COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

DRAFT MEETING AGENDA

Tuesday, July 27 & Wednesday July 28, 2021

DBHDS Central Office, Jefferson Building*
1220 Bank Street, Richmond, VA
Biennial Planning Meeting on Tuesday; no business will be conducted.

<u>Biennial Planning Meeting</u>
Tuesday July 27, 2021 12:30 p.m.
DHBDS, 13th Floor Large Conference Room, Jefferson Building,
1220 Bank Street, Richmond, VA 23219
This meeting will be in person with a physical quorum present, but no business will be conducted, discussion only.

	12:30	**Lunch**		
	1:30	**Welcome & Introductions**	Elizabeth Hilsher *Chair*	
	1:45	**A. Agency Strategic Plan Update** **B. Agency Initiatives Update**	*DBHDS Leadership*	
	2:45	**Break**		
	3:00	**Board Planning Session**	*Facilitator*	
	4:15	**A. Review of Powers & Duties** **B. Orientation** *optional*	Ruth Anne Walker *Director of Regulatory Affairs and Board Liaison*	
	5:00	**Adjourn**		

- **Dinner 6:00 pm – Informal; TBD (no business).**

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

CONCURRENT COMMITTEE MEETINGS

Wednesday, July 17, 2021 8:30 a.m. – 9:45 a.m.
DBHDS Central Office, 13th Floor Large Conference Room, Jefferson Building
1220 Bank Street, Richmond, VA

8:30	• **Policy Committee** ***8th Floor Conference Room*** *Or* ***ZoomGov Meeting*** *https://dbhds.zoomgov.com/j/1617885410* *Meeting ID: 161 788 5410* *Passcode: @cPWu1hq* *OR* *Phone: 1 646 828 7666 US (New York)* *Meeting ID: 161 788 5410* *Passcode: 89225190* _____ • **Planning and Budget Committee** ***13th Floor Large Conference Room*** OR see main meeting info below↓	Josie Mace *Legislative Affairs Manager, QAGR* _____ Ruth Anne Walker *Board Liaison*
9:25	**Adjourn**	

REGULAR MEETING

Wednesday, July 28, 2021
9:30 a.m. – 2:00 p.m.
DBHDS Central State Office, 13th Floor Large Conference Room, Jefferson Building
1220 Bank Street, Richmond, VA 23219

This meeting will be in person with a physical quorum present, but electronic or phone connection is available:
ZoomGov Meeting: https://dbhds.zoomgov.com/j/1615686293
Meeting ID: 161 568 6293
Passcode: c4eQjP&M

OR
By Phone: +1 646 828 7666
Meeting ID: 161 568 6293
Passcode: 77234857

1.	9:30	**Call to Order and Introductions** **Approval of July 28, 2021 Agenda** ➢ *Action Required* **Approval of Draft Minutes** **Regular Meeting, April 14, 2021** ➢ *Action Required*	Elizabeth Hilscher *Chair*	**p.5**
2.	9:35	**Officer Elections** **A. Presentation of the Slate of Candidates** **B. Nominations from the Floor**	Moira Mazzi *Chair, Nominating Committee*	

		C. Election ➢ *Action Required* **D. Passing of the Gavel**		
3.	9:45	**Public Comment** (*3 minute limit per speaker*)		
4.	10:00	**MOVED TO 11:15! Commissioner's Report**	Cort Kirkley, CAO for Alison Land, *Commissioner*	
5.	10:45	**Regulatory Actions** **A. Proposed Stage** **1. Licensing Regulations, 12VAC35-105: Behavioral Health Expansion.** **2. Licensing Regulations, 12VAC35-105: ASAM Criteria.** **3. Childrens Residential Regulations, 12VAC35-46: ASAM Criteria.** ➢ *Action requested for Items 1-3: Initiate proposed stage.* **B. Initiate Periodic Reviews:** 1. 12 VAC 35-12 Public Participation Guidelines. 2. 12 VAC 35-190 Regulations for Voluntary Admissions to State Training Centers. 3. 12 VAC 35-200 Regulations for Emergency and Respite Care Admission to State Training Centers. 4. 12 VAC 35-210 Regulations to Govern Temporary Leave from State Facilities. 5. 12 VAC 35-240 Victims of Sterilization Fund Program. ➢ *Action requested Items 1-5: Authorize periodic reviews.* **C. General Update – Regulatory Matrix**	Ruth Anne Walker *Director of Regulatory Affairs* Emily Bowles *Office of Licensing Associate Director – Licensing, Regulatory Compliance, Quality and Training* Jeff VanArnam *Adult Mental Health Services Coordinator Division of Community Behavioral Health Services* Alexis Aplasca *Chief Clinical Officer* Susan Puglisi *Regulatory Research Specialist Office of Regulatory Affairs*	**p.23** **p.74** **p.135** **p.147** **p.23**
6.	11:15	**MOVED TO 10!!! US Department of Justice Settlement Agreement with Virginia** ▪ Monitoring – Compliance and Quality ▪ Exiting the Settlement Agreement. ▪ Investments in Technology and Data.	Heather Norton *Assistant Commissioner, Developmental Services*	
7.	12:00	**Lunch: Break and Collect Lunch**		

8.	12:30	**Committee Reports:** **A. Planning and Budget** **B. Policy Development and Evaluation**		
9.	12:50	**Board Member Spotlight**	Kendall Lee	
10.	1:00	**Update: Virginia Association of Community Services Boards**	Jennifer Faison *VACSB Executive Director*	
11.	1:30	**Biennial Planning Meeting** **A. Report Out from** ➢ *Action required: List of priorities for the 2022-2024 biennium.* **B. Next Steps: Letter to the Governor**	Chair	
12.	1:45	**Meeting Information** **A. Meeting Calendar** ➢ *Action required: Dates through 2022* **B. Next Meeting: September 29, 2021**		
13.	2:00	**Other Business**		
14.	2:30	**Adjournment**		

(Note: Times may run slightly ahead of or behind schedule.
If you are on the agenda, please plan to be present at least 10 minutes in advance.)

2021 MEETING SCHEDULE

DATE	Location
Sept. 29 (Wed)	*Southwestern Virginia Mental Health Institute (SWVMHI)* ***Marion***
Dec: 8 (Wed)	*Central Office, DBHDS* ***Richmond***

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
DRAFT MEETING MINUTES
9:30 a.m., Wednesday, April 14, 2021
This meeting was held entirely electronically. A recording of the meeting is available.

Members Present (virtually)	Elizabeth Hilscher, Chair; Rebecca Graser, Vice Chair; Paige Cash; Jerome Hughes; Kendall Lee; Moira Mazzi; Chris Olivo; Sandra Price-Stroble.
Members Absent	Varun Choudhary.
Staff Present	Heidi Dix, Deputy Commissioner, Division of Quality Assurance and Government Relations. Alex Harris, Policy and Legislative Affairs Director. Alison Land, FACHE, Commissioner. Emma Lowry, Director, Piedmont Geriatric Hospital. Erin Kelley, Policy and Finance Analyst, Office of Budget Development. Ruth Anne Walker, Regulatory Affairs Director and State Board Liaison. Jason Wilson, Director, Virginia Center for Behavioral Rehabilitation.
Guests Present	Invited guests: Jennifer Faison, Executive Director, Virginia Association of Community Services Boards. Other citizens attended.
Call to Order and Introductions	At 9:31 a.m., Elizabeth Hilscher, Chair, called the meeting to order and welcomed everyone. She noted that the State Board was meeting via electronic means, 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). All board members and department staff were able to converse, but 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. Ms. Hilscher noted that there would be a period for public comment, within the timeframe allowed on the agenda. *At 9:33 a.m.,* Ms. Hilscher conducted a roll call of members and announced a quorum was present for the meeting.
Approval of Agenda	*At 9:36 a.m. the State Board to adopt the April 14, 2021, agenda. On a motion by Sandra Price-Stroble and a second by Kendall Lee, the agenda was approved unanimously by roll call vote.*

Approval of Draft Minutes	**Regular Meeting, December 2, 2020** *At 9:38 a.m., on a motion by Paige Cash and a second Becky Graser, the December minutes were approved as final by a roll call vote.*
Public Comment	At 9:40 a.m., Ms. Hilscher noted that a period for public comment was included on the draft agenda, and that it was announced with the meeting packet that anyone wishing to give verbal or written comments needed to email by 5 p.m. on April 13, 2021. No comments were received.
Commissioner's Report	At 9:45 a.m., Alison Land, Commissioner, spoke with the State Board about a number of critical issues including: ▪ Census at state hospitals; ▪ State hospital upward trend of temporary detention orders (TDOs); ▪ State facility staffing shortages (well over 20% and up to 52%) and safety risk for staff and individuals receiving services; ▪ DBHDS working with CSBs on expediting discharges from state hospitals; ▪ New and existing contracts with providers to help alleviate the above issues; ▪ COVID-19 related bed limitations creating delays in state hospital admissions and corresponding increase of law enforcement time to accompany individuals waiting for placement; ▪ Increase in use of alternative transportation; ▪ Solutions for individuals in state hospitals with a primary diagnosis of dementia (a pilot with Mt. Rogers CSB to provide support to nursing facilities taking older adults with behavioral health challenges; $3.5 million for diversion and discharge of individuals with a diagnosis of dementia; $727,000 for a mobile crisis pilot program specifically for individuals with dementia; workgroup to identify existing services for individuals with a diagnosis of dementia and make recommendations to improve the quality and availability of care for those living with dementia). ▪ Transformation of the crisis system including the work to implement the Marcus Alert legislation (2020 Special Session, HB5043/SB5038), which has plans for a crisis call center as the 9-8-8 National Suicide Prevention Lifeline contact point, in line with federal legislation; and 23-hour crisis stabilization units (CSUs) and crisis intervention team assessment centers (CITACs); ▪ System Transformation, Excellence, Performance (STEP-VA) has some aspects implemented, some underway, others that were just funded, and active planning of future steps. Part of this effort includes Behavioral Health Redesign for Access,

	Value and Outcomes (BRAVO) that has six key services: Multi-Systemic Therapy, Functional Family Therapy, Partial Hospitalization Program, Intensive Outpatient Program, Program of Assertive Community Treatment, and Comprehensive Crisis Services. Ms. Price-Stroble remembered the last five years of her mother's care in a congregate setting and thanked the commissioner for the activities regarding individuals with dementia. The commissioner stated that other states had successfully built systems of care for this population. Ms. Hilscher stated that in regard to the board's role with the agency strategic plan that she be with the board at the biennial planning meeting to help the board with her guidance about where she wants the agency to go. Ms. Land said that strategic priorities under development and a senior leadership team meeting was being held the following week to finalize them. She asked Heidi Dix to share them with the board. Ms. Hilscher stated that getting those ahead of time would be incredibly helpful, as she sees the role of the board to facilitate improvements rather than to cast doubt or fight against the priorities. Ms. Graser was particularly interested in the individuals designated as not guilty by reason of insanity (NGRI) in state hospitals, as there is are not enough 'peer bridgers' in the system to help the NGRI transition of the conditions in the discharge plan. Sometimes the number of court conditions placed on the discharge order can make the transition more difficult. Often a letter will go to the court in support for the individual to be released into the community, but the court-appointed therapist says the individual is not yet ready, and those in the NGRI population can get 'stuck' in the system for years even when nonviolent. She applauded the commissioner's focus on the extraordinary barriers to discharge list. Perhaps more Gateway-type homes would be helpful. Ms. Land stated the EBL workgroup is looking at a number of different possibilities, because the process is onerous and then slowed down more during the pandemic. Ms. Dix stated that the criminal justice piece may require a cross agency and cross system conversation to address the length of time. Moira Mazzi wondered about the state hospital staffing shortages, whether there becomes a threshold limit that requires a halt on accepting more individuals into a state hospital. Ms. Land stated that the 'bed of last resort' legislation does not allow for that possibility, but currently under Executive Order 70 it is possible to

	delay admissions. The agency must search the state hospitals from closest to further out to find a bed; the person must be 'admitted' but may have to wait for a bed. Mandatory overtime often is in effect for staff. Ms. Mazzi stated she knows a nurse who works with children in the developmental disability population providing in home services and who will not take overtime because it can be that a staff person works overtime, can make a mistake, and then it comes back on the staff person. Ms. Land concurred that when staff are tired, mistakes are more likely to happen; and she stated that the electronic health record system helps avoid mistakes through the electronic prompts. Ms. Hilscher thanked Ms. Land and looked forward to seeing the commissioner at the biennial planning meeting and the regular meeting, on July 13-14.
Regulatory Actions	**A. Initiate Periodic Review: Eugenics Sterilization Compensation Program [12VAC35-240]** At 10:37 a.m., Ruth Anne Walker, Regulatory Affairs Director and State Board Liaison, provided a background summary of the regulatory periodic review process all state agencies must ensure occurs for each regulation every four years, and background on this regulation. She also gave a brief explanation of the regulation and claims to date. *Upon a motion by Sandra Price-Stroble and a second by Moira Mazzi, the State Board voted unanimously by roll count to authorize the initiation of a periodic review of Chapter 240.* **B. General Update: Regulatory Matrix and 2021 Workplan** Ms. Walker reviewed the regulatory matrix of all current regulatory actions.
Geriatric Services: Piedmont Geriatric Hospital	At 10:45 a.m., Emma L. Lowry, Director, presented information on PGH, which is a 123-bed geropsychiatric hospital located on 300 acres in Nottoway County, and now shares the campus with the Virginia Center for Behavioral Rehabilitation (VCBR). Facts include: • PGH is the only Virginia state facility that exclusively treats older adults (65+ years of age) who are in need of inpatient treatment for mental illness. • Most patients are involuntarily admitted under a temporary detention order (TDO) and then civilly committed. Forensic patients who are court-ordered for evaluation or treatment are also served. • Serves a large catchment area. • Accredited by the national accrediting agency, The Joint Commission, since 1985.

	• Provides comprehensive treatment services on each of four patient-care units. • A full range of clinical services to include: psychiatry, family/internal medicine, nursing, psychology, social work, psychosocial rehabilitation (music therapy, recreation therapy, and activity therapy), physical therapy, occupational therapy, speech and language therapy, and religious services. • Serves as a training site for major universities, colleges, and vocational schools in geropsychiatry and other clinical specialties. • $34 million operating budget and approximately 430 FTEs. Challenges Within five years of the 2014 "Bed of Last Resort" legislation there was a 333 percent increase in TDO admissions, and DBHDS state hospitals are operating at 96 percent with recent periods of as high as 98-100 percent (versus industry standard 85 percent). State hospital beds have become the first resort for civil TDOs while still maintaining a primary role to serve individuals who are forensically involved or those individuals that require longer-term treatment and commitments. Report Document 587 (2019) Other current challenges include: • COVID-19 – Outbreaks – Restricted visitation • High Census / High Acuity • Vacancy / Turnover in Staffing – Compensation – Rural location – Difficult work • Infrastructure – Space limitations – Shared services with VCBR • New Executive Leadership Team Dr. Lee appreciated the presentation as he is from the area and did not know the history of the facility. Ms. Hilscher asked in regard to COVID-19 and the impact of the isolation the pandemic required and related increases in depression and how PGH has tried to address it therapeutically. Dr. Lowry stated that the population is already predisposed to depression and that has a high rate of suicide, and staff have worked hard to engage individuals receiving services. There is a program, that was temporarily on hold during the pandemic, called the Piedmont Geriatric Institute that provides trainings to the community (assisted living facilities and nursing

	homes) that staff are working to recreate virtually and the topic of the isolation during the pandemic will be one item addressed. Ms. Hilscher noted that when she visited the facility, while the physical design of the building is not the best (low ceilings, narrow halls, limited natural light), but the staff overcome those physical challenges and are very loving and dedicated; it is a well-run, beautiful place. Mr. Hughes mentioned a program his organization runs that has to do with loneliness, how to make the best of your time, and that PGH staff or individuals receiving services might find that helpful. Ms. Hilscher stated that the board was due to visit PGH last April, but was restricted due to the pandemic and hope to visit in the future.
Virginia Center for Behavioral Rehabilitation (VCBR) Update	At 11:30 a.m., an update on the center was provided by Jason Wilson, VCBR Director. Mr. Wilson covered the background and history on Virginia's laws regarding sexually violent predators (primarily in Chapter 9 of Title 27.2) and the facility, which –after briefly being housed in existing buildings on the agency's Petersburg campus - opened in 2008 in Nottoway County with a maximum of 300 beds. In 2011, the General Assembly required DBHDS to develop a plan to address the rising census, but the plan could not include construction of new buildings and DBHDS was encouraged to consider double bunking, which was done in 150 rooms (current capacity 450 beds). The groundbreaking of an expansion project occurred in 2018 and the project will add additional beds and treatment spaces (capacity of 632 after expansion). The expansion will have: • 48 bed transitions unit (apartment type setting). • 6 bed female unit. • Separate units to serve specialized populations: – Medically complex – Intellectually disabled – Serious mental illness • Expanded vocation and educational areas. • Expanded medical treatment areas. While most of the project will be completed this year, final completion is scheduled for February 2022. He noted that there are a number of different populations within one setting: diagnoses, ages, languages, physical disabilities, gang affiliation, and complex medical needs. Primary services provided at the facility include: treatment and rehabilitation; security; medical; vocational and educational.

	The census, as of April 13, 2021: • Majority of residents are received directly from the Virginia Department of Corrections. • 376 male residents in-house (plus 2 women at CSH). • 413 individuals are committed to VCBR, but are currently incarcerated, and will return to VCBR after incarceration. • If a resident is charged with a crime while at VCBR, he may need to return to jail. If that resident will remain in jail for an extended period of time, his room/bed may be used by the facility for other residents. However, VCBR must always have a bed available for his return. Research-informed treatment focuses on three phases: Phase 1: Focuses on control over sexual behavior and aggression and accountability for offenses. Phase 2: Focuses on developing insight into risk factors, practicing adaptive coping responses, demonstrating mature, responsible interactions with others, and introducing positive goals for lifestyle change. Phase 3: Focuses on transition back to the community. Mr. Wilson reviewed admission and discharge data, and explained conditional release parameters. He explained the operating budget, and details about staffing. Specifically, staff recruitment, development, and retention: • Currently 627 classified positions. • Estimated to employ 1,098 at *full capacity* after expansion. • FY21 vacancy rate: overall 17.9%. • Most challenging vacancies are direct care (safety, security, treatment technicians): 23.3%. • There are a number of actions being taken to address staff vacancy and turnover rates. Dr. Lee commented that the aesthetics of the new buildings is more residential in nature than prison-like. Mr. Wilson stated that it is hoped that the new aesthetics will encourage rehabilitation and increased discharges. Dr. Lee noted the video with Longwood on the website looked good. Ms. Hilscher noted a lot of work had been done since she visited the facility. She is encouraged by the transitional design tied to treatment phases. She hopes the board can visit in the future once pandemic restrictions are relaxed.

BREAK for Lunch, 30 minutes	At 12:07 p.m., Ms. Hilscher suspended the meeting for a 30 minute lunch break, reconvening at 12:40 p.m.
2021 General Assembly: Pre-Session Legislative and Budget Review	At 12:45 p.m., legislative and budget updates since the Veto Session held the previous week were provided by Alex Harris, Policy and Legislative Affairs Director; and Erin Kelley, Financial and Policy Analyst, Office of Budget Development, Finance Division. Ms. Harris reviewed new legislation that will take effect: • HB2092: Requires contract staff providing direct care services at our licensed providers to go through a similar background check process as employees providing direct care services. • SB1304: Changes from 30 days to 72 hours the time during which a CSB can disagree with an individuals' readiness for discharge and creates a workgroup for expediting the discharge process. • SB1302: Designates the crisis call center as the 988 Crisis Hotline Center and directs part of an increased wireless surcharge toward the Crisis Call Center Fund. • HB2166: Makes changes to the mandatory outpatient treatment (MOT) code to increase its use. • HB2230: Resulted from DBHDS's supported decision-making (SDM) workgroup last year. Lists SDM as a less restrictive alternative to guardianship and directs DBHDS to provide training and education. • HJ578: Creates a workgroup to study the development of a criminal justice and behavioral health records database for more effective interventions. • SB1406: Eliminates penalties for marijuana possession, develops an automatic expungement process, institutes a licensing structure for cultivation and sale, and provides for social equity and behavioral health support. Ms. Kelley summarized the budgetary actions. The Join Conference Committee adopted most of the Governor's budget. Significant changes include: • Removing $2.5 million in Discharge Assistance Planning (DAP) funds; • Removing the capital debt authorization for 48 additional beds at Central State Hospital; • Supplanting $6.4 million in general funds for COVID-19 testing in the facilities with VDH's Epidemiology and Laboratory Capacity (ELC) grant; • Item 322 #1c: $2.1 million the second year from the general fund to expand forensic discharge planning services at three

	additional jails with a high percentage of inmates with serious mental illness. • Item 320 #5c: $3.8 million the second year from the general fund to fully restore funding for alternative inpatient options to state behavioral health hospital care through the establishment of two-year pilot projects to reduce census pressures on state hospitals. • Item 326 #1c: $765,428 the second year from the general fund to provide critical clinical staffing at the Commonwealth Center for Children and Adolescents. For Mental Health Hospitals: • Provide funding for pharmacy costs at state facilities o Governor's Budget: Provides general fund support of $2,648,663 in FY2021 and $2,648,663 in FY2022 to address increased pharmacy costs at state facilities as a result of growth in census and increased cost medication. • Add funding to cover costs of required IT upgrades at Western State Hospital o Governor's Budget: Provides general fund support of $546,122 in FY2021 and $376,148 in FY2022 to account for the required costs of transitioning wireless access point services at Western State Hospital from an out-of-scope vendor to the Virginia Information Technologies Agency. Other updates covered funding decisions for community behavioral health services including STEP-VA, waiver services for individuals with developmental disabilities and transitions from training center services, capital projects, and other administrative programs and projects. She provided tables that summarized incremental changes by activity and agency. (The presentation is available upon request.) Ms. Hilscher observed that it appeared the agency and system did not do too badly. Ms. Kelley stated that was the case, and mentioned that the mental health and substance abuse federal block grants along with 8M for LIPOS* funding allowed increased flexibility in how those funds are used. * Local Inpatient Purchase of Service Project (**LIPOS**) is to serve indigent individuals from the CSB catchment areas who require inpatient hospitalization for a serious mental illness as an alternative to state hospital admission. **LIPOS** funds are used to

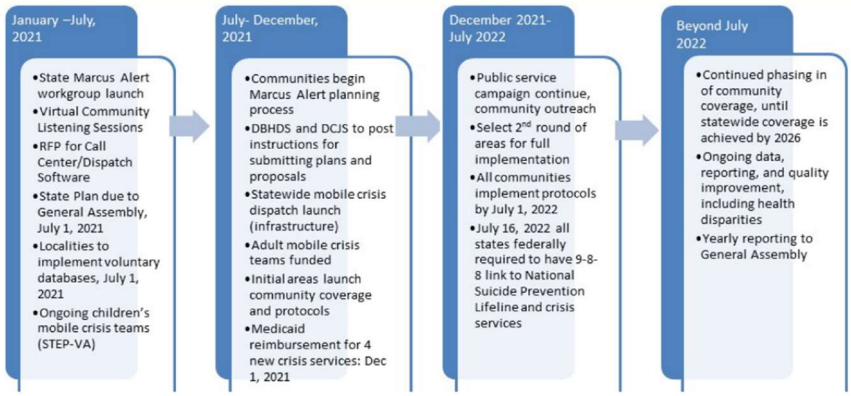
	purchase acute stabilization psychiatric services from acute care providers.
Update: Virginia Association of Community Services Boards (VACSB)	At 1:05 p.m., Jennifer Faison, Executive Director of VACSB, updated the board on the following: • Marijuana legalization legislation: It is with the Governor now in a very different format than when introduced. Based on the recommendations of the VACSB Mental Health Council, Substance Use Disorder (SUD) Council, and Prevention Council, the association opposed the legislation, particularly because of the impact it could have on children and adolescents. However, VACSB came to the table to try to reshape it once it was clear that it would pass. Now, it will be legal to possess and grow; there is 1M funding for prevention programs. Recognizing there will need to be additional treatment resources on the backend, the association is working with DMAS on the SUD (ARTS) benefit. Currently, beginning in 2024, 25% of the revenues from retail sales will go to prevention and treatment services that will come through DBHDS to the CSBs. This provision was one VACSB thought was important to include. This bill has a reenactment clause (it will have to be passed again in the 2022 Session of the General Assembly). • While hundreds of other bills were tracked during the session, there were no others that were extremely impactful. However, the mandatory outpatient treatment (MOT) legislation, which intended to expand the use of MOT across Virginia. MOT can be a less restrictive alternative to inpatient care. Special justices were not comfortable ordering MOT because of confusion of how the Code of Virginia read prior to this clarifying language. Additional reporting from the MOT coordinator that will hopefully be funded next year; also, funding for CSBs to expand existing MOT and to help CSBs start MOT. However, this will take a high level of wraparound support around the individual. • It was helpful to see the reallocation of funding for the publicly funded system of care that had been held during part of last year to assess the impact of the pandemic. There was celebration of the successes during the past year. • Vaccinations have gone well. While there are still a number of people in residential settings that have not received a vaccine, it is expected that good progress will continue over the next month or so. CSB staff were included as essential staff in Phases 1A and 1B of the vaccine rollout. It was more difficult to get support staff included. Telehealth resources and flexibilities have been utilized and are expected to be in the

	future; services have maintained or increased in a number of areas compared to last year. • Focusing on the wave of individuals who will come forward in behavioral health and substance use disorders as the pandemic ebbs. The depths of despair experienced during this past year are not entirely known, so there will be a focus on this in the midterm planning. • Noted CSBs would be grappling with the Marcus Alert implementation. Ms. Graser asked about the MOT legislation and number of days it involves. Ms. Faison stated there was an increase from 90 to 180 days for the initial order. There were a number of advocates who were concerned about this change (i.e., employment concerns). There was success getting language into the legislation that the special justice must take such issues into consideration, and not necessarily default to 180 days. Ms. Graser did not like the term 'mandatory,' and whether if someone was doing well could the timeframe be revisited. Ms. Faison stated that now the individual could request an earlier status hearing. The treatment order will now have things like medications included versus just in the treatment plan. Now the person no longer has to consent to the order. Ms. Mazzi asked for additional description for being placed into involuntary inpatient versus MOT at the commitment hearing. Ms. Faison stated that now the criteria is in alignment. Ms. Mazzi asked what it would look like to be in MOT. Ms. Faison stated it is a very complex process on the front end. The special justice ultimately makes the decision on if the person is appropriate for MOT; the services available also are a significant consideration to have them safely supported in the community. In terms of the check-ins, the details must be in the order. The CSB must describe the specifics; there must be monthly reports to the court on how the person is doing. The treatment plans must be very person-centered and specific to the person. Ms. Hilscher stated that this is an issue near and dear to her heart in regard to the tragedy at Virginia Tech as Mr. Cho was ordered to MOT, the law was very weak, he did not get set up with treatment, there was no reporting to the court. It has taken 14 years for real progress on the law that will tighten up a lot of those failures. However, she appreciates Ms. Graser's perspective of individual's rights. She needs to read the bill, but it sounds like the legislation makes additional provision to protect the public from someone who

	might be harmful to themselves or others, while also allowing the individual to be more involved in decisions about treatment. Ms. Mazzi asked about the fairness in regard to patients' rights and the variation of the availability of MOT and the services by region. Ms. Faison agreed that this is a longstanding issue and that is why there is an attempt through STEP-VA to set a minimum that should be available in every community in order to try to equalize that unfairness.
Board Member Spotlight (New)	At 1:30 p.m., Ms. Hilscher stated that with about half the board members coming on the board in less than two years, combined with the restrictions from in person meetings, members have not had a chance to get to know one another as they typically would due to volume of new members and social distance. For the foreseeable future, this standing10 minute segment will allow time to hear more about one of the members. Ms. Hilscher had asked Jerome Hughes to be the first to present under this new standing agenda item. Mr. Hughes grew up in Alexandria, played basketball and football in school, he has an adult daughter who is a career White House employee and a young son. Years ago, he went to a drop in center because he was in need of services. While there, after he had attended meetings regularly for some time, the program offered him a job as a driver. He attended a VOCAL conference. [VOCAL is a peer run, peer advocacy organization with a mission to create a climate in Virginia where peers are empowered to understand and find their own recovery through programs that achieve: a) personal transformation, b) community transformation, and c) systems transformation.] He had never heard of VOCAL, and he fell in love with peer work, realizing that it did not feel like work. By the time the contract with his job expired, he was working as a supervisor at the Consumer Wellness Center in Falls Church. While working with another organization, On My Own Alexandria and worked directly for Bill Yolton, a longtime advocate for mental health services. Drop in centers are now called recovery centers. His partner, Lisa Goodwin, used to run another program called the Lloyd Mitchell Center. Both his contract and Ms. Goodwin's ended at the same time. They partnered for two centers, and five centers were put in the contract. Recovery Program Solutions of Virginia was established. Mr. Hughes shared a video about the peer run organization. The five centers are: Annandale Consumer Wellness Center, Arlington Peers Helping Peers in Recovery, Merrifield Peer Recovery Center, Reston Wellness Center, and the South County Alexandria Recovery and Drop In Center. There are 25 peer specialists and 15 certified peer recovery specialists.

	Mr. Hughes stated that there is a new virtual program, and if anyone needs a meeting, they can come to the meetings – daily if they want. Ms. Graser stated that if more people understood the value of peer support, there would be less of a census problem in state hospitals or the need for inpatient services.
Behavioral Health Update: Marcus Alert	At 1:40 p.m., Lisa Jobe-Shields, Community Services Director, in the Division of Community Behavioral Health, spoke of the latest implementation activities related to the 'Marcus Alert' legislation and also generally about the STEP-VA initiative. Dr. Jobe-Shields stated that the legislation is a very complicated. She first spoke about the broader vision of Virginia's system of services. Last summer, in addition to the pandemic, there were a number of events having to do with facing the impact of systemic racism. This reemphasized the need to ensure that when individuals are having a behavioral health crisis that they are met with a behavioral health response (versus i.e., law enforcement) and that the response can meet them where they are with their natural supports in their community. Virginia has been recently aligning investments with the Crisis Now national model that has four components: high tech call centers, 24/7 mobile crisis services; crisis stabilization programs; and essential principles and practices. These compliment other recent developments: STEP-VA, the US DOJ Settlement Agreement with Virginia has a crisis component (REACH), and CIT assessment sites. At the same time, sustainable Medicaid crisis rates were being brought online that will become available December 1, 2021, for high quality services that have been shown to work. These are services that currently exist and are licensed in Virginia at large **but are not covered or adequately funded by Medicaid.** • PHP/IOP: These exist in Medicaid for ARTS and their addition has been shown to draw down costly ER visits and inpatient hospitalizations. A workforce exists, programs exist…they just need a rate and service definition to be able to also serve members with primary mental health problems. • MST/FFT: These evidence-based practices for high risk youth exist through the DJJ transformation but do not have a Medicaid Rate. This creates access and equity issues for Virginia's kids wherein they need DJJ referral to participate in these high-quality services. These could help with diversion and

	step down from the Commonwealth Center and reduce the need for residential treatment. • PACT: This exists but is not reimbursed at a rate that covers the service, which limits the ability to adhere to the fidelity standards of the program and maximize effectiveness and access across the state. DBHDS has excellent data on cost efficiencies of this service and we see it as a critical component of the plan for those who are some of the most likely to use inpatient hospitalization on a frequent basis. • Comprehensive Crisis: This brings on Medicaid rates for the services recommended through the Crisis workgroups of STEP-VA and assures we reimburse appropriately and draw down federal match for members who participate in crisis care. These services include mobile crisis response, community-based crisis stabilization (a crisis-avoidance service that provides short term support between immediate response and availability of referral to longer term services), crisis stabilization units (residential) and 23-hour beds. Last summer, a racial equity lens was brought to these efforts as part of reforms in response to mass, nationwide protests. This focus builds on recent and ongoing work to provide community based mental health supports to decrease reliance on law enforcement as the *de facto* response in Virginia and decrease law enforcement time spent responding to behavioral health emergencies. Without the Marcus Alert, the crisis system transformation would be at risk of decreased access for minority populations and ongoing over-representation in law enforcement encounters (discretionary diversion based on perceptions of safety). It looks at how the interactions between law enforcement and individuals in behavioral health crisis are going. Diversion from 911 to the crisis line, the collaboration on the scene between law enforcement and behavioral health services, and how law enforcement presents and responds when no behavioral health provider is present. The Marcus Alert requirements are best understood in terms of three required protocols: 1. Community coverage; 2. Voluntary database; and 3. Data and quality improvement. **Marcus Alert Milestones Across Projects**

	 Ms. Graser commented that she is excited about the changes to coordinate the different services, though she does not understand all the nuance of it yet. Ms. Hilscher stated she was amazed that Virginia did not have a 9-8-8 number before now. She hopes that Dr. Jobe-Shields will report back later on.
Committee Reports:	**C.** Policy Development and Evaluation At 2 p.m., Alex Harris, Policy and Legislative Affairs Director, stated that the committee had decided last year to look at the safety next system and how a STEP-VA fits with the current Policy 1038 (SYS) 06-1 The Safety Net of Public Services, or perhaps consolidating a couple policies into one. Dr. Jobe-Shields and Mira Signer, Chief Deputy Commissioner joined the committee. The committee discussed briefly a policy taken up in 2019 but that was not finalized, Policy 2011 (ADM ST BD) 88-3 Naming of Buildings, Rooms and Other Areas at State Facilities. Angela Harvell, Deputy Commissioner, Facility Services, gave suggestions for edits. Those edits were approved by the committee and will be coming to the board. As discussed in December, there are a number of policies the committee is reviewing this year. **D.** Planning and Budget At 2:10 p.m., Ms. Walker reported that the committee heard from Emily Lafon, Policy and Finance Analyst, Office of Budget Development who updated on the State Board budget report.

Item	Budgeted	Expended	Remaining
Office Supplies	$205	$0	$205
Food Services	$1,000	$145	$856
Travel	$13,600	$0	$13,600
Training	$3,095	$489	$2,606
Premiums	$100	$70	$30
Total	**$18,000**	**$704**	**$17,296**

It came up in the meeting as a reminder to members that they can attend VACSB conferences (they are occurring though virtual) or other such meetings. Members should send an email with the information for the chair and department to consider.

The committee met in January to finalize the meeting topics for the 2021 meetings (previously sent to the State Board). There are 'have to' blocks at each meeting (commissioner's report, regulatory or policy action), and other optional blocks for presentations.

The committee also has an eye toward the biennial planning meeting in July, which will be held the afternoon before the July 14th meeting (afternoon of July 13th) is the biennial planning meeting. Ms. Walker explained the timing of the biennial planning meeting is such that the board sets it priorities for the new biennium so that a timely letter can be sent to the Governor and General Assembly to consider as the new biennium budget is developed. She provided further logistical explanation of how the biennial planning meeting is organized and conducted.

The committee had a brief review of the current structure of the Annual Executive Summary from the State Board to the Governor and General Assembly.

The Grant Review Committee received an update of a grant in development and pending with the Governor's Office. The committee works by email with the Finance staff to review any requests for federal funds before submitted, and give any remarks, or to ask questions.

The committee also reviewed a revised board liaison letter, which was intentionally postponed as the timing of reaching out to CSB and facility directors seemed too much right on top of the session. The letters are planned to go out in June. The committee was asked to give feedback on that letter.

	A new draft guide for the board member spotlight segments was reviewed and confirmed.
Miscellaneous	**A. Board Liaison Assignments** Ms. Hilscher stated a list of liaison assignments was finalized in December. Ms. Walker already spoke with three board members on the liaison role and will continue to get with each of member before June to provide contact information for the CSB and facility directors in assigned to each member area. **B. Quarterly Budget Report** There were no changes to the budget.
Other Business & Adjournment	CORRECTION: The board packet mistakenly listed the fall meeting date. The meeting will be on the last Wednesday in September (September 29th). Next Meeting: The biennial planning meeting will be on the afternoon of July 13th and the July 14th will be the quarterly regular meeting. There being no other business, Ms. Hilscher adjourned the meeting at 2:30 p.m.

REGULATORY ACTIVITY STATUS REPORT: JULY 2021 (REVISED 07/15/21)

Board STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

VAC CITATION	CHAPTER TITLE (FULL TITLE)	REGULATIONS IN PROCESS		
		PURPOSE	STAGE	STATUS
12 VAC 35-46 Certain sections **and NEW** Sections 1150-1250.	**Regulations for Children's Residential Facilities**	In accordance with Item 318.B. of the 2020 Appropriation Act to align with the American Society of Addiction Medicine (ASAM) Levels of Care Criteria or an equivalent set of criteria.	• **Emergency: To Standard.**	• Effective 2/20/2021. Expires 8/19/2022. ➢ ***Action requested:*** *Initiate proposed.*
12 VAC 35-46 Certain sections **and NEW** Sections.	*same*	In accordance with Item 318.D. of the 2021 Appropriation Act to align with the requirements of the federal Family First Prevention Service Act to meet the standards as qualified residential treatment programs (QRTPs).	• ***Emergency/NOIRA***	*Draft finalized; expect at September meeting. Must be effective by early January.*
12 VAC 35-105 Certain sections.	**Rules and Regulations for Licensing Facilities and Providers of Mental Health, Mental Retardation and Substance Abuse Services**	In accordance with Item 318.B. of the 2020 Appropriation Act, amendments to align with ASAM criteria.	• **Emergency: To Standard.**	• Effective 2/20/2021. Expires 8/19/2022. ➢ ***Action requested:*** *Initiate proposed.*
12 VAC 35-105 Certain sections.	*same*	In accordance with Item 318.B. of the 2020Appropriation Act, amendments to align with enhanced behavioral health services.	• **Emergency: To Standard.**	• Effective 2/20/2021. Expires 8/19/2022. ➢ ***Action requested:*** *Initiate proposed.*
12 VAC 35-105 All sections.	*same*	*Response to periodic review ('overhaul' to service-specific chapters).*	• ***Draft***	• *As a response to periodic, a revised general chapter and two additional supporting chapters were posted for public comment.*
12 VAC 35-115	**Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services**	To protect the legal and human rights of all individuals who receive services in programs and facilities operated, funded, or licensed by DBHDS.	• ***Fast Track***	• *A public comment forum closed on 1/25/2021. Draft in progress.*
12 VAC 35-225	**Requirements for Virginia's Early Intervention System**	To provide the requirements for Virginia's early intervention services system.	• **Fast Track.**	• Response to periodic review (nonsubstantive). Effective 5/28/2021.
12 VAC 35-240	**Victims of Sterilization Fund Program**	To provide administrative guidelines for appropriate documentation to verify the claim of individuals who were victims of forced sterilization to be compensated pursuant to the Virginia Eugenical Sterilization Act	• **Periodic Review**	Comment Period ended on 6/14/2021.

COMMONWEALTH of VIRGINIA
DEPARTMENT OF
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MEMORANDUM

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

Fr: Ruth Anne Walker, Director of Regulatory Affairs

Date: July 15, 2021

Re: Regulatory Package – Seven Action Items

I. Proposed Stage: Licensing Regulations, 12VAC35-105: Behavioral Health Expansion.

Background: With the filing of the 'notice of intended regulatory action' (NOIRA) when the emergency regulation was filed, the public received notification that a *permanent* regulatory change was planned, there was a 30-day public comment period, after which the agency reviewed the comments as it developed the proposed stage draft. Once the proposed stage is published, there is a 60-day public comment period.

Purpose: The amendments consist of only those changes that are necessary to align the 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.

The proposed stage must be filed by August 18, 2021.

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	Emergency	02/20/2021

Next Steps:

- If approved, staff initiates the proposed stage action.

Town Hall Form

Proposed Regulation
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 30, 2021

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 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.

The General Assembly included the following requirements for the Department of Medical Assistance Services (DMAS) within Item 313 of the 2020 *Appropriation Act* (HB 2005, Chapter 56):

> *YYY.3. Effective on or after January 1, 2021, DMAS shall implement programmatic changes and reimbursement rates for the following services: assertive community treatment, multi-systemic 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 further the implementation of these programmatic changes, the General Assembly directed the Department of Behavioral Health and Developmental Services (DBHDS), within Item 318.B. of the 2020 *Appropriation Act*, 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 to the Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services ("Licensing Regulations") [12VAC35-105] contained in this action consist of only those changes that are necessary to align the 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 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 the behavioral health enhancement initiative (Project BRAVO). Substantive changes have been made to the service specific sections in the 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

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in 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."

The 2020 General Assembly, per Item 318.B. of the 2020 *Appropriation Act*, directed DBHDS to promulgate emergency regulations, to be effective within 280 days or less from the enactment of the *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 and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

Section 37.2-203 of the Code of Virginia authorizes the State Board 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 of Virginia and other laws of the Commonwealth administered by the DBHDS Commissioner or the department. On July 15, 2020, the State Board adopted the emergency amendments to regulation 12VAC35-105 and initiated a notice of intended regulatory action for the standard permanent process. The State Board of Behavioral Health and Developmental Services voted to adopt this proposed stage regulatory action on _____, 2021.

Purpose

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

The purpose of this regulatory action is to align the 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 regulations for behavioral health providers 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.

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;
3) The creation of ACT as a newly licensed service in place of the previously licensed 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;
4) Removal of the provisions of the regulations related to intensive community treatment (ICT) as it will no longer be a licensed service.

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. The primary advantages of this regulatory action to the public are: 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 ACT, and 3) aligning DBHDS licensing regulations and Medicaid service expectations to ensure that the licensing and funding of behavioral health services are congruent.

The aligning of DBHDS and DMAS regulations regarding behavioral health enhancement initiatives will prove an advantage to the Commonwealth because a continuum of publicly funded, high quality, community-based behavioral health services will reduce the need for more costly inpatient hospitalization.

There are no known disadvantages to the public or the Commonwealth to these regulatory changes.

Requirements More Restrictive than Federal

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

There are no identified requirements which are more restrictive than applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

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

The DMAS regulations and funding streams are complementary to these regulations and the licensed services they address.

Localities Particularly Affected
Many community services boards provide behavioral health services, including PACT and ICT, and will be affected similarly to private providers, but no locality will be particularly affected.

Other Entities Particularly Affected

Any person, entity, or organization offering behavioral health services that is licensed by DBHDS will be affected.

Economic Impact

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

Impact on State Agencies

For your agency: projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources	DBHDS will incur costs related to the promulgation of regulations, training for providers, and conducting additional inspections. Specifically, DBHDS will issue conditional licenses for six months and conduct an inspection to ensure regulatory compliance. DBHDS anticipates needing to conduct approximately 250 initial inspections after the first six month period. The outcome of those inspections will determine if an additional inspection is required later that year. Additional new initial inspections may be required if there are new providers as a result of this regulatory change. Additionally, the agency will need to provide technical assistance to providers, to include issuing corrective action plans (CAPs) and confirming implementation of the CAPs.
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.	None known.
For all agencies: Benefits the regulatory change is designed to produce.	The regulatory changes will ensure that the Licensing Regulations support high quality, community-based, behavioral 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. This will lower the use of more costly inpatient hospitalization.

Impact on Localities

Projected costs, savings, fees or revenues resulting from the regulatory change.	Private and many community services board providers will be affected by new and changing services outlined in this regulation. Providers will incur costs applying for the new service licenses, and hiring and training staff in a manner that ensures service delivery is in alignment with regulatory requirements. **ACT** is an existing service that is being adjusted in a manner that increases service delivery requirements. The higher service level is expected to come at a higher cost, for which the new DMAS rates are expected to be sufficient for the increased costs. However, current ACT teams may experience temporary revenue declines while they adjust operations to align with the regulatory changes. **MFT/FFT** – These regulations will not have a fiscal impact on CSB providers. However, the associated DMAS state plan changes will have up-front costs such as hiring, reporting, and performance monitoring. **MH/IOP** is a newly licensed service, but existing outpatient programs will likely bill for these services. The fiscal impact is unknown. **Crisis** – There will be three new licenses created - 23 hour observation, community based crisis stabilization (72 hours), and mobile crisis. It is anticipated that this will require the CSBs to change their crisis operations. The fiscal impact is unknown.
Benefits the regulatory change is designed to produce.	The regulatory change will ensure that the Licensing Regulations support a continuum of high quality, community-based, behavioral 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.

Impact on Other Entities

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.	Providers of behavioral health services licensed by DBHDS, particularly PACT or ICT.
Agency's best estimate of the number of such entities that will be affected. Include an estimate of the number of small businesses affected. Small	DBHDS currently licenses 1,355 providers. Thirty-four provider organizations are currently licensed to provide PACT or ICT.

business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	There is no way to estimate the number of small businesses within the pool of all providers.
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	An unknown number of providers will need to submit an application for a new license for each service they seek to provide. Providers may incur costs hiring and training staff to align their operational practices with the regulatory requirements.
Benefits the regulatory change is designed to produce.	The regulatory change will ensure that the Licensing Regulations support high quality, community-based, behavioral health services across the Commonwealth 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.

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 that would meet the essential purpose of the action. This action is brought under a mandate by the General Assembly.

Regulatory Flexibility Analysis

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

There are no other alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law that will assure the Commonwealth's compliance with the requirements within Item 318.B. of the 2020 *Appropriation Act*.

There are no exemptions of small providers from all or any part of the requirements contained in the regulatory change.

Periodic Review and Small Business Impact Review Report of Findings

If you are using this form to report the result of a periodic review/small business impact review that is being conducted as part of this regulatory action, and was announced during the NOIRA stage, indicate whether the regulatory change meets the criteria set out in Executive Order 14 (as amended, July 16, 2018), e.g., is necessary for the protection of public health, safety, and welfare; minimizes the economic impact on small businesses consistent with the stated objectives of applicable law; and is clearly written and easily understandable.

In addition, as required by § 2.2-4007.1 E and F of the Code of Virginia, discuss the agency's consideration of: (1) the continued need for the regulation; (2) the nature of complaints or comments received concerning the regulation; (3) the complexity of the regulation; (4) the extent to the which the regulation overlaps, duplicates, or conflicts with federal or state law or regulation; and (5) the length of time since the regulation has been evaluated or the degree to which technology, economic conditions, or other factors have changed in the area affected by the regulation. Also, discuss why the agency's decision, consistent with applicable law, will minimize the economic impact of regulations on small businesses.

This action is not being used to announce a periodic review or a small business impact review.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

Please see the attachment below that includes responses to all public comments received during the public comment period.

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.

DHBDS 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, (iii) the potential impacts of the regulation, and (iv) the agency's regulatory flexibility analysis stated in that section of this background document.

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

Chesna Gore
DBHDS Office of Licensing
Jefferson Building, 4th Floor
P.O. Box 1797
Richmond, Virginia 23218-1797
Phone: 804-773-9782
Fax: 804-692-0066
Email: Chesna.Gore@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 this 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 proposed regulation. If existing VAC Chapter(s) or sections are being repealed and replaced, ensure Table 1 clearly shows both the current number and the new number for each repealed section and the replacement section.

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
20		Defines terms used within the Licensing Regulations, including: "Intensive community treatment service" or "ICT" "Program of assertive community treatment" or "PACT"; Substance Abuse Intensive Outpatient Service	 Removes definition of Intensive community treatment service or "ICT" Removes definition of Program of assertive community treatment or "PACT". Updates definition of Substance Abuse Intensive Outpatient Service

			Adds new definitions for: • Assertive community treatment or “ACT” • Mental Health Intensive Outpatient Service, and
30		Lists services for which providers may be licensed by DBHDS, including: Intensive community treatment (ICT) and Program of Assertive Community Treatment (PACT)	Adds “Mental health intensive outpatient service” as a DBHDS licensed service. Removes “Intensive community treatment (ICT)” and “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) Removes language related to ICT. Adds personality disorder and brain injury to the list of sole diagnoses that render an individual ineligible for ACT services. Updates the criteria for discharge. 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 • 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. • 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 a Registered Nurse (RN).	Removes references to PACT and ICT Creates separate treatment team and staffing requirements for ACT teams. Makes substantive changes to ACT team staffing requirements to align with ACT service requirements, including • 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. • Differentiates nurse staffing requirements based on the size of the ACT Team. ○ Small ACT teams shall have at least one full-time nurse, who shall be either an RN or an LPN.

		• Requires ICT and PACT teams to have one full-time vocational specialist and one full-time substance abuse specialist	○ Medium ACT teams shall have at least one full time RN, and at least one additional full-time nurse, who shall be LPN's or RNs. ○ 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.
		• 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. • 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	• Requires Vocational Specialist to be a registered QMHP with demonstrated expertise in vocational services through experience or education. • 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. • Requires a peer recovery specialist to be a Certified Peer Recovery Specialist (CPRS) or certify as a CPRS within the first year of employment.
		• 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. • N/A • 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. • N/A	• 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. • Requires generalist clinical staff as follows: ○ Small ACT teams shall have at least one generalist clinical staff; ○ Medium ACT teams shall have at least two generalist clinical staff; ○ Large ACT teams shall have at least three generalist clinical staff. • Defines minimum staff to individual ratios that ACT teams must maintain based on the size of the team and the team's caseload.

			• Requires ACT teams to have 24-hour responsibility for directly responding to psychiatric crises, including meeting the following criteria: ○ 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; ○ The team shall be the first-line crisis evaluator and responder for individuals serviced by the team; and ○ 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 ICT and PACT and replaces with ACT. • Language changes for clarity • Requires documentation of attempts to make contact with individuals
1390		Requires daily organizational meetings and progress notes be maintained by ICT and PACT teams	Removes references to ICT and PACT and replaces with ACT
1410		Defines minimum service requirements for ICT and PACT teams Providers 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;	Amends service requirements to align with ACT service expectations and philosophy. Providers 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. Co-occurring diagnosis substance use disorder services that are non-confrontational, trauma informed,

		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 ; 7. Individual supportive therapy; 8. Skills training in activities of daily living, social skills, interpersonal relationships, and leisure time; 9. Supportive in-home services; 10. Work-related services to help find and maintain employment; 11 . Support for resuming education; 12. Support, psychoeducation, consultation, and skill-teaching to family members, and significant others; 13. Collaboration with families and assistance to individuals with children; 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 15. Mobile crisis assessment, interventions to prevent or resolve potential crises, and admission to and discharge from psychiatric hospitals.	person-centered, consider interactions of mental illness and substance use, and have goals determined by the individual; 7. Empirically supported interventions and psychotherapy; 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; 9. Work-related services to help find and maintain employment; 10. Support for resuming education; 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; 12. Collaboration with families and development of family and other natural supports; 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 obtain legal and advocacy services, financial support, money-management services, medical and dental services, transportation, and natural supports in the community; and 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; 18. Peer support services, such as coaching, mentoring, assistance with self-advocacy and self-direction, and modeling recovery practices.

If the regulatory change is replacing an **emergency regulation**, but changes have been made since the emergency regulation became effective, also complete Table 3 to describe the changes made since the emergency regulation.

Table 3: Changes to the Emergency Regulation

Emergency chapter-section number	New chapter-section number, if applicable	Current emergency requirement	Change, intent, rationale, and likely impact of new or changed requirements since emergency stage
12VAC35-105-20		"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.	"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. • Definition changed to align with changes from SB 1421. https://lis.virginia.gov/cgi-bin/legp604.exe?211+sum+SB1421
		"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;	• The definition and requirements related to ICT have been removed from the proposed stage draft. DMAS will no longer reimburse for ICT services beginning July 1, 2021 and the Office of Licensing will be phasing out the ICT license in favor of the Small ACT Team service license to more closely align with the standards and practices of high-fidelity Assertive Community Treatment.

		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.	
		"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 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 ~~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. • Minor edits made to align with the definition of mental health intensive outpatient in the Amendments to align the General Regulations with ASAM criteria.
		N/A	"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;

		N/A	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. • Definition of mental health outpatient was brought over from the Amendments to align the General Regulations with ASAM criteria to align the two actions. "Mental health partial hospitalization service" means time-limited active treatment interventions that are more intensive than outpatient services, designed to stabilize and ameliorate acute symptoms, and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization is provided through a minimum of 20 hours per week of skilled treatment services focused on individuals who require intensive, highly coordinated, structured, and inter-disciplinary ambulatory treatment within a stable environment that is of greater intensity than intensive outpatient, but of lesser intensity than inpatient. • Definition of mental health partial hospitalization was brought over from the Amendments to align the General Regulations with ASAM criteria to align the two actions. • Definition of outpatient service was removed as service specific definitions have been included for mental health outpatient and substance abuse outpatient.

		"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. N/A	"Substance abuse outpatient service" means a center based substance abuse treatment delivered to individuals for fewer than nine hours of service per week for adults or fewer than six hours per week for adolescents on an individual, group, or family basis. Substance abuse outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Substance abuse outpatient service includes substance abuse services or an office practice that provides professionally directed aftercare, individual, and other addiction services to individuals according to a predetermined regular schedule of fewer than nine contact hours a week. Substance abuse outpatient service also includes: 1. Substance abuse services operated by a community services board or a behavioral health authority established

		N/A	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. • Definition of substance abuse outpatient was brought over from the Amendments to align the General Regulations with ASAM criteria to align the two actions. "Substance abuse partial hospitalization services" means a short-term, nonresidential substance use treatment program provided for a minimum of 20 hours a week that uses multidisciplinary staff and is provided for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment. This level of care is designed to offer highly structured intensive treatment to those individuals whose condition is sufficiently stable so as not to require 24-hour-per-day monitoring and care, but whose illness has progressed so as to require consistent near-daily treatment intervention. • Definition of substance abuse partial hospitalization was brought over from the Amendments to align the General Regulations with ASAM criteria to align the two actions.
12VAC35-105-30		N/A	• The list of licensed services was updated to include mental health outpatient, mental health partial hospitalization, substance abuse outpatient and substance abuse partial hospitalization and remove Intensive community treatment.

12VAC35-105-1360		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 use disorder or developmental disability, personality disorder, or brain injury, are not eligible for services.	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 a substance use disorder, developmental disability, personality disorder, traumatic brain injury, or an autism spectrum disorder are not the intended service recipients and should not be referred to ACT if they do not have a co-occurring psychiatric disorder. • Minor amendments made to align admission criteria with clinical best practices.
		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;	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. ~~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~~ The individual and, if appropriate, the legally responsible person, choose to withdraw from services and documented attempts by the program to re-engage the individual with the service have not been successful; or
		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	4. ~~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.~~ The individual and team determine that ACT services are no longer needed based on the attainment of goals as identified in the person

		minimal team contact and support for at least two years as determined by both the individual and ICT or <u>ACT</u> team.	<u>centered plan and a less intensive level of care would adequately address current goals.</u> • Amendments made to align discharge criteria with clinical best practices following the public comment period and individual provider meetings.
12VAC35-105-1370		A. Services are delivered by interdisciplinary teams. 1. ICT teams shall include the following positions: a. Team 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 - ICT 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. ICT teams shall have at least one qualified full-time nurse. 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	• The definition and requirements related to ICT have been removed from the proposed stage draft. DMAS will no longer reimburse for ICT services beginning July 1, 2021 and the Office of Licensing will be phasing out the ICT license in favor of the Small ACT Team service license to more closely align with the standards and practices of high-fidelity Assertive Community Treatment. • Clarifying edits were made to the transition plan noted within subpart E, including adding a time limit to approved transition plans.

		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. b. ICT 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. …… 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	4 1. 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 work experience in the provision of mental health services to adults with serious mental illness; a resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; a resident in psychology who is under supervision of a licensed clinical psychologist and is registered

		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.	with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; a supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; or one full time registered QMHP-A 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. • The requirements for an ACT team leader were amended to also include LMHP-Es following the public comment period to address concerns related to work force shortages.
		….. 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.	c. Vocational specialist – one or more full-time vocational specialists, who shall be registered QMHP with demonstrated expertise in vocational services through experience or education. • Amended to clarify an ACT team may utilize more than one full-time vocational specialist, if appropriate. d. Co-occurring disorder specialist – one or more full-time co-occurring disorder specialists, who shall be LMHP, a resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; a supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10; registered QMHP, or certified substance

			abuse specialist (CSAC) with training or experience working with adults with co-occurring serious mental illness and substance use disorder. • The requirements for a co-occurring disorder specialist were amended to also include LMHP-Es following the public comment period to address concerns related to work force shortages.
		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.	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 as a peer recovery specialist in accordance with 12VAC35-250, or shall become certified in the first year of employment. The peer specialist shall be a fully integrated team member who provides peer support directly to individuals and provides leadership to other team members in understanding and supporting individuals' recovery goals. • Clarifying edits were made to cross-reference to the regulatory requirements for certified peer recovery specialists.
		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. …..	f. Program assistant - one full-time or two part-time program assistants ~~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. • Language was amended to allow for one full-time or two part-time program assistants on an ACT team.
		B. ICT and ACT teams shall meet daily Monday	~~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.~~ • This language was removed and pulled down into 1390 for consistency. B. ~~C. ICT teams shall operate a minimum of eight hours per day, five days per~~

		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. 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 ACT team shall make crisis services directly available 24 hours a day but may arrange coverage through another crisis services provider if the team coordinates with the crisis services provider daily. E. The ACT team shall have 24-hour responsibility for directly responding to psychiatric	~~week and shall provide services on a case-by-case basis in the evenings and on weekends~~. ACT teams shall be available to individuals 24 hours per day and shall operate a minimum of 12 hours each weekday and eight hours each weekend day and each holiday. C. ~~D.~~ The ~~ICT or~~ ACT team shall make crisis services directly available 24 hours a day but may arrange coverage through another crisis services provider if the team coordinates with the crisis services provider daily. D. ~~E.~~ The ACT team shall operate an after-hours on-call system and shall be available to individuals by telephone, ~~or~~ and in person when needed as determined by the team. ~~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.~~ • Requirements related to crisis response by ACT teams were amended following individual provider meetings and the public comment period to clarify the crisis response responsibilities of the team and that the team may arrange for crisis coverage through another crisis provider if the team coordinates with the crisis services provider daily. E. A transition plan shall be required of ACT teams that will allow for "start-up" when newly forming teams are not in full compliance with the ACT model relative

		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.	to staffing patterns and individuals receiving services capacity. • Language was originally removed during the emergency action but restored during the proposed stage.
12VAC35-105-1380		A. The ICT and ACT team shall have sufficient capacity to provide multiple contacts per week to individuals experiencing severe symptoms or significant problems in daily living. 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 ACT services shall be seen face-to-face by an employee or contractor as specified in the individual's ISP. Providers shall document all attempts to make contact and if contact is not made, the reasons why contact was not made.	A. The ~~ICT and~~ 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~~ ACT services shall be seen face-to-face by an employee or contractor as specified in the individual's ISP. Providers shall document all attempts to make contact and if contact is not made, the reasons why contact was not made. • Language related to the aggregate average of contacts was removed following individual provider meetings as well as the public comment period as the requirement no longer seemed appropriate for licensing regulations and enforcement.
12VAC35-105-1390		A. ICT teams and 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	A. ~~ICT teams and~~ ACT teams shall conduct ~~daily~~ organizational meetings Monday through Friday at least four days per week 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

		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 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.	needed, plan for emergency and crisis situations, and to add service contacts that are identified as needed. • The language requiring team meetings at least four days per week was moved down from section 1370 to provide greater clarity following the public comment period. B. A daily log that provides a roster of individuals served in the ~~ICT or~~ ACT services program and documentation of services provided and contacts made with them shall be maintained and utilized in the ~~daily~~ team meeting. Daily logs shall not be considered progress notes. C. There shall also be ~~at least a weekly~~ individual progress notes documenting services provided in accordance with the ISP each time the individual receives services which shall be included within the individual's record. ACT ~~Providers~~ teams shall also document within the individual's record attempts at outreach and engagement. ~~or attempts to engage the individual in services.~~ • Language related to daily logs and progress notes was amended for greater consistency with billing requirements for DMAS and to provide greater clarification to providers regarding their responsibility to record attempts at outreach and engagement.
12VAC35-105-1410		ICT and ACT 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,	~~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;

		symptom assessment, and recovery education; 5. Psychopharmacological treatment, administration, and monitoring; 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; 7. Empirically supported interventions and psychotherapy; 8. 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. Work-related services 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; 10. Support for resuming education; 11. Support, education, consultation, and skill-teaching to family members, significant others, and broader natural support systems, which shall be directed exclusively to the well-	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; 7. Empirically supported interventions and psychotherapy; 8. Psychiatric rehabilitation, which may include skill-building, coaching, and facilitating 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. Work-related services 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; 10. Support for resuming education; 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;

		being and benefit of the individual; 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 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.	12. Collaboration with families and development of family and other natural supports ~~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 obtain legal and advocacy services, financial support, money-management services, medical and dental services, transportation, and natural supports in the community; ~~and~~ 15. ~~Mobile~~ ~~c~~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. • Clarifying edits were made to this section based on feedback received during the public comment period.

NOTE: DBHDS response to comments in separate attachment.

PROPOSED STAGE DRAFT: Chapter 105

BEHAVIORAL HEALTH ENHANCEMENTS.

12VAC35-105-20. Definitions and units of measurement.

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

"Abuse" 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 an individual receiving care or treatment for mental illness, developmental disabilities, or substance abuse. Examples of abuse include acts such as:

1. Rape, sexual assault, or other criminal sexual behavior;
2. Assault or battery;
3. Use of language that demeans, threatens, intimidates, or humiliates the individual;
4. Misuse or misappropriation of the individual's assets, goods, or property;
5. Use of excessive force when placing an individual in physical or mechanical restraint;
6. Use of physical or mechanical restraints on an individual that is not in compliance with federal and state laws, regulations, and policies, professional accepted standards of practice, or his individualized services plan; or
7. Use of more restrictive or intensive services or denial of services to punish an individual or that is not consistent with his 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 each individual's needs over time;
6. Assist individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles (such as worker, family member, resident, spouse, tenant, or friend);
7. Carry out planned assertive engagement techniques, including rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques;

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

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

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

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

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

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

1. Improved behavioral functioning and effectiveness;

2. Alleviation of symptoms of psychopathology; or

3. Reduction of challenging behaviors.

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

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

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

"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.

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

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

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

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

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

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

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

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

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

"Developmental services" means planned, individualized, and person-centered services and supports provided to individuals with developmental disabilities for the purpose of enabling these

individuals to increase their self-determination and independence, obtain employment, participate fully in all aspects of community life, advocate for themselves, and achieve their fullest potential to the greatest extent possible.

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

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

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

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

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

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

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

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

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

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

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

"Informed consent" means the voluntary written agreement of an individual, or that individual's authorized representative, to surgery, electroconvulsive treatment, use of psychotropic medications, or any other treatment or service that poses a risk of harm greater than that ordinarily

encountered in daily life or for participation in human research. To be voluntary, informed consent must be given freely and without undue inducement; any element of force, fraud, deceit, or duress; or any form of constraint or coercion.

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

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

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

~~"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 developmental disability. Intensive in-home service is usually time-limited and is provided typically in the residence of an individual who is at risk of being moved to out-of-home placement or who is being transitioned back home from an out-of-home placement. The service includes 24-hour per day emergency response; crisis treatment; individual and family counseling; life, parenting, and communication skills; and case management and coordination with other services.

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

"Investigation" means a detailed inquiry or systematic examination of the operations of a provider or its services regarding an alleged violation of regulations or law. An investigation may

be undertaken as a result of a complaint, an incident report, or other information that comes to the attention of the department.

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

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

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

"Mental health intensive outpatient service" means a structured program of skilled treatment services focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to treatment. This service is provided ~~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 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 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or
3. Mental health services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

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

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

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

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

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

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

rehabilitation, and community resource development oriented toward empowerment, recovery, and competency.

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

"Qualified mental health professional" or "QMHP" means a person who by education and experience is professionally qualified and registered by the Board of Counseling in accordance with 18VAC115-80 to provide collaborative mental health services for adults or children. A QMHP 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).

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

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

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

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

"Screening" means the process or procedure for determining whether the individual meets the minimum criteria for 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 incident" means any event or circumstance that causes or could cause harm to the health, safety, or well-being of an individual. The term "serious incident" includes death and serious injury.

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

"Level II serious incident" includes a significant harm or threat to the health or safety of others caused by an individual. Level II serious incidents include:

1. A serious injury;

2. An individual who is or was missing;

3. An emergency room visit;

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

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

6. Ingestion of any hazardous material; or

7. A diagnosis of:

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

b. A bowel obstruction; or

c. Aspiration pneumonia.

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

1. Any death of an individual;

2. A sexual assault of an individual; or

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

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

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

"Shall" means an obligation to act is imposed.

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

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

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

1. Substance abuse services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;
2. Substance abuse services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia;
3. Substance abuse services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

"Substance abuse partial hospitalization services" means a short-term, nonresidential substance use treatment program provided for a minimum of 20 hours a week that uses multidisciplinary staff and is provided for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment. This level of care is designed to offer highly structured intensive treatment to those individual 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.

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

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

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

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

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

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

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

12VAC35-105-30. Licenses.

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

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

1. Assertive community treatment (ACT);
2. Case management;
~~2.~~ 3. ICF/IID;
~~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;~~ Emergency;
~~9.~~ 10. Group home and community residential;

~~9.~~ 11. 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;

16. Mental health outpatient;

17. Mental health partial hospitalization;

~~14.~~ ~~16~~18. Opioid treatment/medication assisted treatment;

~~15. Emergency;~~

~~16. 18. Outpatient;~~

~~17. 19. Partial hospitalization;~~

~~18. Program of assertive community treatment (PACT);~~

~~19.~~ ~~20~~19. Psychosocial rehabilitation;

~~20.~~ ~~21~~20. Residential treatment;

~~21.~~ ~~22~~21. Respite care;

~~22~~ .~~23~~22. Sponsored residential home;

~~23. 24. Substance abuse residential treatment for women with children;~~

~~24.~~ ~~25.~~23. Substance abuse intensive outpatient;

24. Substance abuse outpatient;

25. Substance abuse partial hospitalization;

26. Substance abuse residential treatment for women with children;

~~25.~~ ~~26~~27. Supervised living residential; and

~~26.~~ ~~27~~28. 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 a substance ~~addiction or abuse~~ use disorder, or developmental disability, personality disorder, ~~or~~ traumatic brain injury, ~~are not eligible for services~~ or an autism spectrum disorder are not the intended service recipients and should not be referred to ACT if they do not have a co-occurring psychiatric disorder.

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~~ ~~ACTor ICT~~ ACT 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~~2. 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~~ ~~ACTor ICT~~ ACT services upon the individual's anticipated return to the community if the individual wishes to return to services and the service level is appropriate to his needs;

~~4~~3. ~~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~~ The individual and, if appropriate, the legally responsible person, choose to withdraw from services and documented attempts by the program to re-engage the individual with the service have not been successful; or

~~5~~4. ~~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~~ The individual and team determine that ACT services are no longer needed based on the attainment of goals as identified in the person centered plan and a less intensive level of care would adequately address current goals.

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

A. ACT 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 of 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. PeerICT 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 standardsfor ICT teams:

a. At least 80% of the clinical employees or contractorson an ICT team, not including the program assistant or psychiatrist, 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.

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 capacityfor 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.

~~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.~~

~~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.~~

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

a. Team leader - one full-time LMHP with three years work experience in the provision of mental health services to adults with serious mental illness; a resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; a supervisee, in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; or one full-time registered QMHP-A 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; or a licensed practical nurse shall have three years of experience in the provision of mental health services to adults with serious mental illness.

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

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

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

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

d. Co-occurring disorder specialist - one ~~full-time co-occurring disorder specialist, who shall be a LMHP, registered QMHP,~~or more full-time co-occurring disorder specialists, who shall be a LMHP; a resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; a supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10; registered

QMHP; or certified substance abuse specialist (CSAC) with training or experience working with adults with co-occurring serious mental illness and substance use disorder.

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

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

g. Psychiatric care provider - 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% 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~~2. Staff to individual ratios for ACT Teams:

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

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

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

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

ED. The PACT ACT team *[restored]* 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, includingby telephone, orand 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; and3. The team shall have access to the practical, individualized crisis plans developed to help them address crises for each individual receiving services.

E. ACT teams in development may submit a transition plan to the department for approval that will allow for "start-up" when newly forming teams are not in full compliance with the PACT ACT model relative to staffing patterns and individuals receiving services capacity. Approved transition plans shall be limited to a 6 month period.

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 and PACT ACT services shall be seen face-to-face by an employee or contractor; or the employee or contractor should attempt to make contact as specified in the individual's 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 least four days per week 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. Daily logs shall not be considered progress notes.

C. There shall also be at least a weekly individual progress notenotes documenting services provided in accordance with the ISP or attempts to engage the individual in services each time the individual receives services which shall be included within the individual's record. ACT teams shall also document within the individual's record attempts at outreach and engagement.

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 nonconfrontational, 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 facilitating 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~~ development of family and other natural supports;

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; ~~and~~

15. ~~Mobile crisis~~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.

II. Proposed Stage: Licensing Regulations, 12VAC35-105: ASAM Criteria.

Background: With the filing of the 'notice of intended regulatory action' (NOIRA) when the emergency regulation was filed, the public received notification that a *permanent* regulatory change was planned. Also, once the emergency regulation and NOIRA were published, there was a public comment period, after which the agency reviewed the comments as it developed the proposed stage draft. Once the proposed stage is published, there is a 60-day public comment period. Based on the comments received, the agency may modify the proposed text of the regulation for the final stage..

Purpose: The goal of this regulatory action is to amend the licensing regulations to align with the American Society of Addiction Medicine (ASAM) Levels of Care Criteria to ensure the provision of outcome-oriented and strengths-based care in the treatment of addiction. ASAM Levels of Care Criteria help to ensure individualized, clinically driven, participant-directed, and outcome-informed treatment.

Action Requested: Initiate a fast track action to adopt the amendments.

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	Emergency	2/20/2021

Next Steps:

- If approved, staff initiates the proposed stage action.

Town Hall Form

Proposed Regulation
Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services (DBHDS)
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC35-105
VAC Chapter title(s)	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services
Action title	Amend the Licensing regulations to align with the ASAM Criteria
Date this document prepared	June 28, 2021

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 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.

The Department of Behavioral Health and Developmental Services (DBHDS) was directed by the 2020 General Assembly within Item 318.B. of the 2020 *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 ("Licensing Regulations"), 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

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in 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."

The 2020 General Assembly directed DBHDS to promulgate emergency regulations to become effective within 280 days or less from the enactment of the Item 318.B. of the 2020 *Appropriation Act*. This regulatory action is being utilized to codify permanent regulations following the emergency regulations.

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. Executive Order 9 (2016) declared the opioid addiction crisis a public health emergency in Virginia. Since that time, DBHDS and a number of sister agencies have worked to make policy changes 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 and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

DBHDS 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 State 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 of Virginia and other laws of the Commonwealth administered by the DBHDS Commissioner. The State Board of Behavioral Health and Developmental Services voted to adopt this regulatory action on _____, 2021.

Purpose

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

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 the 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 of Virginia.

Substance related disorders affect individuals needing or receiving services, 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 that span the spectrum of levels of care are available throughout the Commonwealth. 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 to align with the ASAM Levels of Care Criteria which ensures individualized, clinically driven, individual-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 (Medically managed intensive inpatient services),
- 3.7 (Medically monitored intensive inpatient services),
- 3.5 (Clinically managed high-intensity residential services),
- 3.3 (Clinically managed population-specific high-intensity residential services),
- 3.1 (Clinically managed low-intensity residential services),
- 2.5 (substance abuse partial hospitalization services),
- 2.1 (Substance abuse intensive outpatient services),
- (Substance abuse outpatient services), and
- Medication assisted opioid treatment services.

Issues

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

The primary 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 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.

Requirements More Restrictive than Federal

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

No requirements within the regulation exceed applicable federal requirements. The requirements regarding opioid treatment programs bring the Licensing Regulations into alignment with the federal regulations regarding Certification and Treatment Standards for Opioid Treatment Programs (42 CFR Part 8 Subpart C).

Agencies, Localities, and Other Entities Particularly Affected

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:

The Department of Medical Assistance Services (DMAS) may be particularly affected by the regulatory action as DMAS is a payor to many of the DBHDS providers affected by the regulatory action. DBHDS collaborated with DMAS on the development of this regulatory action.

Localities Particularly Affected:

No locality is particularly affected to the knowledge of DBHDS.

Other Entities Particularly Affected:

Providers of substance abuse services may be particularly affected by the regulation in order come into compliance with the regulations.

Economic Impact

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

Impact on State Agencies

For your agency: projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources	DBHDS will incur costs related to the promulgation of regulations, training for providers, and conducting additional inspections. The costs shall 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.	None known.
For all agencies: Benefits the regulatory change is designed to produce.	The citizens of the Commonwealth will receive more effective treatment of substance related conditions.

Impact on Localities

Projected costs, savings, fees or revenues resulting from the regulatory change.	None known.
Benefits the regulatory change is designed to produce.	The citizens of the Commonwealth will receive more effective treatment of substance related conditions.

Impact on Other Entities

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.	DBHDS providers that provide substance abuse services. Individuals served by those providers. No other entities will be affected by these regulations.
Agency's best estimate of the number of such entities that will be affected. Include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	DBDHS approximates that 283 entities will be affected. There is no way to estimate the number of small businesses within the pool of all providers.
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	Approximately 250 providers will need to obtain an updated license from DBHDS at no cost. These changes bring DBHDS' regulations into alignment with the current requirements of the Department of Medical Assistance Services (DMAS). DMAS has required third-party administrative verification that providers were in compliance with the ASAM criteria for payment. Therefore, any provider utilizing Medicaid as a payor should be in compliance with these regulations and not incur any costs. However, a physical DBHDS inspection could reveal that providers currently billing Medicaid need to make changes to ensure ASAM is being implemented properly. Providers who do not participate in Medicaid *and* whose services do not meet these requirements may incur some costs related to hiring and training staff in the use of the ASAM criteria.
Benefits the regulatory change is designed to produce.	The citizens of the Commonwealth will receive more effective treatment of substance related conditions.

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.

Regulatory Flexibility Analysis

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

There are no other alternative regulatory methods consistent with health, safety, environmental, and economic welfare that will accomplish the objectives of the General Assembly mandate. The proposed regulatory changes align the Licensing Regulations with the ASAM criteria as directed. There are no exemptions of small business providers from all or any part of the requirements contained in the regulatory change.

Periodic Review and Small Business Impact Review Report of Findings

If you are using this form to report the result of a periodic review/small business impact review that is being conducted as part of this regulatory action, and was announced during the NOIRA stage, indicate whether the regulatory change meets the criteria set out in Executive Order 14 (as amended, July 16, 2018), e.g., is necessary for the protection of public health, safety, and welfare; minimizes the economic impact on small businesses consistent with the stated objectives of applicable law; and is clearly written and easily understandable.

In addition, as required by § 2.2-4007.1 E and F of the Code of Virginia, discuss the agency's consideration of: (1) the continued need for the regulation; (2) the nature of complaints or comments received concerning the regulation; (3) the complexity of the regulation; (4) the extent to the which the regulation overlaps, duplicates, or conflicts with federal or state law or regulation; and (5) the length of time since the regulation has been evaluated or the degree to which technology, economic conditions, or other factors have changed in the area affected by the regulation. Also, discuss why the agency's decision, consistent with applicable law, will minimize the economic impact of regulations on small businesses.

Neither a periodic review nor a small business impact review was conducted related to this action

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

Commenter	Comment	Agency response
Loudoun MHSADS	**SA Intensive Outpatient Services** **12VAC35-105-1740 <u>Substance abuse intensive outpatient services program criteria</u>** 1. Mention of programming in a "structured environment." What does the agency identify or measure as a structured environment? 3. In number 2 there is a requirement that consultation is available within 24 hours by telephone; however, in number 3, emergency consultation is required to be available 24 hours a day. I believe the emergency requirement is requiring instantaneous availability, but the language of number 2 convolutes the meaning of number 3 to a degree. If the intent is instantaneous availability, it would be clarifying to say so. **12VAC35-105-1760 <u>Substance abuse intensive outpatient services discharge criteria</u>** 2. This point allows discharge when "unable to achieve the goals of the individual's treatment but could achieve the individual's goals with a different type of treatment." Guidance requested as to how this should be measured and expectations regarding the identification of the individual's ability to achieve goals and identification of the alternative treatment. What about discharge when an individual no longer wishes to achieve the goals of treatment? **12VAC35-105-1820 <u>Substance abuse outpatient services co-occurring enhanced programs</u>** Recommend removing the requirement for intensive case	Questions regarding the content of the regulations and methods to comply are best answered via direct contact with DBDHS rather than through the public comment forum. DBHDS encourages all providers who have questions regarding compliance to attend the Department's ASAM trainings. Information regarding the Department's trainings can be found: https://dbhds.virginia.gov/quality-management/Office-of-Licensing The removal of the requirement for intensive case management as part of substance abuse outpatient services enhanced co-occurring would mean the service would no longer be in alignment with the ASAM Criteria and would be contradictory to the General Assembly mandate.

	management as part of enhanced co-occurring.	

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.

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, (iii) the potential impacts of the regulation, and (iv) the agency's regulatory flexibility analysis stated in that section of this background document.

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

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
12VAC35-105-20. Definitions		Provides current definitions for the Licensing Regulations. The following term is being amended: "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),	Change: Adding the following definitions for terms utilized within the ASAM criteria: • Allied health professionals; • ASAM; • Clinically managed high-intensity residential care; • Clinically managed low-intensity residential care; • Credentialed addiction treatment professional; • Diagnostic and Statistical Manual of Mental Disorders • Intensity of Service;

		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.	• Medically managed intensive inpatient service; •Medically monitored intensive inpatient treatment • Medication assisted treatment; • Mental health intensive outpatient services; • Mental health outpatient service; • Mental health partial hospitalization service; • Motivational enhancement; • Specific high-intensity residential services; • Substance abuse intensive outpatient service; • Substance abuse outpatient service; and • Substance abuse partial hospitalization services. Removing the following terms which will no longer be used due to alignment with ASAM: • Medically managed withdrawal services; • Outpatient service; • Partial hospitalization service; • Social detoxification service; and • Substance abuse intensive outpatient service. Amending the following terms: • Medical detoxification; and • Medication assisted opioid treatment
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. Removal of terms which will not be utilized due to ASAM alignment including:

			• Managed withdrawal, including medical detoxification and social detoxification; • Opioid treatment/medication assisted treatment; • Outpatient; and • Partial hospitalization. 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 with opioid addiction.		Provides the standards for providers of services to individuals with opioid addictions.	Change: Update the requirements of providers of services to individuals with opioid addictions, specifically requirements related to personnel, and minimum services provided. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
12VAC35-105-930. Registration certification or accreditation		Provides requirements for opioid treatment services with regard 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.” Impact: Clarity of the regulations.
	12VAC35-105-935. Criteria for patient admission.		Change: Adding the required patient admission criteria for providers of services to individuals with opioid addictions. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
12VAC35-105-940. Criteria for involuntary termination from treatment.		Provides requirements for opioid treatment services with regard to involuntary termination from treatment	Change: Minor corrections Impact: Clarity of the regulations.
	12VAC35-105-940. Criteria for patient discharge.		Change: Adding the required patient discharge criteria for providers of services to individuals with opioid addictions. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
12VAC35-105-950.		Provides service operation schedule requirements for	Change: Adding a requirement that each provider must have a policy that

Service operation schedule.		providers of opioid treatment services	addresses medication for new and at-risk patients within opioid treatment programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth. Alignment with federal regulations.
12VAC35-105-960. Initial and periodic assessment services.		Provides requirements for the physical examination of individuals receiving opioid treatment services.	Change: Clarifying that the report of the individual's physical examination shall be documented within the individual's service record. Adding the requirement for a consent to treatment form. Adding the requirement for additional coordination by providers to prevent medication duplication. Impact: Robust, effective substance use disorder treatment within the Commonwealth. Alignment with federal regulations.
	12VAC35-105-965. Special services for pregnant individuals.		Change: Adding the required services for patients who are pregnant and being treatment for opioid addictions. Impact: Robust, effective substance use disorder treatment within the Commonwealth. Alignment with federal regulations.
12VAC35-105-980. Drug screens.		Provides requirements for opioid treatment services regarding drug screens.	Change: Increasing the requirements to one drug screen per month. Impact: Robust, effective substance use disorder treatment within the Commonwealth. Alignment with federal regulations.
12VAC35-105-990. Take-home medication.		Provides requirements for opioid treatment services regarding take-home medication.	Change: Adding requirements regarding the determination for approval of take home medication. Adding the requirements regarding the amount of take home medication. Additionally adding that individuals within short-term detoxification are not qualified for unsupervised take home use. Finally requiring that providers maintain policies and procedures to identify the theft or diversion of take-home medication. Impact: Robust, effective substance use disorder treatment within the Commonwealth. Alignment with federal regulations.
12VAC35-105-1000. Preventing		Requires opioid treatment service providers to take steps to prevent the	Change: Updating the terminology within the section to reflect the ASAM terminology. Specifically replacing the

duplication of medication services.		duplication of opioid treatment services.	terms “opioid medication services” and “opioid treatment service” to “medication assisted opioid treatment services.” Impact: Clarity of the regulations.
12VAC35-105-1010. Guests		Provides the requirements for opioid treatment service providers with regards to guest medication.	Change: Updating the terminology within the section to reflect the ASAM terminology. Adding a definition of guest. Impact: Clarity of the regulations.
	12VAC35-105- 1420. (Reserved).		Intent: Space saver section.
	12VAC35-105-1430. Medically managed intensive inpatient staff criteria.		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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1440. Medically managed intensive inpatient 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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1450. Medically managed intensive inpatient admission criteria.		Intent: Provide clear admission requirements within medically managed intensive inpatient programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered.
	12VAC35-105-1460. Medically managed intensive inpatient discharge criteria.		Intent: Provide clear discharge requirements within medically managed intensive inpatient programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered.
	12VAC35-105-1470. Medically managed intensive		Intent: Provide additional licensing requirements for medically managed intensive inpatient programs which treat individuals with co-occurring disorders.

	inpatient co-occurring enhanced programs.		Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-105-1480. Medically monitored intensive inpatient services 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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1490. Medically monitored intensive inpatient services program criteria.		Intent: Provide clear program 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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1500. Medically monitored intensive inpatient admission criteria.		Intent: Provide clear admission requirements within medically monitored intensive inpatient programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered.
	12VAC35-105-1510. Medically monitored intensive inpatient discharge criteria.		Intent: Provide clear discharge requirements within medically monitored intensive inpatient programs. 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.		Intent: Provide additional licensing requirements for medically monitored intensive inpatient programs which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-105-1530.		Intent: Provide clear staff requirements within clinically managed high intensity

	Clinically managed high-intensity residential services staff criteria		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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1540. Clinically managed high-intensity residential services program criteria.		Intent: Provide clear program 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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1550. Clinically managed high-intensity residential services admission criteria.		Intent: Provide clear admission requirements within clinically managed high-intensity residential service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered.
	12VAC35-105-1560. Clinically managed high-intensity residential services discharge criteria.		Intent: Provide clear discharge requirements within clinically managed high-intensity residential service programs. 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.		Intent: Provide additional licensing requirements for clinically managed high-intensity residential service programs which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-105-1580.		Intent: Provide clear staff requirements within high intensity residential services

	Clinically managed population-specific high-intensity residential services staff criteria.		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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1590. Clinically managed population-specific high-intensity residential services program criteria.		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 manner to meet the functional limitations of the individuals served. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1600. Clinically managed population-specific high-intensity residential services admission criteria.		Intent: Provide clear admission requirements within high intensity residential services programs. 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 discharge criteria.		Intent: Provide clear discharge requirements within high intensity residential services programs. 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.		Intent: Provide additional licensing requirements for high intensity residential services programs which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.

	12VAC35-105-1630. Clinically managed low-intensity residential services 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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1640. Clinically managed low-intensity residential services 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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1650. Clinically managed low-intensity residential services admission criteria		Intent: Provide clear admission requirements within clinically managed low-intensity residential service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered.
	12VAC35-105-1660. Clinically managed low-intensity residential services discharge criteria.		Intent: Provide clear discharge requirements within clinically managed low – intensity residential service programs. 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.		Intent: Provide additional licensing requirements for clinically managed low-intensity residential service programs which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-105-1680. Substance abuse partial hospitalization services 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.

			Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1690. Substance abuse partial hospitalization services.		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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1700. Substance abuse partial hospitalization admission criteria.		Intent: Provide clear admission requirements within partial hospitalization programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered.
	12VAC35-105-1710. Substance abuse partial hospitalization discharge criteria.		Intent: Provide clear discharge requirements within partial hospitalization programs. 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.		Intent: Provide additional licensing requirements for partial hospitalization programs which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-105-1730. Substance abuse intensive outpatient 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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1740. Substance abuse		Intent: Provide clear program requirements within intensive outpatient programs, which provide between 9 and 19 hours of structured

	intensive outpatient services program criteria.		treatment consisting primarily of counseling and education. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1750. Substance abuse intensive outpatient services admission criteria.		Intent: Provide clear admission requirements within intensive outpatient service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered.
	12VAC35-105-1760. Substance abuse intensive outpatient services discharge criteria.		Intent: Provide clear discharge requirements within intensive outpatient service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered.
	12VAC35-105-1770. Substance abuse intensive outpatient services co-occurring		Intent: Provide additional licensing requirements for intensive outpatient service programs which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-105-1780. Substance abuse outpatient services 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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1790. Substance abuse outpatient services program criteria.		Intent: Provide clear program requirements within outpatient programs, which provide an organized nonresidential service for fewer than 9 contact hours a week. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-105-1800. Substance abuse outpatient services		Intent: Provide clear admission requirements within outpatient service programs. Impact: Robust, effective substance use disorder treatment within the

	admission criteria.		Commonwealth which is appropriately administered.
	12VAC35-105-1810. Substance abuse outpatient services discharge criteria.		Intent: Provide clear discharge requirements within outpatient service programs. Impact: Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered.
	12VAC35-105-1820. Substance abuse outpatient services co-occurring enhanced programs.		Intent: Provide additional licensing requirements for outpatient service programs which treat individuals with co-occurring disorders. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.

Table 3: Changes to the Emergency Regulation

Emergency chapter-section number	**New chapter-section number, if applicable**	**Current <u>emergency</u> requirement**	**Change, intent, rationale, and likely impact of new or changed requirements since emergency stage**
12VAC35-105-10. Definitions.			Change: Editing the term “medical detoxification” with clarifying language. Editing the term “medication assisted opioid treatment” to include naltrexone as an example of an FDA approved synthetic narcotic utilized for treatment. Impact: Clarity of the regulations.
12VAC35-105-925. Standards for the evaluation of new licenses for providers of services to individuals with opioid addiction.			Change: Aligning the regulations with the requirements within the federal regulations regarding Certification and Treatment Standards for Opioid Treatment Programs (42 CFR Part 8 Subpart C). Specifically incorporating the requirements regarding staffing and minimum program requirements. Due to the addition of the federal requirements to these sections the ASAM provisions regarding staffing and programmatic requirements of medication assisted opioid treatment services were also moved to this section. Impact: Clearer regulations.

	12VAC35-105-935. Criteria for patient admission.		Change: Moving the elements related to ASAM patient admission into the article related to medication assisted opioid treatment so all requirements can be in the same place in the regulations. Incorporating the requirements within the federal regulations regarding Certification and Treatment Standards for Opioid Treatment Programs (42 CFR Part 8 Subpart C). Impact: Clearer regulations. Robust, effective substance use disorder treatment within the Commonwealth which is appropriately administered.
12VAC35-105-940			Change: Correction of a minor typographical error. Clarifying that the signed criteria for involuntary termination from treatment shall be maintained in the individual's service record. Adding that the individual be provided a copy of the grievance procedure at admission. Clarifying that "Individuals who fail to sign the authorization form shall be denied admission to the program." Impact: Clarity of the regulations.
	12VAC35-105-945. Criteria for patient discharge.		Change: Moving the elements related to ASAM patient discharge into the article related to medication assisted opioid treatment so all requirements can be in the same place in the regulations. Impact: Clarity of the regulations.
12VAC35-105-950. Service operation schedule			Change: Updating the "state methadone authority" to the "state opioid treatment authority." Adding the requirement that each program have a policy addressing medication for newly admitted patients and those deemed at risk. This incorporates a requirement within the federal regulations regarding Certification and Treatment Standards for Opioid Treatment Programs (42 CFR Part 8 Subpart C). Impact: Clarity of the regulations. Robust, effective substance use disorder treatment within the Commonwealth which are aligned with federal requirements.

12VAC35-105-960. Physical examinations	12VAC35-105-960. Initial and periodic assessment services.		Change: Clarifying that physical examinations are exempt only for transfers within the Commonwealth. Adding that the report of the physical examinations hall be within the individual's service record. Adding the requirement that the program physician shall review the consent to treatment form with the patient prior to treatment. Adding a requirement that the program have a policy to ensure coordination of care to prevent duplication of medications. This incorporates requirements within the federal regulations regarding Certification and Treatment Standards for Opioid Treatment Programs (42 CFR Part 8 Subpart C). Impact: Clarity of the regulations. Robust, effective substance use disorder treatment within the Commonwealth which are aligned with federal requirements.
	12VAC35-105-965. Special services for pregnant individuals.		Change: Adding requirements for special services the provider must provide for pregnant individuals. This incorporates requirements within the federal regulations regarding Certification and Treatment Standards for Opioid Treatment Programs (42 CFR Part 8 Subpart C). Impact: Robust, effective substance use disorder treatment within the Commonwealth which are aligned with federal requirements.
12VAC35-105-980. Drug screens.			Change: Increasing the number of drug screens to one per month. This incorporates requirements within the federal regulations regarding Certification and Treatment Standards for Opioid Treatment Programs (42 CFR Part 8 Subpart C). Impact: Robust, effective substance use disorder treatment within the Commonwealth which are aligned with federal requirements.
12VAC35-105-990. Take-home medication.			Change: Adding the requirements regarding determinations for take home approval for medication and adding the amount of take home medication that a patient may receive based on their service history. Also adding the requirement that providers

			have procedures to identify theft or diversion of take home medications. These edits incorporate requirements within the federal regulations regarding Certification and Treatment Standards for Opioid Treatment Programs (42 CFR Part 8 Subpart C). Impact: Robust, effective substance use disorder treatment within the Commonwealth which are aligned with federal requirements.
12VAC35-105-1000. Preventing duplication of medication services.			Change: Additional of minor clarifying language. Impact: Clarity of the regulations.
12VAC35-105-1010. Guests.			Change: Minor clarifying language. Addition of a definition of guest. Impact: Clarity of the regulations.
12VAC35-105-1430. Medically managed intensive inpatient staff criteria.			Change: Clarifying that the interdisciplinary team may include a list of professionals. Impact: Clarity of the regulations.
12VAC35-105-1480. Medically monitored intensive inpatient services staff criteria.			Change: Clarifying that the interdisciplinary team may include a list of professionals. Impact: Clarity of the regulations.
12VAC35-105-1680. Substance abuse partial hospitalization services staff criteria.			Change: Clarifying that the interdisciplinary team may include a list of professionals. Impact: Clarity of the regulations.
12VAC35-105-1730. Substance abuse intensive outpatient services staff criteria.			Change: Clarifying that the interdisciplinary team may include a list of professionals. Impact: Clarity of the regulations.

PROPOSED STAGE

Department of Behavioral Health And Developmental Services

Amendments to align with ASAM criteria

12VAC35-105-20. Definitions.

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

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

1. Rape, sexual assault, or other criminal sexual behavior;
2. Assault or battery;
3. Use of language that demeans, threatens, intimidates, or humiliates the individual;
4. Misuse or misappropriation of the individual's assets, goods, or property;
5. Use of excessive force when placing an individual in physical or mechanical restraint;
6. Use of physical or mechanical restraints on an individual that is not in compliance with federal and state laws, regulations, and policies, professional accepted standards of practice, or his individualized services plan; or
7. Use of more restrictive or intensive services or denial of services to punish an individual or that is not consistent with his 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 shall be employed in accordance with the individualized services plan and written policies and procedures governing service expectations, treatment goals, safety, and security.

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

1. Improved behavioral functioning and effectiveness;
2. Alleviation of symptoms of psychopathology; or
3. Reduction of challenging behaviors.

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

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

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

"Clinically managed high-intensity residential care" 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.

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

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

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

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

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

"Credentialed addiction treatment professional" means a person who possesses one of the following credentials issued by the appropriate health regulatory board: (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) a licensed nurse practitioner or a licensed physician assistant with experience or training in addiction medicine; (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical social worker; (vi) a licensed professional counselor; (vii) a licensed 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); or (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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"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 developmental disability. Intensive in-home service is usually time-limited and is provided typically in the residence of an individual who is at risk of being moved to out-of-home placement or who is being transitioned back home from an out-of-home placement. The service includes 24-hour per day emergency response; crisis treatment; individual and family counseling; life, parenting, and communication skills; and case management and coordination with other services.

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

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

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

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

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

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

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

~~"Medically managed withdrawal services" means detoxification services to eliminate or reduce the effects of alcohol or other drugs in the individual's body.~~

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

"Medically monitored intensive inpatient treatment" 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, emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment but who does not need the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program.

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

"Medication administration" means the 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), or naltrexone, 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" or "MAT" means the use of ~~FDA~~ U.S. Food and Drug Administration approved medications in combination with counseling and behavioral therapies to provide treatment of substance use disorders. Medication assisted treatment includes 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" or "MCHSS" means the provision of recovery-oriented services to individuals with long-term, severe mental illness. MHCSS includes skills training and assistance in accessing and effectively utilizing services and supports that are essential to meeting the needs identified in the individualized services plan and development of environmental supports necessary to sustain active community living as independently as possible. MHCSS may be provided in any setting in which the individual's needs can be addressed, skills training applied, and recovery experienced.

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

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

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

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

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

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

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

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

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

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

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

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

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

with 18VAC115-80 to provide collaborative mental health services for adults or children. A QMHP 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).

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

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

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

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

"Screening" means the process or procedure for determining whether the individual meets the minimum criteria for 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 incident" means any event or circumstance that causes or could cause harm to the health, safety, or well-being of an individual. The term "serious incident" includes death and serious injury.

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

"Level II serious incident" includes a significant harm or threat to the health or safety of others caused by an individual. Level II serious incidents include:

1. A serious injury;

2. An individual who is or was missing;

3. An emergency room visit;

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

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

6. Ingestion of any hazardous material; or

7. A diagnosis of:

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

b. A bowel obstruction; or

c. Aspiration pneumonia.

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

1. Any death of an individual;

2. A sexual assault of an individual; or

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

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

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

"Shall" means an obligation to act is imposed.

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

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

"Substance abuse outpatient service" means a center based substance abuse treatment delivered to individuals for fewer than nine hours of service per week for adults or fewer than six hours per week for adolescents on an individual, group, or family basis. Substance abuse outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Substance abuse outpatient service includes substance abuse services or an office practice that provides professionally directed aftercare, individual, and other addiction services to individuals according to a predetermined regular schedule of fewer than 9 contact hours a week. Substance abuse outpatient service also includes:

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

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

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

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

"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.

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

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

"Supportive in-home service" (formerly supportive residential) means the provision of community support services and other structured services to assist individuals, to strengthen

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

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

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

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

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

12VAC35-105-30. Licenses.

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

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

1. Case management;

2. Clinically managed high-intensity residential care;

3. Clinically managed low-intensity residential care;

4. Community gero-psychiatric residential;

~~3.~~ 5. ICF/IID;

~~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;

~~14. Opioid treatment/medication assisted treatment;~~

~~15.~~ 18. Mental health intensive outpatient;

19. Mental health outpatient;

20. Mental health partial hospitalization;

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;

~~22.~~ 26. Specific high-intensity residential;

27. Sponsored residential home;

~~23.~~ 28. Substance abuse residential treatment for women with children;

~~24.~~ 29. Substance abuse intensive outpatient;

~~25.~~ 30. Substance abuse outpatient;

31. Substance abuse partial hospitalization;

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.

Article 1

~~(Opioid Treatment Services)~~ Medication Assisted Opioid Treatment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~2.~~3. The medical director shall be a board-certified addictionologist or have successfully completed or will complete within one year a course of study in opiate addiction that is approved by the department; and:

~~3~~a. Is responsible for ensuring all medical, psychiatric, nursing, pharmacy, toxicology, and other services offered by the medication assisted opioid treatment provider are conducted in compliance with federal regulations at all times; and

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

~~3~~4. A minimum of one pharmacist~~.~~;

~~4.~~ 5. Nurses;

~~5.~~6. 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.~~7. Personnel to provide support services~~.~~;

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

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

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

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

12. The applicant may provide peer recovery specialists (PRS). Peer recovery specialists shall be professionally qualified by education and experience in accordance with 12VAC35-105-250. A registered peer recovery specialist shall be a PRS registered with the Board of Counseling in accordance with 18VAC115-70 and provide such services as an employee or independent contractor of DBHDS, a provider licensed by the DBHDS, a practitioner licensed by or holding a permit issued from the Department of Health Professions, or a facility licensed by the Department of Health.

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

~~F.~~G. 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~~ onsite security and services adequate to ensure the safety of patients, staff, and property; and

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

~~G~~H. 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;~~General

~~2~~a. Psychological services;

b. Social services;

~~3~~c. Vocational services;

~~4~~d. Educational services, including HIV/AIDS education and other health education services; and

~~5~~e. Employment services.

~~H~~2. Initial medical examination services.

3. Special services for pregnant patients.

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

5. Counseling services.

6. Drug abuse testing services.

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

~~H~~I. 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~~J. Applicants shall provide policies and procedures that shall address assessment, administration, and regulation of medication and dose levels appropriate to the individual. The

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

~~J~~K. Applicants shall submit policies and procedures describing services they will provide to individuals who wish to discontinue medication assisted opioid treatment services.

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

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

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

1. The federal Drug Enforcement Administration;
2. The federal Department of Health and Human Services; and
3. The Virginia Board of Pharmacy.

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

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

A. Before a medication assisted opioid treatment program 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 opioid use disorder as defined within the DSM; and 2) meet the admission criteria of Level 1.0 of ASAM. The policies shall be consistent with subsections B - E.

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

C. Maintenance treatment. An medication assisted opioid treatment program shall maintain current procedures designed to ensure that individuals are admitted to maintenance treatment by qualified personnel who have determined, using accepted medical criteria that the person is currently addicted to an opioid drug, and that the individual became addicted at least 1 year before admission for treatment. In addition, a program physician shall ensure that each individual voluntarily chooses maintenance treatment, and that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the individual, and that each individual provides informed written consent to treatment.

D. Maintenance treatment for persons under age 18. A person under 18 years of age is required to have had two documented unsuccessful attempts at short-term detoxification or drug-free treatment within a 12-month period to be eligible for maintenance treatment. No individual under 18 years of age may be admitted to maintenance treatment unless parent, legal guardian,

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

E. Maintenance treatment admission exceptions. If clinically appropriate, the program physician may waive the requirement of a 1-year history of addiction under paragraph C of this section, for individuals released from penal institutions (within 6 months after release), for pregnant patients (program physician must certify pregnancy), and for previously treated individuals (up to 2 years after discharge).

12VAC35-105-940. Criteria for involuntary termination from treatment.

A. The provider shall establish criteria for involuntary termination from treatment that describe the rights of the individual receiving services and the responsibilities and rights of the provider.

B. The provider shall establish a grievance procedure as part of the rights of the individual.

C. On admission, the individual shall be given a copy of the criteria and grievance procedure and shall sign a statement acknowledging receipt of same. The signed acknowledgement shall be maintained in the individual's service record.

D. Upon admission and annually thereafter all individuals shall sign an authorization for disclosure of information to allow the provider access to the Virginia Prescription Monitoring System. Individuals who fail to sign this authorization shall be denied admission to the program.

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

Before a medication assisted opioid treatment 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 medication assisted opioid treatment level of care;

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

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

12VAC35-105-950. Service operation schedule.

A. The service's days of operation shall meet the needs of the individuals served. If the service dispenses or administers a medication requiring daily dosing, the service shall operate seven days a week, 12 months a year, except for official state holidays. Prior approval from the state methadone authority shall be required for additional closed days.

B. The service may close on Sundays if all the following criteria are met:

1. The provider develops and implements policies and procedures that address recently admitted individuals receiving services, individuals not currently on a stable dose of medication, individual who present noncompliance treatment behaviors, individuals who previously picked up take-home medications on Sundays, security of take-home medication doses, and health and safety of individuals receiving services.

2. The provider receives prior approval from the state opioid treatment authority (SOTA) for Sunday closings. Each program must have a policy that addresses medication for the newly inducted patients and those who are deemed at risk, e.g. still actively using illicit substances or medical issues that may warrant closer monitoring of medication.

3. Once approved, by the state opioid treatment authority to close on Sundays, the provider shall notify individuals receiving services in writing at least 30 days in advance of their intent to close on Sundays. The notice shall address the risks to the individuals and the security of take-home medications. All individuals shall receive an orientation

addressing take-home policies and procedures, and this orientation shall be documented in the individual's service record prior to receiving take-home medications.

4. The provider shall establish procedures for emergency access to dosing information 24 hours a day, seven days a week. This information may be provided via an answering service, pager, or other electronic measures. Information needed includes the individual's last dosing time and date, and dose.

C. Medication dispensing hours shall include at least two hours each day of operation outside normal working hours, i.e., before 9:00 a.m. and after 5:00 p.m. The SOTA may approve an alternative schedule if it determines that schedule meets the needs of the population served by the provider.

12VAC35-105-960. ~~Physical examinations~~Initial and periodic assessment services.

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

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.~~The program physician shall review a consent to treatment form with the patient and sign the form prior to the individual receiving the first dose of medication.

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

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

12VAC35-105-965. Special services for pregnant individuals.

The program shall ensure that every pregnant woman has the opportunity for prenatal care, prenatal education, and postpartum follow-up, either: 1. Onsite; or 2. By referral to appropriate healthcare providers.

12VAC35-105-980. Drug screens.

A. The provider shall perform at least one random drug screen per month unless the conditions in subdivision B of this subsection apply;

B. Whenever an individual's drug screen indicates continued illicit drug use or when clinically and environmentally indicated, random drug screens shall be performed weekly.

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

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

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

A. Prior to dispensing regularly scheduled take-home medication, the provider shall ensure the individual demonstrates a level of current lifestyle stability as evidenced by the following:

1. Regular clinic attendance, including dosing and participation in counseling or group sessions;

2. Absence of recent alcohol abuse and illicit drug use;

3. Absence of significant behavior problems;

4. Absence of recent criminal activities, charges, or convictions;

5. Stability of the individual's home environment and social relationships;

6. Length of time in treatment;

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

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

B. Determinations for the take-home approval shall be based on the clinical judgement of the physician in consultation with the treatment team and shall be documented in the individual's service record.

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

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

2. A single dose each week during the first 90 days of treatment (beyond that in C 1 of this subsection). The individual shall ingest all other doses under the supervision of a medication administration trained employee.

3. Two doses per week in the second 90 days of treatment (beyond that in C 1 of this subsection).

4. Three doses per week in the third 90 days of treatment (beyond that in C 1 of this subsection).

5. A maximum 6-day supply of take-home doses in the remaining months of the first year of treatment.

6. A maximum 2-week supply of take-home medication after one year of continuous treatment.

7. One month's supply of take-home medication after 2 years of continuous treatment with monthly visits made by the individual served.

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

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

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

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

To prevent duplication of medication assisted opioid ~~medication~~ treatment services to an individual, prior to admission of the 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.

12VAC35-105-1010. Guests.

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

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

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

Article 2

Medically ~~Managed Withdrawal~~ Monitored Intensive Inpatient Services.

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 (Reserved.)

Part VII

Addition Medicine Service Requirements

Article 1

Medically Managed Intensive Inpatient

12VAC35-105-1430. Medically managed intensive inpatient staff criteria.

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~~which may include 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 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

9. Comply with 12VAC35-105-1055 through 12VAC35-105-1130.

12VAC35-105-1450. Medically managed intensive inpatient 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 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 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 co-occurring enhanced programs.

A. 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. 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.

Article 2

Medically Monitored Intensive Inpatient Services

12VAC35-105-1480. Medically monitored intensive inpatient services staff criteria.

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 ensure 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 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~~which may include 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. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1490. Medically monitored intensive inpatient services 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 12VAC35-105-1055 through 12VAC35-105-1130.

12VAC35-105-1500. Medically monitored intensive inpatient 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 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 co-occurring enhanced programs.

A. 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 four hours of admission and in person with 24 hours following admission. An LMHP shall conduct a behavioral health-focused assessment at the time of admission. A registered nurse shall monitor the individual's progress and administer or monitor the individual's self-administration of psychotropic medications.

B. 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. 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.

Article 3

Clinically Managed High-Intensity Residential Services

12VAC35-105-1530. Clinically managed high-intensity residential services staff criteria.

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 seven 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 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 level of 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 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 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 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 co-occurring enhanced programs.

A. 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 eight hours and onsite or closely coordinated offsite within 24 hours.

B. 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. 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.

Article 4

Clinically Managed Population-Specific High Intensity Residential Services

12VAC35-105-1580. Clinically managed population-specific high-intensity residential services staff criteria.

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, a licensed nurse practitioner, or a physician assistant in case of emergency related to an individual's substance use disorder 24 hours a day, seven days a week;

2. Have allied health professional staff onsite 24 hours a day. At least one clinician with competence in the treatment of substance use disorder shall be available onsite 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. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1590. Clinically managed population-specific high-intensity residential services program criteria.

A high-intensity residential services program shall meet the following programmatic requirements. The program shall:

1. Provide daily clinical services that 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 that 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, and 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 to 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 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 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 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 co-occurring enhanced programs.

A. 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 eight hours and onsite or closely coordinated offsite within 24 hours, as appropriate to the severity and urgency of the individual's mental condition.

B. 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. 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.

Article 5

Clinically Managed Low-Intensity Residential Services

12VAC35-105-1630. Clinically managed low-intensity residential services 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 in case of emergency related to an individual's substance use disorder, available 24 hours a day, seven days a week. The program shall also provide allied health professional staff onsite 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. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1640. Clinically managed low-intensity residential services 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 level of 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 random 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 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 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 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 co-occurring enhanced programs.

A. 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 onsite or closely coordinated offsite, as appropriate to the severity and urgency of the individual's mental condition.

B. 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. 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.

Article 6

Partial Hospitalization

12VAC35-105-1680. Substance abuse partial hospitalization services (ASAM LOC 2.5) staff criteria.

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~~which may include counselors, psychologists, social workers, 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. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1690. Substance abuse partial hospitalization services program criteria.

A substance abuse partial hospitalization program shall meet the following programmatic requirements. The program shall:

1. Offer no fewer 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 level of 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, seven 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 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 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 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 co-occurring enhanced programs.

A. 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 onsite or closely coordinated offsite, within a shorter time than in a co-occurring capable program.

B. 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 shall involve 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. Substance abuse partial hospitalization co-occurring enhanced programs shall offer intensive case management, assertive community treatment, medication management, and psychotherapy.

Article 7

Intensive Outpatient Services

12VAC35-105-1730. Substance abuse intensive outpatient services staff criteria.

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~~which may include 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 are 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. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1740. Substance abuse intensive outpatient services 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 fewer than nine hours and no more than 19 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, seven 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 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 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 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 co-occurring enhanced programs.

A. Substance abuse intensive outpatient services co-occurring enhanced programs shall offer psychiatric services appropriate to the individual's mental health condition. Such services shall be available by telephone and onsite or closely coordinated offsite, within a shorter time than in a co-occurring capable program.

B. 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. Substance abuse intensive outpatient services co-occurring enhanced programs shall offer intensive case management, assertive community treatment, medication management, and psychotherapy.

Article 8

Substance Abuse Outpatient Services

12VAC35-105-1780. Substance abuse outpatient services staff criteria.

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. Ensure all clinical staff are qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.

12VAC35-105-1790. Substance abuse outpatient service 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, seven days a week;

3. Provide individual or group counseling, motivational enhancement, family therapy, educational groups, occupational and recreational therapy, psychotherapy, addiction and pharmacotherapy as indicated by each individual's needs;

4. For individuals with mental illness, ensure the use of psychotropic medication, mental health treatment and that the individual's relationship to substance abuse disorders shall be addressed as the need arises;

5. Provide medical, psychiatric, psychological, laboratory, and toxicology services onsite or through consultation or referral. Medical and psychiatric consultation shall be available within 24 hours by telephone, or if in person, within a timeframe 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 response to treatment.

12VAC35-105-1800. Substance abuse outpatient service 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 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 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;

12VAC35-105-1820. Substance abuse outpatient services co-occurring enhanced programs.

A. Substance abuse outpatient services co-occurring enhanced programs shall offer ongoing intensive case management for highly crisis-prone individuals with co-occurring disorders.

B. 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. Substance abuse outpatient services co-occurring enhanced programs shall offer therapies to actively address, monitor, and manage psychotropic medication, mental health treatment, and interaction with substance-related and addictive disorders.

~~**12VAC35-105-1830 Medication assisted opioid treatment staff criteria**~~

~~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.~~**~~12VAC35-105-1840 Medication assisted opioid treatment 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 onsite and offsite treatment services provided as neededProvide 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 eight times per year; and~~

~~6. Comply with 12VAC35-105-925 through 12VAC35-105-1050.~~

~~**12VAC35-105-1850 Medication assisted opioid treatment 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 discharge criteria**~~

~~Before a medication assisted opioid treatment 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 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.~~

12VAC35-105-9999. Documents Incorporated By Reference

The ASAM: Treatment for Addictive, Substance-Related and Co-Occuring Conditions, Third Edition, American Society of Addiction Medicine, Address, asam.org.

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. DSM-5, American Psychiatric Association, 800 Maine Avenue, S.W., Suite 900 Washington, DC 20024, psychiatry.org.

III. Proposed Stage: Childrens Residential Regulations, 12VAC35-46: ASAM Criteria.

Background: With the filing of the 'notice of intended regulatory action' (NOIRA) when the emergency regulation was filed, the public received notification that a *permanent* regulatory change was planned. Also, once the emergency regulation and NOIRA were published, there was a public comment period, after which the agency reviewed the comments as it developed the proposed stage draft. Once the proposed stage is published, there is a 60-day public comment period. Based on the comments received, the agency may modify the proposed text of the regulation for the final stage.

Purpose: The goal of this regulatory action is to amend the regulations to align with the American Society of Addiction Medicine (ASAM) Levels of Care Criteria, which ensure individualized, clinically driven, participant-directed and outcome-informed treatment. ASAM Levels of Care Criteria help to ensure individualized, clinically driven, participant-directed, and outcome-informed treatment.

Action Requested: Initiate a fast track action to adopt the amendments.

VAC Citation	Title	Last Activity	Date
12 VAC 35-46	Regulations for Children's Residential Facilities	Emergency	2/20/2021

Next Steps:

- If approved, staff initiates the proposed stage action.

Town Hall Form

Proposed Regulation
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	5/21/2021

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 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.

The Department of Behavioral Health and Developmental Services (DBDHS) was directed by the 2020 General Assembly within Item 318.B. of the 2020 *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

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in 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."

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*. This regulatory action is being utilized to codify permanent regulations following the emergency regulations.

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 and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

DBDHS was directed by the 2020 General Assembly within Item 318.B. of the 2020 *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. This regulatory action is being utilized to codify permanent regulations following the emergency regulations. 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. The State Board of Behavioral Health and Developmental Services voted to adopt this regulatory action on _____.

Purpose

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

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, or sexual abuse, or other trauma.

Behavioral therapies, delivered by trained clinicians, can help an adolescent stay off drugs by strengthening his motivation to change. The ASAM criteria 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 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 to the Regulations for Children's Residential Facilities is that citizens of the Commonwealth will receive 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.

Requirements More Restrictive than Federal

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

No requirements within the regulation exceed applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

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:

The Department of Medical Assistance Services (DMAS) may be particularly affected by the regulatory action as DMAS is a payor to many of the DBHDS providers affected by the regulatory action. DBHDS collaborated with DMAS on the development of this regulatory action.

Localities Particularly Affected:

No locality is particularly affected to the knowledge of DBHDS.

Other Entities Particularly Affected:

Providers of substance abuse services may be particularly affected by the regulation in order come into compliance with the regulations.

Economic Impact

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

Impact on State Agencies

For your agency: projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources	DBHDS will incur costs related to the promulgation of regulations, training for providers, and conducting additional inspections. Specifically, DBHDS will issue conditional licenses for six months and conduct an inspection to ensure regulatory compliance. DBHDS anticipates needing to conduct ~ 250 initial inspections after the first six month period. The outcome of those inspections will determine

	if an additional inspection is required later that year. Additionally, the agency will need to provide technical assistance to providers, to include issuing Corrective Action Plans and confirming their implementation. DBHDS will require one additional full-time specialist to absorb the increased workload associated with this ASAM regulatory change.
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.	None known.
For all agencies: Benefits the regulatory change is designed to produce.	The citizens of the Commonwealth will receive more effective treatment of substance related conditions.

Impact on Localities

Projected costs, savings, fees or revenues resulting from the regulatory change.	None known.
Benefits the regulatory change is designed to produce.	The citizens of the Commonwealth will receive more effective treatment of substance related conditions.

Impact on Other Entities

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.	DBHDS providers that provide substance abuse services. Individuals served by those providers. No other entities will be affected by these regulations.
Agency's best estimate of the number of such entities that will be affected. Include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	DBHDS estimates the number of entities that will be affected is 63. There is no way to estimate the number of small businesses within the pool of all providers.
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	Children's residential providers will need to obtain an updated license from DBHDS at no cost. These changes bring DBHDS' regulations into alignment with the current requirements of the Department of Medical Assistance Services (DMAS). DMAS has required third-party administrative verification that providers were in compliance with the ASAM criteria for payment. Therefore, any provider utilizing Medicaid as a payor should be in compliance with these regulations and not incur any costs. However, a physical DBHDS inspection could reveal that

	providers currently billing Medicaid need to make changes to ensure ASAM is being implemented properly. Providers who do not participate in Medicaid *and* whose services do not meet these requirements may incur some costs related to hiring and training staff in the use of the ASAM criteria.
Benefits the regulatory change is designed to produce.	The citizens of the Commonwealth will receive more effective treatment of substance related conditions.

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.

Regulatory Flexibility Analysis

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

There are no other alternative regulatory methods consistent with health, safety, environmental and economic welfare that will accomplish the objectives of the General Assembly mandate. The proposed regulatory changes align the Regulations for Children's Residential Facilities with the ASAM criteria as directed. There are no exemptions of small business providers from all or any part of the requirements contained in the regulatory change.

Periodic Review and Small Business Impact Review Report of Findings

If you are using this form to report the result of a periodic review/small business impact review that is being conducted as part of this regulatory action, and was announced during the NOIRA stage, indicate whether the regulatory change meets the criteria set out in Executive Order 14 (as amended, July 16, 2018), e.g., is necessary for the protection of public health, safety, and welfare; minimizes the economic impact on small businesses consistent with the stated objectives of applicable law; and is clearly written and easily understandable.

In addition, as required by § 2.2-4007.1 E and F of the Code of Virginia, discuss the agency's consideration of: (1) the continued need for the regulation; (2) the nature of complaints or comments received concerning the regulation; (3) the complexity of the regulation; (4) the extent to the which the regulation overlaps, duplicates, or conflicts with federal or state law or regulation; and (5) the length of time since the regulation has been evaluated or the degree to which technology, economic conditions, or other factors have changed in the area affected by the regulation. Also, discuss why the agency's decision, consistent with applicable law, will minimize the economic impact of regulations on small businesses.

Neither a periodic review nor a small business impact review was conducted related to this action.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

No public comment was received during the public comment period.

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.

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, (iii) the potential impacts of the regulation, and (iv) the agency's regulatory flexibility analysis stated in that section of this background document.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail, email or fax to **Susan Puglisi, 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 this 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 proposed regulation. If existing VAC Chapter(s) or sections are

being repealed and replaced, ensure Table 1 clearly shows both the current number and the new number for each repealed section and the replacement section.

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
12VAC35-46-10. Definitions.		Provides current definitions for the Children's Residential Licensing Regulations	Change: Adding the following definitions for terms utilized within the ASAM criteria: • Allied health professionals; • ASAM; • Clinically managed, low-intensity residential care; • Clinically managed, medium intensity residential care; • DSM; • Medication assisted treatment; and • Motivational enhancement. Impact: Clear regulations.
	12VAC35-46-1150. (Reserved).		Intent: Space saver section.
	12VAC35-46-1160. Clinically managed, medium intensity residential services 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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-46-1170. Clinically managed medium-intensity residential services 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. 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. 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. 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. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.
	12VAC35-46-1210. Clinically managed low-intensity residential services 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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-46-1220. Clinically-managed low-intensity residential services 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. Impact: Robust, effective substance use disorder treatment within the Commonwealth.
	12VAC35-46-1230. Clinically managed low-intensity		Intent: Provide clear admission requirements within clinically managed low-intensity residential service programs.

	residential services admission criteria.		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. 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. Impact: Clarity of the regulations. Clear requirements for providers treating individuals with co-occurring disorders.

PROPOSED STAGE DRAFT: Chapter 46

ASAM CRITERIA.

*NOTE: The language is **unchanged** from the current emergency regulation to the proposed stage draft **except for two minor edits** pasted below. The full current emergency text can be viewed here: http://register.dls.virginia.gov/details.aspx?id=9397.*

12VAC35-46-10. Definitions.

"Allied health ~~professionals~~ 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.

12VAC35-46-1180. Clinically managed, medium-intensity residential services 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 to:

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)~~DSM; and

2. Meet the admission criteria of Level 3.5 of ASAM, including the specific criteria for adolescent populations.

IV-VII. Required Periodic Reviews of Four Regulations

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

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

The next periodic review must be initiated by this quarter of 2021.

Purpose: The four regulations are submitted to the State Board for consideration for review.

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

VAC Citation	Title	Last Review
12 VAC 35-12	Public Participation Guidelines.	2017
12 VAC 35-190	Regulations for Voluntary Admissions to State Training Centers.	2017
12 VAC 35-200	Regulations for Emergency and Respite Care Admission to State Training Centers.	2017
12 VAC 35-210	Regulations to Govern Temporary Leave from State Facilities.	2017

Next Steps:
If approved, staff initiates the periodic reviews. At the conclusion of the 21-day (minimum) comment periods, staff develops recommended Board action on each of the regulations, for consideration at the September meeting. The choices for action are:

A. Propose to retain the regulation in its current form.
B. Propose to amend or abolish the regulation. (Notice of Intended Regulatory Action)
C. Propose to amend the regulation through an exempt action.

DIRECTIONS

Tuesday, July 17, 2021

Virginia Department of Behavioral Health and Developmental Services,
13th FloorLarge Conference Room, Jefferson Building, 1220 Bank Street, Richmond, VA 23219

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

- **Planning and Budget Committee** will meet in the 3th Floor Conference Room.
- **Policy and Evaluation Committee** will meet in the 12th Floor Large Conference Room.

Regular Meeting Location: **Virginia Department of Behavioral Health and Developmental Services, 13th Floor Large Conference Room, Jefferson Building, 1220 Bank Street, Richmond, VA 23219**

This page has **driving directions to the DBHDS Central Office in the Jefferson Building**, 1220 Bank Street. Below are general directions based on your starting point. View a Capitol area site plan (http://www.dbhds.virginia.gov/documents/sitePlan-RichCapitol.pdf) that you can adjust for magnification.

FROM I-64 EAST AND WEST OF RICHMOND

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

FROM I-95 NORTH OF RICHMOND

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

FROM I-95 SOUTH OF RICHMOND

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

➢ CONTINUE DOWNTOWN - DIRECTIONS AFTER EXITING I-95

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

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

➢ **The location for the Biennial Planning Meeting is in the same location as the regular meeting**.

If you have any questions about the information in this meeting packet,
contact Ruth Anne Walker, ruthanne.walker@dbhds.virginia.gov, 804.225-2252.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Planning and Budget Committee
DRAFT MINUTES

April 14, 2021
This meeting was held entirely virtually.

Members present: Elizabeth Hilscher, Board and Committee Chair; E. Paige Cash; Jerome Hughes; Chris Olivo.
Staff present: Emily Lafon; Ruth Anne Walker.

I. Call to Order
A quorum being present, at 8:32 a.m., Elizabeth Hilscher, Chair, called the meeting to order.

II. Welcome and Introductions
Ms. Hilscher welcomed all present.

III. Adoption of Minutes, January 5, 2021
On a motion from Jerome Hughes and a second from Chris Olivo the meeting minutes from January 5, 2021, were adopted unanimously.

IV. Standing Item: *Identification of services and support needs, critical issues, strategic responses, and resource requirements to be included in long-range plans; work with the department to obtain, review, and respond to public comments on draft plans; and monitor department progress in implementing long-range programs and plans.*

A. Review of topic areas for board meetings through December 2021.

a. Review new draft description for Board spotlight segment.
The committee reviewed a draft description of the purpose of a standing item in the regular meetings titled 'Board Member Spotlight.' Ms. Hilscher stated that Mr. Hughes will be the first to speak during this segment. There were no edits to the draft.

V. Standing Item: *Ensure that the agency's budget priorities and submission packages reflect State Board policies and shall, through the Board's biennial planning retreat, review and comment on major funding issues affecting the behavioral health and developmental services system, in accordance with procedures established in POLICY 2010 (ADM ST BD) 10-1.*

A. State Board Budget Quarterly Report.

Emily Lafon, Finance & Policy Analyst, Office of Budget Development, Division of Finance, provided an update on the budget. Understandably, there were minimal expenses in the past fiscal year due to the pandemic ($704). The budget 'resets' at the start of the new fiscal year to the 18Kannual base.

Ms. Walker reminded the committee that the member attendance at conferences of the Virginia Association of Community Services Boards (VACSB) can be paid out of the board budget. Ms. Hilscher stated the conferences she attended were worthwhile with some excellent speakers.

B. Discussion of Identified Priorities (within the framework of required agency strategic planning and budget development processes): committee eye toward new priorities for consideration at the biennial planning meeting in July.

Ms. Hilscher stated the committee could discuss what priorities it felt should be topics for discussion in the July Biennial Planning Meeting. She also reminded members of the board's practice to send a letter to the Governor stating the priorities and reviewed as an example the three major priorities included in the last letter:

- Utilization of Crisis Intervention Treatment and Assessment Sites (CITACs) for detoxification and 23 hour crisis stabilization to assist in alleviating the current capacity pressures on state hospitals.
- Continued work toward elimination of the Priority 1 Waitlist, but also strongly consider refresh of waiver rates (with regional variation addressed) to address increasing pressures to recruit and retain qualified professionals to provide waiver services.
- Elimination of the gap uninsured Virginians experience, even after Medicaid expansion, and continued focus on the need for resources like STEP-VA to support the un- and under-insured.

In July, the board will discuss what is important, what has been accomplished in the past biennium, and where the board wants to focus going forward. Ms. Walker asked if members were satisfied with the current list of the planned board topics. She also stated the letter to the Governor fulfills one of the duties in the Code of Virginia for the board*, 'to review and comment on all budgets'….*and to '*advise the Governor, Commissioner, and General Assembly on matters relating to'* the services system. The planning meeting is timed to be prior to the Governor's submission of a new biennium budget.

Ms. Hilscher recalled that Ms. Cash had an idea to hear about health equity and a possible outcome the department would want to have on that.

C. Review the ways the Board fulfills its powers and duties, as described in the Annual Executive Summary.

Ms. Walker shared the most recent executive summary, and explained that it is structured around the board's powers and duties. She asked if the committee would look at the structure with a fresh eye.

a. Review revised draft liaison letter.

Ms. Hilscher directed the committee to the draft liaison letter, and explained how acting as a liaison is intended to work. The draft letter is an introduction to help the communication flow better. The intent is to inform board members to inform in making decisions about regulations and policies, and to just be a good board member. Ms. Walker reviewed the changes in the draft, which are intended to make clear for CSB executive directors and state facility directors what the role is intended to be. She reported that she had held the delivery of the letter to send later this spring due to the impact of the pandemic, the General Assembly session, and other activity.

Ms. Hilscher brought to the committee her concern of sitting for an afternoon for the biennial planning meeting and the next day having to sit most of the next day. She asked for members to consider it. Ms. Cash reported that she is fine with it as she sits in front of a computer every day anyway, and Mr. Olivo and Mr. Hughes anconcurred that it is typical.

VI. Semi Annual Federal Grant Report: *The department shall provide a semi-annual report of all federal grants currently under consideration as well as those being actively pursued. Additionally, the report will include all grants that have been submitted in the last six months. Finally, the reward status of all submitted grants will be outlined to the Board.*

A. Grant Review Committee Update: Reviewed summary of draft grant April 1, 2021.
Ms. Walker shared the form of a summary of a grant shared with the Grant Review Committee (Ms. Cash and Dr. Choudhary) in recent weeks. She reviewed the function of the Grant Review Committee. Ms. Cash stated that the purpose of the grant hit home because of a number of students who don't have access to counseling are self-medicating to cope.

VII. Other Business

VIII. Next Steps:

A. Standing Item: *Provide updates on committee planning activities to the Board.*

B. Next Meeting
The next meeting of the committee will be on July 14, 2021.

IX. Adjournment
There being no further business, Ms. Hilscher adjourned the meeting at 9:23 a.m.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Policy and Evaluation Committee
MINUTES

APRIL 14, 2021
8:30-9:25 AM
RICHMOND, VA

Members present: Moira Mazzi, Sandra Price-Stroble, Rebecca Graser
Members absent: Varun Choudhary, Kendall Lee
Staff: Alex Harris and Josie Mace, committee staff
Mira Signer, Chief Deputy for Community Services
Dr. Lisa Jobe-Shields, Deputy Director for Community Services
Angela Harvell-Moore, Deputy Commissioner for Facility Services
Stacy Pendelton, Chief Human Rights Officer
Guests: Scott Castro & Valentina Vega, Representatives of the Medical Society of Virginia

I. Call to Order
Moira Mazzi called the meeting to order.

II. Welcome and Introductions
Ms. Mazzi welcomed all present, and the committee members introduced themselves.
Rebecca Graser joined and assumed chair duties.

III. Review of the Role and Responsibilities of the Committee, Policy vs. Regulations (if new members)
Members did not require a review of responsibilities.

IV. Presentation on STEP-Virginia & Building the Comprehensive Safety Net
Ms. Signer and Dr. Jobe-Shields reviewed plans for STEP-VA and the vision for building a core set of comprehensive services.

V. Review of 2021 Policy Review Plan and Presentation of Policies for Discussion [Becky and Alex] (20 min)

A. 2010 (ADM) 88-2 Policy Development and Evaluation
B. 2011 (ADM) 88-3 Naming New and Existing State Facilities (Angela Harvell)
C. 3000 (CO) 74-10 Appointments of Department Employees to Community Services Boards (Stacy Pendleton)

Alex Harris and Angela Harvell presented information on policies 2010 (ADM) 88-2 Policy Development and Evaluation and 2011 (ADM) 88-3 Naming New and Existing State Facilities.

Further discussion of policies and final review will occur at next committee meeting.

Meeting adjourned at 9:25 AM.

VII. Next Meeting: July 2021

VIII. Other Business (10 min)

IX. Adjournment