|---|---|
| 12VAC35-46-10. Definitions. | | Provides current definitions for the Children's Residential Licensing Regulations. | Change: Adding the following definitions for terms utilized within the ASAM criteria:<br>• Allied health professionals;<br>• ASAM;<br>• Clinically managed, low-intensity residential care;<br>• Clinically managed, medium-intensity residential care;<br>• DSM;<br>• Medication assisted treatment; and<br>• Motivational enhancement.<br><br>Impact: Clear regulations |
| | 12VAC35-46-1150. American Society of Addiction Medicine criteria. | | Intent: Briefly describes the purpose of the ASAM criteria<br>Rationale: Explanation of the new Part of the Children's Residential Licensing Regulations.<br><br>Impact: Clearer regulations. |
| | 12VAC35-46-1160. Clinically managed, medium-intensity residential services (ASAM Level of care 3.5) staff criteria | | Intent: Provide clear staff requirements within clinically-managed, medium-intensity residential care programs, which provide 24 hour supportive treatment. The individuals served by clinically managed medium-intensity residential care are individuals who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-46-1170. Clinically managed medium-intensity residential services (ASAM Level of care 3.5) program criteria | | Intent: Provide clear program requirements within clinically-managed, medium-intensity residential care programs, which provide 24 hour supportive treatment. The individuals served by clinically-managed, medium-intensity residential care are individuals who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service. |

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| | | | Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-46-1180. Clinically-managed, medium intensity residential services admission criteria. | | Intent: Provide clear admission requirements within clinically-managed, medium-intensity residential service programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-46-1190. Clinically managed medium-intensity residential services discharge criteria. | | Intent: Provide clear discharge requirements within clinically-managed medium-intensity residential service programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-46-1200. Clinically managed medium-intensity residential services co-occurring enhanced programs | | Intent: Provide additional licensing requirements for medium-intensity residential services programs which treat individuals with co-occurring disorders.<br><br>Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders. |
| | 12VAC35-46-1210. Clinically-managed low-intensity residential services (ASAM Level of care 3.1) staff criteria | | Intent: Provide clear staff requirements within clinically managed low-intensity residential service program, which provide ongoing therapeutic environment for individuals requiring some structured support.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |
| | 12VAC35-46-1220. Clinically-managed, low-intensity residential services (ASAM Level of care 3.1) program criteria. | | Intent: Provide clear program requirements within clinically managed low-intensity residential service programs, which provide ongoing therapeutic environment for individuals requiring some structured support.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth. |

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| | 12VAC35-46-1230. Clinically managed low-intensity residential services admission criteria. | | Intent: Provide clear admission requirements within clinically managed low-intensity residential service programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-46-1240. Clinically-managed low-intensity residential services discharge criteria. | | Intent: Provide clear discharge requirements within clinically managed low – intensity residential service programs.<br><br>Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered. |
| | 12VAC35-46-1250. Clinically-managed low-intensity residential services co-occurring enhanced programs. | | Intent: Provide additional licensing requirements for clinically managed low-intensity residential service programs which treat individuals with co-occurring disorders.<br><br>Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders. |

## DRAFT TEXT: ASAM Chapter 46

**ASAM Alignment**

**Chapter 46. Regulations for Children's Residential Facilities.**

Part I General Provisions

**12VAC35-46-10. Definitions**

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

"Allegation" means an accusation that a facility is operating without a license or receiving public funds for services it is not certified to provide.

"Allied health professionals" 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.

"Annual" means within 13 months of the previous event or occurrence.

"Applicable state regulation" means any regulation that the department determines applies to the facility. The term includes, but is not necessarily limited to, regulations promulgated by the Departments of Education, Health, Housing and Community Development, or other state agencies.

"Applicant" means the person, corporation, partnership, association, or public agency that has applied for a license.

"ASAM" means the American Society of Addiction Medicine.

"Aversive stimuli" means the physical forces (e.g., sound, electricity, heat, cold, light, water, or noise) or substances (e.g., hot pepper sauce or pepper spray) measurable in duration and intensity that when applied to a resident are noxious or painful to the resident but in no case shall the term "aversive stimuli" include striking or hitting the individual with any part of the body or with an implement or pinching, pulling, or shaking the resident.

"Behavior support" means those principles and methods employed by a provider to help a child achieve positive behavior and to address and correct a child's inappropriate behavior in a constructive and safe manner in accordance with written policies and procedures governing program expectations, treatment goals, child and staff safety and security, and the child's individualized service plan.

"Behavior support assessment" means identification of a resident's behavior triggers, successful intervention strategies, anger and anxiety management options for calming, techniques for self-management, and specific goals that address the targeted behaviors that lead to emergency safety interventions.

"Body cavity search" means any examination of a resident's rectal or vaginal cavities, except the performance of medical procedures by medical personnel.

"Brain injury" means any injury to the brain that occurs after birth, but before age 65, that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include, but are not limited to, 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.

"Brain Injury Waiver" means a Virginia Medicaid home and community-based waiver for persons with brain injury approved by the Centers for Medicare and Medicaid Services.

"Care" or "treatment" means a set of individually planned interventions, training, habilitation, or supports that help a resident obtain or maintain an optimal level of functioning, reduce the effects of disability or discomfort, or ameliorate symptoms, undesirable changes or conditions specific to physical, mental, behavioral, or social functioning.

"Child" means any person legally defined as a child under state law. The term includes residents and other children coming into contact with the resident or facility (e.g., visitors). When the term is used, the requirement applies to every child at the facility regardless of whether the child has been admitted to the facility for care (e.g., staff/child ratios apply to all children present even though some may not be residents).

"Child-placing agency" means any person licensed to place children in foster homes or adoptive homes or a local board of social services authorized to place children in foster homes or adoptive homes.

"Children's residential facility" or "facility" means a publicly or privately operated facility, other than a private family home, where 24-hour per day care is provided to children separated from their legal guardians and is required to be licensed or certified by the Code of Virginia except:

1. Any facility licensed by the Department of Social Services as a child-caring institution as of January 1, 1987, and that receives public funds; and

2. Acute-care private psychiatric hospitals serving children that are licensed by the Department of Behavioral Health and Developmental Services under the Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse, the Individual and Family Developmental Disabilities Support Waiver, and Residential Brain Injury Services, 12VAC35-105.

"Clinically managed, low-intensity residential care" means providing an ongoing therapeutic environment for children requiring some structured support in which treatment is directed toward applying recovery skills; preventing relapse; improving emotional functioning; promoting personal responsibility; reintegrating the child into work, education, and family environments; and strengthening adaptive skills that may not have been achieved or have been diminished during the child's active addiction. A clinically managed, low-intensity residential care is also designed for the child 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, medium-intensity residential care" means a substance use treatment program that offers 24 hour supportive treatment of children with significant psychological and social problems by credentialed addiction treatment professionals in an interdisciplinary treatment approach. The children served by clinically managed, medium-intensity residential care are children who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service.

"Commissioner" means the Commissioner of the Department of Behavioral Health and Developmental Services or his authorized agent.

"Complaint" means an accusation against a licensed facility regarding an alleged violation of regulations or law.

"Contraband" means any item prohibited by law or by the rules and regulations of the department, or any item that conflicts with the program or safety and security of the facility or individual residents.

"Corporal punishment" means punishment administered through the intentional inflicting of pain and discomfort to the body through actions such as, but not limited to (i) striking or hitting with any part of the body or with an implement; or (ii) any similar action that normally inflicts pain or discomfort.

"Counseling" means certain formal treatment interventions such as individual, family, and group modalities, that provide for support and problem solving. Such interventions take place between provider staff and resident families or groups and are aimed at enhancing appropriate psychosocial functioning or personal sense of well-being.

"Corrective action plan" means the provider's pledged corrective action in response to cited areas of noncompliance documented by the department. A corrective action plan must be completed within a specified time.

"Crisis" means any acute emotional disturbance in which a resident presents an immediate danger to self or others or is at risk of serious mental or physical health deterioration caused by acute mental distress, behavioral or situational factors, or acute substance abuse related problems.

"Crisis intervention" means those activities aimed at the rapid management of a crisis.

"Day" means calendar day unless the context clearly indicates otherwise.

"Department" means the Department of Behavioral Health and Developmental Services (DBHDS).

"DOE" means the Department of Education.

"DSM" means the Fifth edition of the Diagnostic and Statistical Manual of Mental Disorders.

"Emergency" means a sudden, generally unexpected occurrence or set of circumstances demanding immediate action. Emergency does not include regularly scheduled time off for permanent staff or other situations that should reasonably be anticipated.

"Emergency admission" means the sudden, unplanned, unexpected admittance of a child who needs immediate care or a court-ordered placement.

"Goal" means expected results or conditions that usually involve a long period of time and that are written in behavioral terms in a statement of relatively broad scope. Goals provide guidance in establishing specific short-term objectives directed toward the attainment of the goal.

"Good character and reputation" means findings have been established and knowledgeable and objective people agree that the individual maintains business or professional, family, and community relationships that are characterized by honesty, fairness, truthfulness, and dependability, and has a history or pattern of behavior that demonstrates that the individual is suitable and able to care for, supervise, and protect children. Relatives by blood or marriage, and persons who are not knowledgeable of the individual, such as recent acquaintances, shall not be considered objective references.

"Group home" means a children's residential facility that is a community-based, homelike single dwelling, or its acceptable equivalent, other than the private home of the operator, and serves up to 12.

"Health record" means the file maintained by the provider that contains personal health information.

"Human research" means any systematic investigation including research development, testing, and evaluation, utilizing human subjects, that is designed to develop or contribute to generalized knowledge. Human research shall not include research exempt from federal research regulations pursuant to 45 CFR 46.101(b).

"Immediately" means directly without delay.

"Independent living program" means a competency-based program that is specifically approved by the department to provide the opportunity for the residents to develop the skills necessary to live successfully on their own following completion of the program.

"Individualized service plan" means a written plan of action developed and modified at intervals to meet the needs of a specific resident. It specifies measurable short and long-term goals, objectives, strategies, and time frames for reaching the goals and the individuals responsible for carrying out the plan.

"Intellectual disability" means mental retardation.

"Legal guardian" means the natural or adoptive parents or other person, agency, or institution that has legal custody of a child.

"License" means a document verifying approval to operate a children's residential facility and that indicates the status of the facility regarding compliance with applicable state regulations.

"Live-in staff" means staff who are required to be on duty for a period of 24 consecutive hours or more during each work week.

"Living unit" means the space in which a particular group of children in care of a residential facility reside. A living unit contains sleeping areas, bath and toilet facilities, and a living room or its equivalent for use by the residents of the unit. Depending upon its design, a building may contain one living unit or several separate living units.

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

"Medication" means prescribed and over-the-counter drugs.

"Medication administration" means the direct application of medications by injection, inhalation, or ingestion or any other means to a resident by (i) persons legally permitted to administer medications; or (ii) the resident at the direction and in the presence of persons legally permitted to administer medications.

<u>“Medication assisted treatment” or “MAT" means the use of FDA-approved medications in combination with counseling and behavioral therapies to provide treatment of substance use disorders.</u>

"Medication error" means an error made in administering a medication to a resident including the following: (i) the wrong medication is given to the resident; (ii) the wrong resident is given the medication; (iii) the wrong dosage is given to a resident; (iv) medication is given to a resident at the wrong time or not at all; and (v) the proper method is not used to give the medication to the resident. A medication error does not include a resident's refusal of offered medication.

"Mental retardation" ("intellectual disability") means a disability originating before the age of 18 years characterized concurrently by (i) significantly subaverage intellectual functioning as

demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean; and (ii) significant limitations in adaptive behavior as expressed as conceptual, social, and practical adaptive skills (§ 37.2-100 of the Code of Virginia). According to the American Association of Intellectual Disabilities (AAID) definition, these impairments should be assessed in the context of the individual's environment, considering cultural and linguistic diversity as well as differences in communication, and sensory motor and behavioral factors. Within an individual limitations often coexist with strengths. The purpose of describing limitations is to develop a profile of needed supports. With personalized supports over a sustained period, the functioning of an individual will improve. In some organizations the term "intellectual disability" is used instead of "mental retardation."

"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.

"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.

"Objective" means expected short-term results or conditions that must be met in order to attain a goal. Objectives are stated in measurable, behavioral terms and have a specified time for achievement.

"On-duty" means that period of time during which a staff person is responsible for the supervision of one or more children.

"On-site" means services that are delivered by the provider and are an integrated part of the overall service delivery system.

"Parent" means a natural or adoptive parent or surrogate parent appointed pursuant to DOE's regulations governing special education programs for students with disabilities." "Parent" means either parent unless the facility has been provided documentation that there is a legally binding instrument, a state law, or court order governing such matters as divorce, separation, or custody, that provides to the contrary.

"Pat down" means a thorough external body search of a clothed resident.

"Personal health information" means oral, written, or otherwise recorded information that is created or received by an entity relating to either an individual's physical or mental health or the provision of or payment for health care to an individual.

"Placement" means an activity by any person that provides assistance to a parent or legal guardian in locating and effecting the movement of a child to a foster home, adoptive home, or children's residential facility.

"Premises" means the tracts of land on which any part of a residential facility for children is located and any buildings on such tracts of land.

"Provider" means any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) residential services to children with mental illness, mental retardation (intellectual disability), or substance abuse; or (ii) residential services for persons with brain injury.

"Record" means up-to-date written or automated information relating to one resident. This information includes social data, agreements, all correspondence relating to the care of the resident, service plans with periodic revisions, aftercare plans and discharge summary, and any other data related to the resident.

"Resident" means a person admitted to a children's residential facility for supervision, care, training, or treatment on a 24-hour per day basis.

"Residential treatment program" means 24-hour, supervised, medically necessary, out-of-home programs designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, or training needs of a child or adolescent in order to prevent or minimize the need for more intensive inpatient treatment. Services include, but shall not be limited to, assessment and evaluation, medical treatment (including medication), individual and group counseling, neurobehavioral services, and family therapy necessary to treat the child. The service provides active treatment or training beginning at admission related to the resident's principle diagnosis and admitting symptoms. These services do not include interventions and activities designed only to meet the supportive nonmental health special needs including, but not limited to, personal care, habilitation, or academic educational needs of the resident.

"Respite care facility" means a facility that is specifically approved to provide short-term, periodic residential care to children accepted into its program in order to give the parents or legal guardians temporary relief from responsibility for their direct care.

"Rest day" means a period of not less than 24 consecutive hours during which a staff person has no responsibility to perform duties related to the facility.

"Restraint" means the use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an individual 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 freedom of movement or functioning of a limb or a 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.

"Routine admission" means the admittance of a child following evaluation of an application for admission and execution of a written placement agreement.

"Rules of conduct" means a listing of a facility's rules or regulations that is maintained to inform residents and others about behaviors that are not permitted and the consequences applied when the behaviors occur.

"Sanitizing agent" means any substance approved by the Environmental Protection Agency to destroy bacteria.

"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 or verbal means so that the individual cannot leave it.

"Self-admission" means the admittance of a child who seeks admission to a temporary care facility as permitted by Virginia statutory law without completing the requirements for "routine admission."

"Serious incident" means:

1. Any accident or injury requiring medical attention by a physician;

2. Any illness that requires hospitalization;

3. Any overnight absence from the facility without permission;

4. Any runaway; or

5. Any event that affects, or potentially may affect, the health, safety or welfare of any resident being served by the provider.

"Serious injury" means any injury resulting in bodily hurt, damage, harm, or loss that requires medical attention by a licensed physician.

"Service" or "services" means planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), or substance abuse through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, mental retardation (intellectual disability), or substance abuse. Services include residential services, including those for persons with brain injury.

"Severe weather" means extreme environment or climate conditions that pose a threat to the health, safety, or welfare of residents.

"Social skills training" means activities aimed at developing and maintaining interpersonal skills.

"Strategies" means a series of steps and methods used to meet goals and objectives.

"Strip search" means a visual inspection of the body of a resident when that resident's outer clothing or total clothing is removed and an inspection of the removed clothing. Strip searches are conducted for the detection of contraband.

"Structured program of care" means a comprehensive planned daily routine including appropriate supervision that meets the needs of each resident both individually and as a group.

"Student/intern" means an individual who simultaneously is affiliated with an educational institution and a residential facility. Every student/intern who is not an employee is either a volunteer or contractual service provider depending upon the relationship among the student/intern, educational institution, and facility.

"Substantial compliance" means that while there may be noncompliance with one or more regulations that represents minimal risk, compliance clearly and obviously exists with most of the regulations as a whole.

"Systemic deficiency" means violations documented by the department that demonstrate defects in the overall operation of the facility or one or more of its components.

"Target population" means individuals with a similar, specified characteristic or disability.

"Temporary contract worker" means an individual who is not a direct salaried employee of the provider but is employed by a third party and is not a consistently scheduled staff member.

"Therapy" means provision of direct diagnostic, preventive, and treatment services where functioning is threatened or affected by social and psychological stress or health impairment.

"Time out" means the involuntary removal of a resident 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.

"Treatment" means individually planned, sound, and therapeutic interventions that are intended to improve or maintain functioning of an individual receiving services in those areas that show impairment as the result of mental disability, substance addiction, or physical impairment. In order to be considered sound and therapeutic, the treatment must conform to current acceptable professional practice.

"Variance" means temporary or permanent waiver of compliance with a regulation or portion of a regulation, or permission to meet the intent of the regulation by a method other than that specified in the regulation, when the department, in its sole discretion, determines (i) enforcement will create an undue hardship and (ii) resident care will not be adversely affected.

"Volunteers" means any individual or group who of their own free will, and without any financial gain, provides goods and services to the program without compensation.

[Part II Administration
Part III Residential Environment
Part IV Programs and Services
Part V Disaster or Emergency Planning
Part VI Special Programs
Part VII- Addiction Medicine Service Requirements]

**12VAC35-46-1150. Addiction Medicine Service Requirements.**

Addiction medicine service criteria facilitate outcome-oriented and strengths-based care in the treatment of addiction including matching individuals to appropriate types and levels of care. Part VII contains requirements for staffing; programs, including co-occurring enhanced programs; admission; and discharge for addiction medicine services. In addition to these

requirements, providers shall comply with American Society of Addiction Medicine (ASAM) level of care (LOC) criteria where indicated.

**12VAC35-46-1160. Clinically managed, medium-intensity residential services (ASAM Level of care 3.5) staff criteria.**

A clinically managed, medium-intensity residential care program shall meet the following staff requirements The program shall:

1. Ensure the availability of emergency consultation with a licensed physician, by telephone or in person, in case of emergency related to an individual's substance use disorder, available 24 hours a day, 7 days a week. The program shall also provide staff 24 hours a day;
2. Provide licensed clinicians who are able to obtain and interpret information regarding the signs and symptoms of intoxication and withdrawal, as well as the appropriate monitoring and treatment of those conditions and how to facilitate entry into ongoing care;
3. Provide appropriately trained staff who are competent to implement physician-approved protocols for the child or adolescent's observation, supervision, and treatment, including over the counter medications for symptomatic relief, determination for the appropriate level of care, and facilitation of the child or adolescent's transition to continuing care;
4. Provide staff training which shall include at a minimum the requirements within 12VAC35-46-310, and all staff administering over the counter medications shall complete the training program approved by the Board of Nursing and required by §54.1-3408 (L) of the Code of Virginia;
5. Provide access, as needed, to medical evaluation and consultation, which shall be available 24 hours a day to monitor the safety and outcome of withdrawal management in this setting, in accordance with the provider's written criteria for admission and discharge as required by 12VAC35-46-640 and 12VAC35-46-765; and
6. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-46-1170. Clinically managed, medium-intensity residential services (ASAM Level of care 3.5) program criteria.**

A clinically managed, medium-intensity residential care program shall meet the following programmatic requirements. The program shall:

1. Provide daily clinical services including a range of cognitive, behavioral, and other therapies in individual or group therapy, programming, and psychoeducation as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
2. Provide counseling and clinical interventions to teach a child or adolescent the skills needed for daily productive activity, prosocial behavior, and reintegration into family and community;
3. Provide motivational enhancement and engagement strategies appropriate to the child or adolescent's stage of readiness to change and comprehension;
4. Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;
5. Provide family and caregiver treatment services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
6. Provide educational, vocational, and informational programming adaptive to individual needs;
7. Utilize random drug screening to monitor progress and reinforce treatment gains as appropriate to an individual treatment plan;
8. Ensure and document that the length of stay is determined by the child or adolescent's condition and functioning;

9. Make medication assisted treatment (MAT) available for all individuals. MAT may be provided by facility staff or coordinated through alternative resources;
10. Provide educational services in accordance with state law to maintain the educational and intellectual development of the child or adolescent while they are admitted to the service. When indicated, additional educational opportunities shall be provided to remedy deficits in the educational level of children or adolescents who have fallen behind because of their involvement with alcohol and other drugs;
11. Ensure that that all children and adolescents served by the residential service have access to the substance use treatment program; and
12. Provide daily clinical services to assess and address the child or adolescent's withdrawal status and service needs. This may include nursing or medical monitoring, use of medications to alleviate symptoms, or individual or group therapy or programming specific to withdrawal and withdrawal support.

**12VAC35-46-1180. Clinically managed, medium-intensity residential services (ASAM Level of Care 3.5) admission criteria.**

A. A clinically managed, medium-intensity residential care program provides treatment for children who have impaired functioning across a broad range of psychosocial domains, including disruptive behaviors, delinquency and juvenile justice involvement, educational difficulties, family conflicts and chaotic home situations, developmental immaturity and psychological problems.

B. Before a clinically managed, medium-intensity residential service program may admit a child or adolescent, the child or adolescent 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 child or adolescent:

1. Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate to high severity as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM); and
2. Meet the admission criteria of Level 3.5 of ASAM including the specific criteria for adolescent populations.

**12VAC35-46-1190. Clinically managed, medium-intensity residential services (ASAM Level of Care 3.5) discharge criteria.**

Before a clinically managed, medium-intensity residential service program may discharge or transfer a child or adolescent, the child or adolescent 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 children or adolescents who have:

1. Achieved the goals of the treatment services and no longer require ASAM 3.5 level of care;
2. Been unable to achieve the goals of the child or adolescent's treatment but could achieve the child or adolescent's goals with a different type of treatment; or
3. Achieved the child or adolescent's original treatment goals, but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

**12VAC35-46-1200. Clinically managed, medium-intensity residential services (ASAM Level of Care 3.5) co-occurring enhanced programs.**

A. Support Systems. Clinically managed, medium-intensity residential services co-occurring enhanced programs shall offer psychiatric services, medication evaluation, and laboratory services. Such services shall be available by telephone within eight hours and on-site or closely coordinated off-site within 24 hours.

B. Staff. Clinically managed, medium-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals, including addiction psychiatrists who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or

registered by the appropriate health regulatory board to serve individuals admitted to the service.

C. Therapies. Clinically managed, medium-intensity residential services co-occurring enhanced programs shall offer planned clinical activities designed to stabilize the child or adolescent's mental health problems and psychiatric symptoms and to maintain such stabilization, including medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental disorder.

**12VAC35-46-1210. Clinically managed, low-intensity residential services (ASAM Level of care 3.1) staff criteria.**

A clinically-managed, low-intensity residential services program shall meet the following staff requirements. The program shall:

1. Offer telephone or in-person consultation with a physician and emergency services, available 24 hours a day, seven days a week, by the clinically managed, low-intensity residential services provider. The program shall also provide allied health professional staff present on-site 24 hours a day;
2. Have clinical staff, with the credentials described in subsection 3, who are knowledgeable about the biological and psychosocial dimensions of substance use disorder and their treatment, and are able to identify the signs and symptoms of acute psychiatric conditions;
3. Have a team comprised of appropriately trained and credentialed medical, addiction, and mental health professionals; and
4. Have staff that shall be knowledgeable about child or adolescent development and experienced in engaging and working with children or adolescents.
5. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

**12VAC35-46-1220. Clinically managed, low-intensity residential services (ASAM Level of care 3.1) program criteria.**

A clinically-managed, low-intensity residential services program shall meet the following programmatic requirements. The program shall:

1. Offer a minimum of five hours a week of professionally directed treatment in addition to other treatment services offered to children or adolescents, such as partial hospitalization or intensive outpatient treatment. Services shall be designed to stabilize the child or adolescent's substance use disorder, improve the child or adolescent's ability to structure and organize the tasks of daily living and recovery;
2. Collaborate with care providers to develop an individual treatment plan for each child or adolescent with time-specific goals and objectives;
3. Provide counseling and clinical monitoring to support successful initial involvement in regular, productive daily activity;
4. Provide case management services;
5. Provide motivational interventions appropriate to the child or adolescent's stage of readiness to change and comprehension;
6. Maintain direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services. Include the ability to arrange for needed procedures as appropriate to the severity and urgency of the child or adolescent's condition;
7. Provide family and caregiver treatment and peer recovery support services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
8. Provide addiction pharmacotherapy and the ability to arrange for pharmacotherapy for psychiatric medications;

9. Utilize random drug screening to monitor progress and reinforce treatment gains;
10. Ensure that that all children and adolescents served by the residential service have access to the substance use treatment program; and
11. Make MAT available for all children. MAT may be provided by facility staff or coordinated through alternative resources.

**12VAC35-46-1230. Clinically managed, low-intensity residential services (ASAM Level of care 3.1) admission criteria.**

Before a clinically-managed, low-intensity residential service program may admit a child or adolescent, the child or adolescent 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 child or adolescent to:

1. Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate to high severity as defined by the DSM; and
2. Meet the admission criteria of Level 3.1 of ASAM, including the specific criteria of adolescent populations.

**12VAC35-46-1240. Clinically managed, low-intensity residential services (ASAM Level of care 3.1) discharge criteria.**

Before a clinically-managed, low-intensity residential service program may discharge or transfer a child or adolescent, the child or adolescent 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 children or adolescents who have:

1. Achieved the goals of the treatment services and no longer require ASAM 3.1 level of care;
2. Been unable to achieve the goals of the child or adolescent's treatment but could achieve the child or adolescent's goals with a different type of treatment; or
3. Achieved the child or adolescent's original treatment goals, but have developed new treatment challenges that can only be adequately addressed in a different type of treatment.

**12VAC35-46-1250. Clinically managed, low-intensity residential services (ASAM Level of care 3.1) co-occurring enhanced programs.**

A. Support Systems. Clinically managed low-intensity residential services co-occurring enhanced programs shall offer appropriate psychiatric services, including medication evaluation and laboratory services. Such services shall be provided on-site or closely coordinated off-site, as appropriate to the severity and urgency of the child or adolescent's mental condition.
B. Staff. Clinically managed low-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals who are able to assess and treat co-occurring disorders with the capacity to involve addiction-trained psychiatrists.
C. Therapies. Clinically managed low-intensity residential services co-occurring enhanced programs shall offer planned clinical activities that are designed to stabilize the child or adolescent's mental health problems and psychiatric symptoms and to maintain such stabilization, including medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental disorder.

## 3. Emergency Action: Amendments for Enhanced Behavioral Health Services

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# Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

| | |
|---|---|
| **Agency name** | Virginia Department of Behavioral Health and Developmental Services |
| **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** | Amend the Licensing Regulations to align with enhanced behavioral health services |
| **Date this document prepared** | June 29, 2020 |

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), 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 the subject matter, intent, and goals of this 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 or changes. If applicable, generally describe the existing regulation.*

Within the 2020 – 2022 biennium budget (HB 30), the General Assembly included the following requirements for the Department of Medical Assistance Services (DMAS) within Item 313:

3. *Effective on or after January 1, 2021, DMAS shall implement programmatic changes and reimbursement rates for the following services: assertive community treatment, multisystemic therapy and family functional therapy.*

4. *Effective on or after July 1, 2021, DMAS shall implement programmatic changes and reimbursement rates for the following services: intensive outpatient services, partial*

*hospitalization programs, mobile crisis intervention services, 23 hour temporary observation services, crisis stabilization services and residential crisis stabilization unit services.*

In order to assist with the implementation of these programmatic changes, the General Assembly directed the Department of Behavioral Health and Developmental Services (DBHDS), within Item 318, to promulgate emergency regulations to ensure that the DBHDS licensing regulations support high quality, community-based mental health services and align with the changes being made to the Medicaid behavioral health regulations for the services funded in the budged that support evidence-based, trauma-informed, prevention-focused and cost-effective services for members across the lifespan.

The amendments contained in this emergency action consist of only those changes that are necessary to align DBHDS licensing regulations with anticipated changes to Medicaid behavioral health regulations by removing provisions that would conflict with newly funded behavioral health services and establishing new licensed services for those newly funded behavioral health services that cannot be nested under an existing DBHDS license.

As stated above, most of the anticipated newly funded behavioral health services are consistent with already existing DBHDS licensed services. For these services, including functional family therapy, multisystemic family therapy, intensive outpatient services, partial hospitalization programs, mobile crisis intervention services, 23 hour temporary observation services, crisis stabilization services and residential crisis stabilization unit services; only very minimal changes are included in this action. The existing license requirements for Program for Assertive Community Treatment (PACT) services, however, are inconsistent with the Assertive Community Treatment (ACT) services that will be funded as part of Behavioral Health Enhancement. Substantive changes have been made to the service specific licensing regulations for this service to align licensing requirements with ACT service expectations. These changes are intended to ensure that providers licensed to provide ACT services adhere to a base level of fidelity to the ACT model.

## 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.*

ACT: Assertive Community Treatment
CPRS: Certified Peer Recovery Specialist
CSAC: Certified Substance Abuse Counselor
DBHDS: Department of Behavioral Health and Developmental Services
DMAS: Department of Medical Assistance Services
FFT: Functional Family Therapy
FTE: Full Time Equivalent
ICT: Intensive Community Treatment
LMHP: Licensed Mental Health Professional
LPN: Licensed Professional Nurse
MST: Multi-Systemic Therapy
NP: Nurse Practitioner
QMHP: Qualified Mental Health Professional
RN: Registered Nurse

## Mandate and Impetus (Necessity for Emergency)

*Explain why this rulemaking is an emergency situation in accordance with § 2.2-4011 A and B of the Code of Virginia. In doing so, either:*

*e) Indicate whether the Governor's Office has already approved the use of emergency regulatory authority for this regulatory change.*

*f) Provide specific citations to Virginia statutory law, the appropriation act, federal law, or federal regulation that require that a regulation be effective in 280 days or less from its enactment.*

*As required by § 2.2-4011, also describe the nature of the emergency and of the necessity for this regulatory change. In addition, delineate any potential issues that may need to be addressed as part of this regulatory change*

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The General Assembly, through the 2020 – 2022 biennium budget (HB 30), directed the Department of Behavioral Health and Developmental Services (DBHDS) to promulgate emergency regulations, to be effective within 280 days or less from the enactment of the 2020 appropriations act, to ensure that licensing regulations support high quality community-based mental health services and align with the changes being made to the Medicaid behavioral health regulations.

## 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 or Acts and 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.*

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Section 37.2-203 of the Code of Virginia authorizes the Board of Behavioral Health and Developmental Services to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code and other laws of the Commonwealth administered by the DBHDS Commissioner or the department.

## Purpose

*Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.*

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The purpose of this regulatory action is to align DBHDS licensing regulations with ongoing interagency efforts to enhance Virginia's behavioral health services system. The changes in this regulatory action will ensure that DBHDS's behavioral health provider licensing regulations align with changes to Medicaid funded behavioral health services in the Commonwealth by eliminating licensing provisions that conflict with Medicaid service expectations and creating new licensed services for those newly funded services that cannot be nested under an existing DBHDS licensed service.

## 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.

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The substantive provisions of this regulatory action include:

1) The creation of a service definition and license for Mental Health Intensive Outpatient Service;
2) Revised definition of Substance Abuse Intensive Outpatient Service; and
3) The creation of Assertive Community Treatment (ACT) as a newly licensed service in place of the previously licensed Program of Assertive Community Treatment (PACT) service. This includes

modification of the licensing requirements to align with the ACT service model and ensure that providers licensed to provide ACT services meet a basic level of fidelity to the ACT model.

The new services defined in this action will ensure that Virginia's licensing regulations align with and support the Commonwealth's initiatives to enhance behavioral healthcare in Virginia and support high quality community-based mental health 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.

Virginia's behavioral health system is undergoing a multi-phased, interagency process of enhancing the behavioral health services available in the Commonwealth. This process requires coordination between agencies with responsibilities for licensing, funding, and overseeing the delivery of behavioral health services in the Commonwealth. This regulatory action will benefit the public by 1) ensuring that Virginians have access to a continuum of high quality behavioral health services, 2) ensuring that a base level of model fidelity is adhered to by providers of Assertive Community Treatment (ACT), and 3) aligning DBHDS licensing regulations with Medicaid service expectations to ensure that the licensing and funding of behavioral health services are in alignment.

There are no known disadvantages to the public or the Commonwealth to these regulatory changes.

## 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.*

There are no alternatives to the regulatory changes contained herein that could achieve the essential purpose of this regulatory action. The regulatory changes contained herein are limited to only those that are necessary to ensure consistency between DBHDS licensing regulations and DMAS behavioral health regulations. Misalignment between the two would be problematic for providers of behavioral health services, including small business providers, as well as those who receive behavioral health services in the commonwealth.

## Periodic Review and Small Business Impact Review Announcement

If you wish to use this regulatory action to conduct, and this Emergency/NOIRA to announce, a periodic review (pursuant to § 2.2-4017 of the Code of Virginia and Executive Order 14 (as amended, July 16, 2018)), and a small business impact review (§ 2.2-4007.1 of the Code of Virginia) of this regulation, keep the following text. Modify as necessary for your agency.

*This NOIRA is not being used to announce a periodic review or a small business impact review.*

## 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. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

The Department of Behavioral Health and Developmental Services is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, and (iii) the potential impacts of the regulation.

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:

John Cimino
1220 Bank Street
Richmond, VA 23219
Phone: (804)298-3279
FAX: (804) 692-0066
John.cimino@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.

A public hearing will not be held prior to the implementation of the emergency action.

## 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 emergency 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 |
|---|---|---|---|
| 20 | | Defines terms used within the Licensing Regulations, including:<br><br>"Program of assertive community treatment" or "PACT";<br><br>Substance Abuse Intensive Outpatient Service | <br><br>Removes definition of Program of assertive community treatment or "PACT".<br><br>Updates definition of Substance Abuse Intensive Outpatient Service |

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| | | | Adds new definitions for:<br>• Assertive community treatment or “ACT”<br>• Mental Health Intensive Outpatient Service, and |
| 30 | | Lists services for which providers may be licensed by DBHDS, including:<br><br>Program of Assertive Community Treatment (PACT) | Adds “Mental health intensive outpatient service” as a DBHDS licensed service.<br><br>Removes “Program of Assertive Community Treatment (PACT)” from list of licensed services, and replaces with “Assertive Community Treatment (ACT)” |
| 1360 | | Defines admission and discharge criteria for Intensive Community Treatment (ICT) and Program of Assertive Community Treatment (PACT) providers | Changes Program of Assertive Community Treatment (PACT) to Assertive Community Treatment (ACT)<br><br>Adds personality disorder and brain injury to the list of sole diagnoses that render an individual ineligible for ICT and ACT services.<br><br>Makes the following non-substantive language changes: replaces “substance addition or abuse” with “substance use disorder”. |
| 1370 | | Defines the minimum treatment team and staffing requirements for ICT and PACT teams<br><br>Requires<br><br>• Requires ICT and PACT team leader to be a QMHP-A with at least three years experience in the provision of mental health services to adults with serious mental illness.<br>• Requires ICT teams to be staffed with at least one full time nurse, and PACT teams to be staffed with at least two full time nurses, at least one of whom shall be | Removes references to PACT<br><br>Creates separate treatment team and staffing requirements for ACT teams.<br><br>Makes substantive changes to ACT team staffing requirements to align with ACT service requirements, including<br>• Requires ACT team leader to be a Licensed Mental Health Professional (LMHP), or a Registered Qualified Mental Health Professional-Adult (QMHP-A) if already employed by the employer as a team leader prior to July 1, 2020.<br>• Differentiates nurse staffing requirements based on the size of the ACT Team.<br>o Small ACT teams shall have at least one full-time nurse, who shall be either an RN or an LPN.<br>o Medium ACT teams shall have at least one |

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| | | a Registered Nurse (RN).<br><br>• Requires ICT and PACT teams to have one full-time vocational specialist and one full-time substance abuse specialist<br><br>• Requires a peer specialist who is a QPPMH or QMHP-A who is or has been a recipient of mental health services for severe and persistent mental illness.<br>• Requires a psychiatrist who is a physician who is board certified in psychiatry or who is board eligible in psychiatry and is licensed to practice medicine in Virginia<br><br>• Requires each team to have a psychiatrist on staff, who must be a physician who is board certified in psychiatry or who is board eligible in psychiatry.<br>• N/A | full time RN, and at least one additional full-time nurse, who shall be LPN's or RNs.<br>○ Large ACT teams shall have at least one full-time RN, and at least two additional full-time nurses who shall e LPNs or RNs.<br><br>• Requires Vocational Specialist to be a registered QMHP with demonstrated expertise in vocational services through experience or education<br>• Requires ACT Co-occurring disorder specialist to be a LMHP, 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<br>• Requires a peer recovery specialist to be a Certified Peer Recovery Specialist (CPRS) or certify as a CPRS within the first year of employment<br><br>• Allows a Psychiatric Nurse Practitioner practicing within the scope of practice of a Psychiatric Nurse Practitioner to fill the psychiatrist position on an ACT team<br><br>• Requires generalist clinical staff as follows:<br>○ Small ACT teams shall have at least one generalist clinical staff;<br>○ Medium ACT teams shall have at least two generalist clinical staff; |

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| | | • Defines minimum staffing capacity for ICT and PACT teams. PACT teams shall have at least 10 full-time equivalent clinical employees or contractors. And PACT and ICT teams must maintain a minimum staff to individual ratio of 1:10.<br><br>• N/A | ○ Large ACT teams shall have at least three generalist clinical staff.<br>• Defines minimum staff to individual ratios that ACT teams must maintain based on the size of the team and the team's caseload.<br><br>• Requires ACT teams to have 24-hour responsibility for directly responding to psychiatric crises, including meeting the following criteria:<br>○ The team shall be available to individuals in crisis 245 hours per day, seven days per week, including in person when needed as determined by the team;<br>○ The team shall be the first-line crisis evaluator and responder for individuals serviced by the team; and<br>○ The team shall have access to the practical, individualized crisis plans developed to help them address crises for each individual receiving services. |
| 1380 | | Defines minimum number of contacts that ICT and PACT teams must make with individuals receiving services, and requires face-to-face contact, or attempts to make face-to-face contact with individuals in accordance with the individual's individualized services plan | • Removes references to PACT and replaces with ACT.<br>• Language changes for clarity<br>• Requires documentation of attempts to make contact with individuals |
| 1390 | | Requires daily organizational meetings and progress notes | Removes references to PACT and replaces with ACT |

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| | | be maintained by ICT and PACT teams | |
| 1410 | | Defines minimum service requirements for ICT and PACT teams<br><br>Providers shall document that the following services are provided consistent with the individual's assessment and ISP.<br>1. Ongoing assessment to ascertain the needs, strengths, and preferences of the individual;<br>2. Case management;<br>3. Nursing;<br>4. Support for wellness self-management, including the development and implementation of individual recovery plans, symptom assessment, and recovery education;<br>5. Psychopharmacological treatment, administration, and monitoring;<br>6. Substance abuse assessment and treatment for individuals with a co-occurring diagnosis of mental illness and substance abuse ;<br>7. Individual supportive therapy;<br>8. Skills training in activities of daily living, social skills, interpersonal relationships, and leisure time;<br>9. Supportive in-home services;<br>10. Work-related services to help find and maintain employment;<br>11 . Support for resuming education;<br>12.<br>Support, psychoeducation, consultation, and skill-teaching to family members, and significant others;<br>13. Collaboration with families and assistance to individuals with children; | Amends service requirements to align with ACT service expectations and philosophy.<br><br>Providers shall document that the following services are provided consistent with the individual's assessment and ISP.<br>1. Ongoing assessment to ascertain the needs, strengths, and preferences of the individual;<br>2. Case management;<br>3. Nursing;<br>4. Support for wellness self-management, including the development and implementation of individual recovery plans, symptom assessment, and recovery education;<br>5. Psychopharmacological treatment, administration, and monitoring;<br>6. Co-occurring diagnosis substance use disorder services that are non-confrontational, trauma informed, person-centered, consider interactions of mental illness and substance use, and have goals determined by the individual;<br>7. Empirically supported interventions and psychotherapy;<br>8. Psychiatric rehabilitation to include skill-building, coaching, and access to necessary resources to help individuals with personal care, safety skills, money management skills, grocery shopping, cooking, food safety and storage, purchasing and caring for clothing, household maintenance and cleaning skills, social skills, and use of transportation and other community resources;<br>9. Work-related services to help find and maintain employment;<br>10. Support for resuming education;<br>11. Support, psychoeducation, consultation, and skill-teaching to family members, and significant others, and broader natural support systems, which shall be directed exclusively to the well-being and benefit of the individual;<br>12. Collaboration with families and assistance to individuals with children; |

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| | | 14. Direct support to help individuals secure and maintain decent, affordable housing that is integrated into the broader community and to obtain legal and advocacy services, financial support, money-management services, medical and dental services, transportation, and natural supports in the community; and<br>15. Mobile crisis assessment, interventions to prevent or resolve potential crises, and admission to and discharge from psychiatric hospitals. | 13. Assistance in obtaining and maintaining safe, decent, and affordable housing that follows the individual's preferences in level of independence and location, consistent with an evidence based Supportive Housing Model.<br>14. Direct support to help individuals obtain legal and advocacy services, financial support, money-management services, medical and dental services, transportation, and natural supports in the community; and<br>15. Mobile crisis assessment, interventions to prevent or resolve potential crises, and admission to and discharge from psychiatric hospitals.<br>16. Assistance in developing and maintaining natural supports and social relationships;<br>17. Medication education, assistance, and support;<br>18. Peer support services, such as coaching, mentoring, assistance with self-advocacy<br>and self-direction, and modeling recovery practices. |

**DRAFT TEXT: ENHANCED BEHAVIORAL HEALTH – CHAPTER 105**

**Emergency: Enhanced BH**

Article 2
**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" (§ 37.2-100 of the Code of Virginia) means 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 a person receiving care or treatment for mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders). 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 person;

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

5. Use of excessive force when placing a person in physical or mechanical restraint;

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

7. Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with the person'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.

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

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

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

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

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

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

5. Offer varying levels of care for all individuals receiving ACT services, and appropriately adjust service levels according to individuals’ needs over time;

6. Assist individuals in advancing towards 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 his or her 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 must 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.

"Brain injury" means any injury to the brain that occurs after birth, but before age 65, 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" or "treatment" 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" means services that can include assistance to individuals and their family members in assessing needed services that are responsive to the person's individual 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 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.

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

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

"Community intermediate care facility/mental retardation" or "ICF/MR" means a residential facility in which care is provided to individuals who have mental retardation (intellectual disability)

or a developmental disability who need more intensive training and supervision than may be available in an assisted living facility or group home. Such facilities shall comply with Title XIX of the Social Security Act standards and federal certification requirements, provide health or rehabilitative services, and provide active treatment to individuals receiving services toward the achievement of a more independent level of functioning or an improved quality of life.

"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, mental retardation (intellectual disability), or substance abuse (substance use disorders); brain injury; or developmental disability.

"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. A corrective action plan must be completed within a specified time.

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

"Crisis" means a deteriorating or unstable situation often developing suddenly or rapidly that produces acute, heightened, emotional, mental, physical, medical, or behavioral distress or any situation or circumstance in which the individual perceives or experiences a sudden loss of the individual's ability to use effective problem-solving and coping skills.

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

"Day support service" means structured programs of activity or training services for adults with an intellectual disability or a developmental disability, generally in clusters of two or more continuous hours per day 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 disabilities" means autism or a severe, chronic disability that meets all of the following conditions identified in 42 CFR 435.1009:

1. Attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, that is found to be closely related to mental retardation (intellectual disability) because this condition results in impairment of general intellectual functioning or adaptive behavior similar to behavior of individuals with mental retardation (intellectual disability) and requires treatment or services similar to those required for these individuals;

2. Manifested before the individual reaches age 18;

3. Likely to continue indefinitely; and

4. Results in substantial functional limitations in three or more of the following areas of major life activity:

a. Self-care;

b. Understanding and use of language;

c. Learning;

d. Mobility;

e. Self-direction; or

f. Capacity for independent living.

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

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

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

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

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

"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.

"IFDDS Waiver" means the Individual and Family Developmental Disabilities Support Waiver.

"Individual" or "individual receiving services" means a person receiving services that are licensed under this chapter whether that person is referred to as a patient, consumer, client, resident, student, individual, recipient, family member, relative, or other term. When the term is used, 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.

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

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

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

"Intensive community treatment service" or "ICT" means a self-contained interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a full-time psychiatrist that:

1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illness, especially those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services;

2. Minimally refers individuals to outside service providers;

3. Provides services on a long-term care basis with continuity of caregivers over time;

4. Delivers 75% or more of the services outside program offices; and

5. Emphasizes outreach, relationship building, and individualization of services.

"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 mental retardation (intellectual 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.

"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.

"Medically managed withdrawal services" means detoxification services to eliminate or reduce the effects of alcohol or other drugs in the individual's body.

"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 effects 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.

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

"Medication administration" means the direct application of medications 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 treatment (Opioid treatment service)" means an intervention strategy that combines outpatient treatment with the administering or dispensing of synthetic narcotics, such as methadone or buprenorphine (suboxone), approved by the federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.

"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 (MHCSS)" 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 focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach. This service is provided weekly 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 illness" means 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.

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

"Neglect" means the failure by an individual 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 a person receiving care or treatment for mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders).

"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.

"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. 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. "Outpatient service" specifically includes:

1. 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. 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. 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.

"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 focused on individuals with serious mental illness, substance abuse (substance use disorders), or co-occurring disorders at risk of hospitalization or who have been recently discharged from an inpatient setting.

"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.

~~"Program of assertive community treatment service" or "PACT" means a self-contained interdisciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a full- or part-time psychiatrist that:~~

~~1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses, including those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services;~~

~~2. Minimally refers individuals to outside service providers;~~

~~3. Provides services on a long-term care basis with continuity of caregivers over time;~~

~~4. Delivers 75% or more of the services outside program offices; and~~

~~5. Emphasizes outreach, relationship building, and individualization of services.~~

"Provider" means 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, mental retardation (intellectual disability), or substance abuse (substance use disorders), (ii) services to individuals who receive day support, in-home support, or crisis stabilization services funded through the IFDDS Waiver, or (iii) residential services for individuals with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123 of the Code of Virginia, community services board, behavioral health authority, private provider, and any other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601 and 54.1-3701 of the Code of Virginia.

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

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

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

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

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

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

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

"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 mental retardation (intellectual disability), the concept

of recovery does not apply in the sense that individuals with mental retardation (intellectual disability) will need supports throughout their entire lives although these may change over time. With supports, individuals with mental retardation (intellectual disability) are capable of living lives that are fulfilling and satisfying and that bring meaning to themselves and others whom they know.

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

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

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

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

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

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

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

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

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

"Restraints for behavioral purposes" means using a physical hold, medication, or a mechanical device to control behavior or involuntary restrict the freedom of movement of an

individual in an instance when all of the following conditions are met: (i) there is an emergency; (ii) nonphysical interventions are not viable; and (iii) safety issues require an immediate response.

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

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

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

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

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

"Serious injury" means any injury resulting in bodily damage, harm, or loss that requires medical attention by a licensed physician, doctor of osteopathic medicine, physician assistant, or nurse practitioner while the individual is supervised by or involved in services, such as attempted suicides, medication overdoses, or reactions from medications administered or prescribed by the service.

"Service" means (i) planned individualized interventions intended to reduce or ameliorate mental illness, mental retardation (intellectual disability), 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, mental retardation (intellectual disability), or substance abuse (substance use disorders). Services include outpatient services, intensive in-home services, 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, halfway house, and other residential services; (ii) day support, in-home support, and crisis stabilization services provided to individuals under the IFDDS Waiver; and (iii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports or 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.

"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.

"Social detoxification service" means providing nonmedical supervised care for the individual's natural process of withdrawal from use of alcohol or other drugs.

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

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

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

"Substance abuse (substance use disorders)" means 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" means treatment provided in a concentrated manner for two or more consecutive hours per day to groups of individuals in a nonresidential setting. This service is provided over a period of time for individuals requiring more intensive services than an outpatient service can provide. Substance abuse intensive outpatient services include multiple group therapy sessions during the week, individual and family therapy, individual monitoring, and case management.~~

"Substance abuse intensive outpatient service" 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 9 to 19 hours of services per week for adults or 6 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 residential treatment for women with children service" means a 24-hour residential service providing an intensive and highly structured substance abuse service for women with children who live in the same facility.

"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.

"Therapeutic day treatment for children and adolescents" means a treatment program that serves (i) children and adolescents from birth through age 17 and under certain circumstances up to 21 with serious emotional disturbances, substance use, or co-occurring disorders or (ii) children from birth through age seven 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.

## Part II
## Licensing Process

**12VAC35-105-30. Licenses.**

A. Licenses are issued to providers who offer services to individuals who have mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); have developmental disability and are served under the IFDDS Waiver; 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)

~~1.~~ 2. Case management;

~~2.~~ 3. Community gero-psychiatric residential;

~~3.~~ 4. Community intermediate care facility-MR;

~~4.~~ 5. Residential crisis stabilization;

~~5.~~ 6. Nonresidential crisis stabilization;

~~6.~~ 7. Day support;

~~7.~~ 8. Day treatment, includes therapeutic day treatment for children and adolescents;

~~8.~~ 9. Group home and community residential;

~~9.~~ 10. Inpatient psychiatric;

~~10.~~ 11. Intensive Community Treatment (ICT);

~~11.~~ 12. Intensive in-home;

~~12.~~ 13. Managed withdrawal, including medical detoxification and social detoxification;

~~13.~~ 14. Mental health community support;

15. Mental health intensive outpatient

~~14.~~ 16. Opioid treatment/medication assisted treatment;

~~15.~~ 17. Emergency;

~~16.~~ 18. Outpatient;

~~17.~~ 19. Partial hospitalization;

~~18. Program of assertive community treatment (PACT)~~

~~19.~~ 20. Psychosocial rehabilitation;

~~20.~~ 21. Residential treatment;

~~21.~~ 22. Respite care;

~~22.~~ 23. Sponsored residential home;

~~23.~~ 24. Substance abuse residential treatment for women with children;

~~24.~~ 25. Substance abuse intensive outpatient;

~~25~~ 26. Supervised living residential; and

~~26~~ 27. 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.

Article 7
Intensive Community Treatment and ~~Program of~~ Assertive Community Treatment Services

**12VAC35-105-1360. Admission and discharge criteria.**

A. Individuals must meet the following admission criteria:

1. Diagnosis of a severe and persistent mental illness, predominantly schizophrenia, other psychotic disorder, or bipolar disorder that seriously impairs functioning in the community.

Individuals with a sole diagnosis of substance ~~addiction or abuse~~ use disorder or ~~mental retardation (intellectual disability)~~ developmental disability, personality disorder, or brain injury, are not eligible for services.

2. Significant challenges to community integration without intensive community support including persistent or recurrent difficulty with one or more of the following:

a. Performing practical daily living tasks;

b. Maintaining employment at a self-sustaining level or consistently carrying out homemaker roles; or

c. Maintaining a safe living situation.

3. High service needs indicated due to one or more of the following:

a. Residence in a state hospital or other psychiatric hospital but clinically assessed to be able to live in a more independent situation if intensive services were provided or anticipated to require extended hospitalization, if more intensive services are not available;

b. Multiple admissions to or at least one recent long-term stay (30 days or more) in a state hospital or other acute psychiatric hospital inpatient setting within the past two years; or a recent history of more than four interventions by psychiatric emergency services per year;

c. Persistent or very recurrent severe major symptoms (e.g., affective, psychotic, suicidal);

d. Co-occurring substance addiction or abuse of significant duration (e.g., greater than six months);

e. High risk or a recent history (within the past six months) of criminal justice involvement (e.g., arrest or incarceration);

f. Ongoing difficulty meeting basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless; or

g. Inability to consistently participate in traditional office-based services.

B. Individuals receiving ~~PACT~~ ACT or ICT services should not be discharged for failure to comply with treatment plans or other expectations of the provider, except in certain circumstances as outlined. Individuals must meet at least one of the following criteria to be discharged:

1. Change in the individual's residence to a location out of the service area;

2. Death of the individual;

3. Incarceration of the individual for a period to exceed a year or long term hospitalization (more than one year); however, the provider is expected to prioritize these individuals for ~~PACT~~ ACT or ICT services upon their anticipated return to the community if the individual wishes to return to services and the service level is appropriate to his needs;

4. Choice of the individual with the provider responsible for revising the ISP to meet any concerns of the individual leading to the choice of discharge; or

5. Significant sustained recovery by the individual in all major role areas with minimal team contact and support for at least two years as determined by both the individual and ICT or ~~PACT~~ ACT team.

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

A. Services are delivered by interdisciplinary teams.

1. ~~PACT and~~ ICT teams shall include the following positions:

a. Team ~~Leader~~ leader - one full-time QMHP-A with at least three years experience in the provision of mental health services to adults with serious mental illness. The team leader shall oversee all aspects of team operations and shall routinely provide direct services to individuals in the community.

b. Nurses - ~~PACT and~~ ICT nurses shall be full-time employees or contractors with the following minimum qualifications: A registered nurse ~~(RN)~~ shall have one year of experience in the provision of mental health services to adults with serious mental illness. A licensed practical nurse ~~(LPN)~~ shall have three years of experience in the provision of mental health services to adults with serious mental illness. ICT teams shall have at least one qualified full-time nurse. ~~PACT teams shall have at least three qualified full-time nurses at least one of whom shall be a qualified RN.~~

c. One full-time vocational specialist and one full-time substance abuse specialist. These staff members shall provide direct services to individuals in their area of specialty and provide leadership to other team members to also assist individuals with their self-identified employment or substance abuse recovery goals.

d. ICT Peer specialists - one or more full-time equivalent QPPMH or QMHP-A who is or has been a recipient of mental health services for severe and persistent mental illness. 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 individuals' recovery goals.

e. Program assistant - one full-time person 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 provide receptionist activities.

f. Psychiatrist - one physician who is board certified in psychiatry or who is board eligible in psychiatry and is licensed to practice medicine in Virginia. An equivalent ratio to 20 minutes (.008 FTE) of psychiatric time for each individual served must be maintained. The psychiatrist shall be a fully integrated team member who attends team meetings and actively participates in developing and implementing each individual ISP.

2. QMHP-A and mental health professional standards for ICT teams:

a. At least 80% of the clinical employees or contractors on an ICT team, not including the program assistant or psychiatrist, shall be QMHP-As qualified to provide the services described in 12VAC35-105-1410.

b. Mental health professionals - At least half of the clinical employees or contractors on an ICT team, not including the team leader or nurses and including the peer specialist if that person holds such a degree, shall hold a master's degree in a human service field.

3. Staffing capacity for ICT teams:

a. An ICT team shall have at least five full-time equivalent clinical employees or contractors. ~~A PACT team shall have at least 10 full-time equivalent clinical employees or contractors.~~

b. ICT ~~and PACT~~ teams shall include a minimum number of employees (counting contractors but not counting the psychiatrist and program assistant) to maintain an employee to individual ratio of at least 1:10.

c. ICT teams may serve no more than 80 individuals. ~~PACT teams may serve no more than 120 individuals.~~

~~d. A transition plan shall be required of PACT teams that will allow for "start-up" when newly forming teams are not in full compliance with the PACT model relative to staffing patterns and individuals receiving services capacity.~~

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

a. Team leader - one full time LMHP with three years of experience in the provision of mental health services to adults with serious mental illness; or one full time registered QMHP-A with at least three years of experience in the provision of mental 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. 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 - one 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 - one full-time co-occurring disorder specialist, who shall be a LMHP, 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 - one or more 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 a certified peer recovery specialist (CPRS), 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 individuals' recovery goals.

f. Program assistant – one full-time person 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 – 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 – 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 percent of whom shall be LMHPs, QMHP-As, QMHP-Es, 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.

5. 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. ICT and ~~PACT~~ ACT teams shall meet daily Monday through Friday or at least four days per week to review and plan routine services and to address or prevent emergency and crisis situations.

C. ICT teams shall operate a minimum of eight hours per day, five days per week and shall provide services on a case-by-case basis in the evenings and on weekends. ~~PACT~~ 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.

D. The ICT ~~or PACT~~ 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.

E. The ~~PACT~~ ACT team shall ~~operate an after-hours on-call system and be available to individuals by telephone or in person~~ have 24-hour responsibility for directly responding to psychiatric crises, including meeting the following criteria:

1. The team shall be available to individuals in crisis 24 hours per day, seven days per week, including in person when needed as determined by the team;

2. The team shall be the first-line crisis evaluator and responder for individuals served by the team; and

3. The team shall have access to the practical, individualized crisis plans developed to help them address crises for each individual receiving services.

**12VAC35-105-1380. Contacts.**

A. The ICT and ~~PACT~~ ACT team shall have ~~the~~ sufficient capacity to provide multiple contacts per week to individuals experiencing severe symptoms or significant problems in daily living.~~,~~ ~~for an~~ The team shall provide a minimum aggregate average of three contacts per individual per week. A minimum aggregate average of two hours per individual per week shall be face to face.

B. Each individual receiving ICT or ~~PACT~~ ACT services shall be seen face-to-face by an employee or contractor as specified in the individual's ISP. ~~;or the employee or contractor should attempt to make contact as specified in the ISP~~ Providers shall document all attempts to make contact and if contact is not made, the reasons why contact was not made.

**12VAC35-105-1390. ICT and ~~PACT~~ ACT service daily operation and progress notes.**

A. ICT teams and ~~PACT~~ ACT teams shall conduct daily organizational meetings Monday through Friday at a regularly scheduled time to review the status of all individuals and the outcome of the most recent employee or contractor contact, assign daily and weekly tasks to employees and contractors, revise treatment plans as needed, plan for emergency and crisis situations, and to add service contacts that are identified as needed.

B. A daily log that provides a roster of individuals served in the ICT or ~~PACT~~ ACT services program and documentation of services provided and contacts made with them shall be maintained and utilized in the daily team meeting. There shall also be at least a weekly individual

progress note documenting services provided in accordance with the ISP or attempts to engage the individual in services.

**12VAC35-105-1410. Service requirements.**

~~Providers~~ ICT and ACT teams shall document that the following services are provided consistent with the individual's assessment and ISP.

1. Ongoing assessment to ascertain the needs, strengths, and preferences of the individual;

2. Case management;

3. Nursing;

4. Support for wellness self-management, including the development and implementation of individual recovery plans, symptom assessment, and recovery education;

5. Psychopharmacological treatment, administration, and monitoring;

6. ~~Substance abuse assessment and treatment for individuals with a co-occurring diagnosis of mental illness and substance abuse~~ Co-occurring diagnosis substance use disorder services that are non-confrontational, trauma informed, person-centered, consider interactions of mental illness and substance use, and have goals determined by the individual;

7. ~~Individual supportive therapy~~ Empirically supported interventions and psychotherapy;

8. ~~Skills training in activities of daily living, social skills, interpersonal relationships, and leisure time~~ Psychiatric rehabilitation, which may include skill-building, coaching, and access to necessary resources to help individuals with personal care, safety skills, money management, grocery shopping, cooking, food safety and storage, purchasing and caring for clothing, household maintenance and cleaning skills, social skills, and use of transportation and other community resources;

9. ~~Supportive in-home services;~~

~~10.~~ Work-related services ~~to help find and maintain employment~~ that follow evidence-based Supported Employment principles, such as direct assistance with job development, locating preferred jobs, assisting the individual through the application process, and communicating with employers;

~~11~~ 10. Support for resuming education;

~~12~~ 11. Support, education, consultation, and skill-teaching to family members, ~~and~~ significant others, and broader natural support systems, which shall be directed exclusively to the well-being and benefit of the individual;

~~13~~ 12. Collaboration with families and assistance to individuals with children;

13. Assistance in obtaining and maintaining safe, decent, and affordable housing that follows the individual's preferences in level of independence and location, consistent with an evidence based supportive housing model;

14. Direct support to help individuals ~~secure and maintain decent, affordable housing that is integrated into the broader community and to~~ obtain legal and advocacy services, financial support, money-management services, medical and dental services, transportation, and natural supports in the community;

15. Mobile crisis assessment, interventions to prevent or resolve potential crises, and admission to and discharge from psychiatric hospitals;

16. Assistance in developing and maintaining natural supports and social relationships;

17. Medication education, assistance, and support; and

18. Peer support services, such as coaching, mentoring, assistance with self-advocacy and self-direction, and modeling recovery practices.

# *DIRECTIONS*

**Wednesday, July 15, 2020**
**James Monroe Building, Conference Rooms C-D-E**
**101 N. 14th Street**
**Richmond, VA 23219**

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This page has **driving directions to the James Monroe Building and instructions on how to log in electronically to the meeting.**

Time: **NO COMMITTEE MEETINGS.** Regular Board Meeting at 9:00 a.m.

Regular Meeting Location: **James Monroe Building, Conference Rooms C-D-E**
**101 N. 14th Street**
**Richmond, VA 23219**

DIRECTIONS TO JAMES MONROE BUILDING:
**From the North:** Follow I-95 South to Exit 74B (Franklin Street). The James Monroe Building is the tall building on the right.

**From the South:** Take I-95 North to Exit 74C. Follow Exit 74C, then take the Broad Street East ramp to the right. Turn right onto Broad Street. Go to the first traffic light that is N. 14th Street and turn left.

**From the West:** Take I-64 East. As you get into the central Richmond area, I-64 merges with I-95. Follow signs for I-95 South to Exit 74B (Franklin Street) *(do not get back onto I-64).* The James Monroe Building is the tall building on the right.

**From the East:** Take I-64 West to I-95 South. Follow I-95 South to Exit 74B (Franklin Street). The James Monroe Building is the tall building on the right.

** **There is an entrance from 14th Street under a walking bridge that goes across 14th Street.** Go in that door, and take the elevator or stairs all the way up. You will come outside to the plaza. Go in the main door to the security desk. You must have a mask on and personal ID to present to security. The meeting rooms are straight back all the way down the hall behind the security desk. The board meeting will be held in the Personnel Training Center on the mezzanine level off of the main lobby near the cafeteria entrance (conference rooms C-D-E).

**Board Member Parking:** Board members will receive specific instructions for arranged parking near the Monroe Building.

**Public Parking:** Parking is not permitted in Commonwealth of Virginia parking areas. Public parking areas are available on nearby streets; you must place a parking meter 'ticket' in your dash from the meter machines spaced on each block (not at each space). There are also paid lots and garages nearby.

# MEETING PARTICIPATION INSTRUCTIONS

**State Board of Behavioral Health and Developmental Services Regular Meeting**

**9:00 a.m. Wednesday, July 15, 2020**

**Time:** The Regular Meeting of the State Board will begin at 9:00 a.m. It is recommended that you connect to the meeting prior to the start time. No committee meetings will be held.

**Meeting Location:** Via Google Meets or Phone

**THIS PAGE HAS INSTRUCTIONS TO LISTEN ONLY OR TO LISTEN AND OBSERVE THE MEETING.**

INSTRUCTIONS:

Members of the State Board and DBHDS staff will have the ability to speak. All other have the ability to view the screen and listen, or listen only. There will be no public comment period during this meeting.

- **View and listen:**

If you want to view the meeting packet on screen and listen via the Adobe Connect meeting room, go to this site: **Google Meets Link to Board Meeting**

You will be prompted there to connect by phone from within the online room. Please **mute** all devices (IMPORTANT NOTE: You do not need the number below if you are using the link; simply go to that web address and follow the prompts.)

- **Listen only by phone:**

If you are only going to listen to the meeting (without accessing Google Meets), then use this phone number and passcode:

Conference #: (US) +1 636-498-4352; PIN: 760 962 004#

Please log in ahead of the 9:00 a.m. start time. Please **mute** all devices (computers or phones).

- If you have difficulty connecting by either means, email ruthanne.walker@dbhds.virginia.gov or susie.puglisi@dbhds.virginia.gov.