

AGENDA PACKET

AS ADOPTED

State Board of Behavioral Health and Developmental Services

Schedule of Events

WEDNESDAY, DECEMBER 10, 2025

DBHDS Central Office, 13th Floor South Large Executive Board Room Jefferson Building, 1220 Bank Street, Richmond, VA 23219																
Meetings is in person with a physical quorum present; however, electronic meeting access is available.																
8:30 a.m.	POLICY AND EVALUATION COMMITTEE MEETING NOTE: Planning and Budget Committee will not meet <table><tr><th colspan="2">Electronic Meeting Access:</th></tr><tr><td>Microsoft Teams</td><td>Click here to join Committee Meeting</td></tr><tr><td>Meeting ID:</td><td>249 614 168 568 33</td></tr><tr><td>Passcode:</td><td>C89Pd2H7</td></tr><tr><td>Audio only</td><td></td></tr><tr><td>Dial in by phone:</td><td>434-230-0065</td></tr><tr><td>Phone Conference ID:</td><td>635 246 404#</td></tr></table>	Electronic Meeting Access:		Microsoft Teams	Click here to join Committee Meeting	Meeting ID:	249 614 168 568 33	Passcode:	C89Pd2H7	Audio only		Dial in by phone:	434-230-0065	Phone Conference ID:	635 246 404#	Agenda, pages 19-36
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9:30 a.m.	REGULAR QUARTERLY BOARD MEETING<table><tr><th colspan="2">Electronic Meeting Access:</th></tr><tr><td>Microsoft Teams</td><td>Click here to join Full Board Meeting</td></tr><tr><td>Meeting ID:</td><td>227 433 888 500 43</td></tr><tr><td>Passcode:</td><td>Mt6if7Sd</td></tr><tr><td>Audio only</td><td></td></tr><tr><td>Dial in by phone:</td><td>434-230-0065</td></tr><tr><td>Phone Conference ID:</td><td>748 391 014#</td></tr></table>	Electronic Meeting Access:		Microsoft Teams	Click here to join Full Board Meeting	Meeting ID:	227 433 888 500 43	Passcode:	Mt6if7Sd	Audio only		Dial in by phone:	434-230-0065	Phone Conference ID:	748 391 014#	Agenda, pages 2-3
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AGENDA PACKET

AS ADOPTED

State Board of Behavioral Health and Developmental Services

WEDNESDAY, DECEMBER 10, 2025

Regular Quarterly Board Meeting

9:30 a.m.

DBHDS Central Office, 13th Floor South Large Executive Board Room
Jefferson Building, 1220 Bank Street, Richmond, VA 23219

ELECTRONIC MEETING ACCESS

Microsoft Teams	Click here to join
Meeting ID:	227 433 888 500 43
Passcode:	Mt6if7Sd
<i>Audio only</i>	
Dial in by phone:	434-230-0065
Phone Conference ID:	748 391 014#

Meeting is in person with a physical quorum present; however, electronic meeting access is available.

1. CALL TO ORDER

A. Determination of Quorum

B. Welcome and Introductions

C. Adoption of Agenda

D. Approval of Draft Minutes

Action Item

Pages 4-18

2. PUBLIC COMMENT

Public comment on agenda items will be accepted in person or virtually using the electronic meeting access option. Comment will not be accepted on regulatory actions or rulemaking petitions for which the public comment period has closed.

Each commenter, whether in-person or virtual, will be limited to three minutes.

Pre-registration is requested but not required. Persons wishing to comment are asked to email mary.broz-vaughan@dbhds.virginia.gov by 5:00 p.m., on Tuesday, Dec. 9, 2025.

3. COMMISSIONER'S REPORT

Nelson Smith
Commissioner

4. STANDING COMMITTEE REPORTS

5. UNFINISHED BUSINESS

6.	REGULATORY BUSINESS		
	A. Emergency/NOIRA Action to Align Licensing Regulations with Redesigned Medicaid Service: Coordinated Specialty Care (CSC)	Action Item	Pages 38-66
	B. Emergency/NOIRA Action to Align Licensing Regulations with Redesigned Medicaid Service: Recovery and Empowerment Center (Mental Health Clubhouse Services)	Action Item	Pages 67-94
	C. Proposed Regulatory Restructuring Actions	Action Item	Pages 95-368
	D. Petition for Rulemaking	Action Item	Pages 369-387
	E. Regulatory Activity Status Report	Information	Pages 388-389
7.	ANNUAL OFFICE OF HUMAN RIGHTS UPDATE		
	Taneika Goldman State Human Rights Director		
8.	PRE-SESSION LEGISLATIVE AND BUDGET UPDATE		
	Nathan Miles Chief Financial Officer Josie Mace Legislative Affairs Director		
9.	LUNCH		
	<i>Break and collect lunch</i>		
10.	BIENNIAL CONFLICT OF INTEREST TRAINING		
	Stewart Petoe and Matt Hawkins Conflict of Interest and Ethics Advisory Council		
11.	VIRGINIA ASSOCIATION OF COMMUNITY SERVICES BOARDS UPDATE		
	Jennifer Faison VACSB Executive Director		
12.	NEW BUSINESS		
	A. Electronic Meetings Policy	Action Item	Pages 390-400
	B. Board Matters		
	C. Announcements		
13.	ADJOURNMENT		

NEXT MEETING: WEDNESDAY, APRIL 22, 2026
Northern Virginia Mental Health Institute (NVMHI)
3302 Gallows Road, Falls Church

The agenda and packet as adopted by the Board will be made available to the public at the meeting in accordance with the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia).

DRAFT MINUTES

State Board of Behavioral Health and Developmental Services

REGULAR QUARTERLY BOARD MEETING

Wednesday, September 24, 2025

DBHDS Southeastern Virginia Training Center (SEVTC)
 2100 Steppingstone Square, Chesapeake, VA 23320

The meeting was held in person with a physical quorum present and with electronic or phone connection available.

MEMBERS PRESENT	Sandy Chung, MD Rebecca Graser Cindy Lamb Jane McDonald Nina Schroder Tony Vadella	MEMBERS ABSENT	R. Blake Andis Debbie Marrs
DBHDS STAFF present for all or part of the meeting	Eric Billings, Director of Grants Management Mary Broz-Vaughan, Regulatory Affairs Director/State Board Liaison Braden Curtis, Chief Deputy Commissioner Madelyn Lent, Public Policy Manager Meghan McGuire, Deputy Commissioner, Policy and Public Affairs Susan Puglisi, Regulatory Research Specialist Ben Wakefield, Federal Grants Manager		
INVITED GUESTS present for all or part of the meeting	Jennifer Faison, VACSB Executive Director Heather Fisher, SEVTC Director and CEO		
VIRTUAL ATTENDEES	DBHDS: Jae Benz, Director of Licensing; Lauren Cunningham, Communications Director; Rebecca Laubach, Quality Management Coordinator; Mary McQuown, Recovery Services Workforce Development Coordinator; Dev Nair, Assistant Commissioner for Provider Management; Chaye Neal-Jones, Director of Enterprise Management Services; Margaret Steele, Deputy Director of Community Operations EXTERNAL: Charlotte Arbogast, DARS; Martha Bryant; Candy Calloway, Valley CSB; Lauren Gerken, The Arc of Virginia; Christina Nuckols, Sentara; MiMi Sedjat, Eastern Shore CSB; Teresa Smith, OSIG; Brandie Williams, Rappahannock Area CSB; J. Lynne Winebarger, New River Valley CSB; Amanda (no last name); Rachel (no last name)		

DRAFT MINUTES

CALL TO ORDER	Vice Chair Jane McDonald called the meeting to order at 9:50 a.m., and welcomed new member, Nina Schroder, to the board.
Roll Call	Ms. Broz-Vaughan called the roll and reported that a quorum was present. For purposes of determining whether a quorum was physically assembled, Ms. McDonald participated electronically as a person with a disability in accordance with § 2.2-3708.3 of the Code of Virginia.
Remote Participation	Ms. McDonald participated electronically from her home in Fredericksburg, due to a temporary or permanent disability that prevented her physical attendance at the meeting. Dr. Chung participated electronically from her home in Sterling, due to her principal residence being more than 60 miles from the meeting location.
Adoption of Agenda	A motion was made by Ms. Lamb and seconded by Ms. Schroder to adopt the agenda. The motion carried unanimously.
Approval of Minutes	Ms. McDonald called for any additions or corrections to the draft minutes from the meetings on July 8th and 9th. Hearing none, Ms. Lamb moved to approve the draft minutes en bloc. Ms. Schroder seconded the motion, which carried unanimously.
Public Comment Period	Ms. McDonald opened the floor for public comment. No commenters were present. One written comment was received from Martha Bryant and entered into the record.
Commissioner's Report	Mr. Curtis represented Commissioner Nelson Smith and provided an update on the Hiram W. Davis Medical Center draft closure plan. Presentation available from board office upon request.
Standing Committee Reports	Ms. Broz-Vaughan reported that members of the Grant Review Committee reviewed the department's recent submission for a \$250,000 Behavioral IT Pilot Program Grant. Ms. Lent summarized the morning's Policy and Evaluation Committee meeting, noting that members received background information on the next policies scheduled for periodic review: • Policy 3000 (CO) 74-10 – Department Employee Appointments to Community Services Boards, and • Policy 1034 (SYS) 05-1 – Partnership Agreement. After reviewing comments from field review, the committee continued discussion about whether to retain, amend, or rescind Policy 6005 (FIN) 94-2 – Retention of Unspent State Funds by Community Services Boards.

DRAFT MINUTES

	Ms. Lent reported that the committee voted to recommend technical revisions to Policy 4018 (CSB) 86-9 – Community Services Board Performance Contracts to the full board, which she indicated would be included in the next quarterly meeting agenda packet. Ms. McDonald called attention to the committee’s recommended changes to Policy 5008 (FAC) 87-12 – Accreditation/Certification and Policy 5010 (FAC) 00-1 – State Facility Uniform Clinical and Operational Policies and Procedures for the board’s consideration. On a motion by Mr. Vadella, properly seconded by Ms. Lamb, the board unanimously approved the revisions to Policy 5008 as presented. On a motion by Ms. Schroder, properly seconded by Ms. Lamb, the board unanimously approved the revisions to Policy 5010 as presented.
Unfinished Business	At the biennial planning meeting on July 9, 2025, board members drafted priorities for the 2026-28 state budget. Ms. Broz-Vaughan reviewed the board’s practice of sending a letter conveying those priorities to the Governor and the General Assembly. Members received a handout with a draft of the letter previously circulated for review. On a motion by Mr. Vadella, properly seconded by Ms. Graser, the board unanimously adopted the 2026-28 biennial priorities as presented and endorsed the letter as approved by the chair.
Facility Tour	Ms. McDonald recessed the meeting while the board toured the facility. She announced the meeting would reconvene at approximately 11:15 a.m.
The Board recessed at 10:37 a.m. to reconvene at 11:15 a.m.	
The Board reconvened at 11:22 a.m.	
Facility Overview	Heather Fisher, CEO and Director of Southeastern Virginia Training Center, presented on the facility’s history, services, successes, and challenges. Presentation available from board office upon request.
Lunch Recess	Ms. McDonald recessed the meeting for lunch until 12:00 p.m.
The Board recessed at 11:45 a.m. to reconvene at 12:00 p.m.	
The Board reconvened at 12:00 p.m.	
Regulatory Business	Ms. Broz-Vaughan reviewed the emergency regulatory process, describing the legislative directives requiring board action, the temporary nature of emergency regulations, and the simultaneous filing of a Notice of Intended Regulatory Action (NOIRA) to initiate the standard three-stage process to promulgate permanent replacement regulations.
Action Item 1	Emergency Action for Peer Recovery Specialist-Trainee (PRS-T) Designation

DRAFT MINUTES

	Ms. Puglisi explained that the 2025 Session of the General Assembly directed the board to amend its regulations to allow Peer Recovery Specialist trainees to bill Medicaid for their services while working toward certification. She summarized the proposed amendments and their impact. MOTION: Ms. Graser moved to adopt emergency regulations amending 12VAC35-105 and 12VAC35-250 to establish a Peer Recovery Specialist-Trainee designation, as presented, and to issue a NOIRA for permanent replacement regulations. Ms. Lamb seconded, and the motion carried unanimously.
Action Item 2	Emergency Action for Alignment with Medicaid Behavioral Health Services Redesign: Community Psychiatric Support and Treatment (CPST) Ms. Puglisi reviewed the legislative mandate directing the board to restructure the provider licensing regulations to ensure consistency with the new Medicaid services, summarizing the proposed amendments and their impact. The action is intended to improve access to a continuum of high-quality behavioral health services for Virginians; ensure CPST providers adhere to a base level of model fidelity; and reduce administrative burden by aligning licensing regulations with Medicaid service expectations. MOTION: Ms. Schroder moved to adopt emergency regulations amending 12VAC35-105 to align with Medicaid behavioral health services redesign for CPST, as presented, and to issue a NOIRA for permanent replacement regulations. Mr. Vadella seconded, and the motion carried unanimously.
Status Report	Ms. Broz-Vaughan advised members that the NOIRA stage for the comprehensive “overhaul” project to restructure the licensing regulations, approved by the board at its April meeting, is closing. Staff plans to provide the board with a detailed overview of the project prior to the 180-day filing deadline for the proposed stage.
Federal Grant Update	Mr. Billings and Mr. Wakefield reviewed the agency’s federal grants, including a recent application for \$250,000 from the Behavioral Health IT Pilot Program. Presentation available from board office upon request.
Reordering of Agenda	Ms. McDonald noted the meeting was running ahead of schedule and requested unanimous consent to take business out of order. Without objection, the board agreed to reorder the agenda and take New Business up for immediate consideration.

DRAFT MINUTES

New Business	Ms. McDonald directed members to the recommendation for appointment to the State Human Rights Committee. Ms. Graser moved to appoint Mary “Betsy” Lang to the State Human Rights Committee. Dr. Chung seconded the motion, which carried unanimously.
Commending Resolutions	Ms. Broz-Vaughan presented commending resolutions for former board members Moira Mazzi, Sandra Price-Stroble, and Varun Choudhary. On a motion by Ms. Lamb, properly seconded by Ms. Schroder, the board unanimously adopted the resolution honoring the service of former board member Moira Mazzi. On a motion by Ms. Graser, properly seconded by Mr. Vadella, the board unanimously adopted the resolution honoring the service of former board member Sandra Price-Stroble. On a motion by Mr. Vadella, properly seconded by Dr. Chung, the board unanimously adopted the resolution honoring the service of former board member Varun Choudhary.
Recess	Ms. McDonald recessed the meeting for a short break. She announced the meeting would reconvene at 12:45 p.m.
The Board recessed at 12:35 p.m. to reconvene at 12:45 p.m.	
The Board reconvened at 12:45 p.m.	
VACSB Update	Ms. Faison briefed the board on Virginia Association of Community Services Boards (VACSB) budget priorities for the 2026 General Assembly Session, which will be presented at the VACSB Public Policy Conference next week in Roanoke.
ADJOURNMENT	Ms. McDonald adjourned the meeting at 12:57 p.m.
The State Board adjourned at 12:57 p.m.	

NEXT MEETING SCHEDULED FOR WEDNESDAY, DECEMBER 10, 2025

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

DRAFT MINUTES

WRITTEN PUBLIC COMMENT

Received electronically Tuesday, September 23, 2025 12:19 PM

Public comment request for SEVTC mtg September 24, DBHDS State Board

Good afternoon,

Please allow me to provide public comment for 3 minutes tomorrow.

I represent the Family Council of Hiram Davis medical center Petersburg. My son is a SNF resident with profound Intellectual disabilities and related conditions.

Our families participated in 28 meetings virtually in 3 Subgroups about the future of Hiram Davis. Our Community Subgroup presentation with the future capacity needs of the subpopulations is omitted from the Sept 4 Commissioner Nelson Smith presentation.

A single Code Section for the closure of a MH psychiatric hospital does not cover our legal Code Sections and CMS regulations for Skilled Nursing facility Care.

Thanks for the opportunity to participate.

We have no access for planning on SEVTC care.

We strongly object to the architectural drawing for SEVTC SNF renovations with shared bedrooms with beds 4 ft apart and multiple contracts which are less than comparable care at Hiram Davis.

This flawed plan has inadequate capacity for a statewide system and far from our homes.

We are happy to discuss solutions and participate in the care plans for our loved ones.

Our lived experiences with complex needs including wheelchairs, oxygen, onsite pharmacy and cost savings ability for IV fluids and antibiotics onsite deserve to be heard.

The Nursing end users of the renovations are also excluded. Best practices and CDC guidelines 6ft apart for person centered care are compromised.

Thanks,

Martha Bryant, RN, Mother and Guardian

Amherst

UNFINISHED BUSINESS: BOARD PRIORITIES LETTER



COMMONWEALTH of VIRGINIA

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

NELSON SMITH
COMMISSIONER

STATE BOARD OF
BEHAVIORAL HEALTH AND
DEVELOPMENTAL SERVICES

R. BLAKE ANDER, CHAIR
Washington County

SANDY CHUNG, MD
Fauquier County

REBECCA GRACE
Richmond County

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Stafford County

DEBBIE MAFF
Bedford County

JANE McDONALD
Stafford County

NINA SCHROEDER
Richmond City

ANTHONY VADELLA
Powhatan County

VACANCY

September 24, 2025

The Honorable Glenn Youngkin
Governor of Virginia
Patrick Henry Building
P.O. Box 1475
Richmond, VA 23218

Dear Governor Youngkin:

Among its powers and duties pursuant to § 37.2-203 of the Code of Virginia, the State Board of Behavioral Health and Developmental Services is charged with the statutory responsibility to:

- review and comment on all budgets and requests for appropriations for the Department of Behavioral Health and Developmental Services (DBHDS) prior to their submission to the Governor; and
- advise the Administration and the General Assembly on matters relating to mental health, development, and substance use disorder services.

To that end, I am writing on behalf of the board to convey its priorities as you develop your 2026-28 budget proposal for presentation to the General Assembly in December.

At its biennial planning meeting in July, board members reviewed DBHDS's progress on budgetary and strategic initiatives, noting the Commonwealth's historic investments and systemic improvements, particularly through *Right Help, Right Now*, in recent years. Guided by the transformational impact of these major advancements, we offer recommendations in five policy areas for your consideration in the 2026-28 biennium.

Above all, the board strongly supports maintaining Virginia's commitment to the behavioral health and developmental services system transformation. We urge strategic continuity in the upcoming biennium, with special emphasis on crisis care, community supports, competency restoration, and the youth continuum. In particular, the board endorses:

1. Expanding system capacity, building on workforce sustainability investments, and increasing community-based services including support for Virginians with substance use disorders.

DRAFT MINUTES

The Honorable Glenn Youngkin

September 24, 2025

Page Two

2. Reducing overreliance on law enforcement, especially through utilization of crisis care, and decreasing the “criminalization” of behavioral health conditions.
 - Increase the use of special conservators of the peace (or SCOPs) for alternative custody and transportation.
 - Advance technologies that help crisis workers access and share information for more effective triage.
3. Financing waiver services and sustaining provider rates to ensure the availability and long-term success of integrated community settings for Virginians with developmental disabilities and their families.
4. Accelerating expansion of the community-based crisis continuum, which has shown the greatest impact on delivering effective treatment to the Commonwealth’s most vulnerable populations.
 - Provide additional support to build out the elements of the MARCUS Alert system that have proven to be effective, most notably crisis co-response teams and enhanced communication protocols, and other immediate crisis services (CITAC, CRCs, etc.).
 - Review and consider repealing or amending the Bed of Last resort Law to correct significant unintended consequences that overburden the state hospital system, law enforcement, community services boards, and many other system partners.
5. Prioritizing a comprehensive system of care to identify and meet the needs of Virginia’s infants, children, adolescents, and young adults as early as possible.
 - Maintain support for Early Intervention, school-based, and other youth services.
 - Promote the Virginia Mental Health Access Program (VMAP) and other training resources for child-serving providers to serve behavioral health concerns.
 - Incentivize private sector partners to increase access to mental health support services for children from birth to transition age.

The board appreciates your thoughtful consideration of its priorities for the behavioral health and developmental services system. We are hopeful these funding and policy requests will be looked upon favorably by you and the legislature.

Thank you for your continued leadership working with the General Assembly to ensure our communities receive the supports needed to provide life-changing services to all citizens in need.

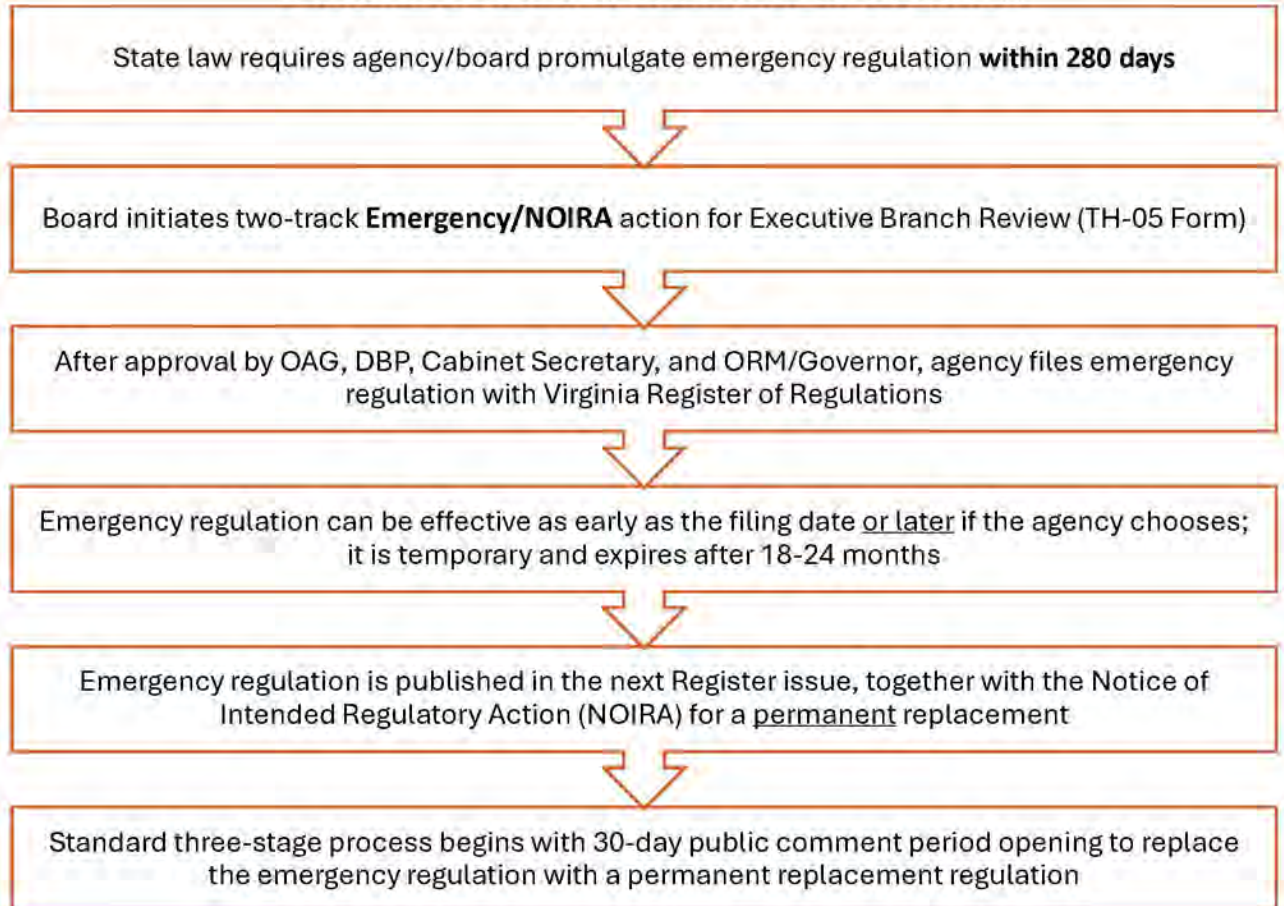
Sincerely,

R. Blake Andis, Chair

cc: The Honorable L. Louise Lucas, Chair, Senate Finance and Appropriations Committee
The Honorable Luke E. Torian, Chair, House Appropriations Committee
The Honorable Janet Kelly, Secretary of Health and Human Resources
Leah Mills, Deputy Secretary of Health and Human Resources
Members, State Board of Behavioral Health and Developmental Services
Nelson Smith, DBHDS Commissioner
Meghan McGuire, DBHDS Deputy Commissioner, Policy and Public Affairs

REGULATORY BUSINESS

EMERGENCY REGULATORY PROCESS OVERVIEW



NEW BUSINESS: COMMENDING RESOLUTIONS



COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Moira C. Mazzi

At its regular meeting on Wednesday, September 24, 2025, the State Board of Behavioral Health and Developmental Services unanimously adopted the following resolution:

WHEREAS, Moira Mazzi served the Commonwealth with distinction as a member of the State Board of Behavioral Health and Developmental Services for eight years; and

WHEREAS, Moira Mazzi was first appointed by Governor Terry McAuliffe to a full four-year term in 2017 and was subsequently appointed to a second full term by Governor Ralph Northam in 2021; and

WHEREAS, Moira Mazzi devoted generously of her time by serving as Vice Chair and as Chair of the Board; and

WHEREAS, during her tenure, Moira Mazzi did faithfully endeavor to protect the rights and safety of individuals and their families, and to strengthen Virginia's system of community mental health, developmental, and substance use disorder services; and

WHEREAS, Moira Mazzi's diligence, integrity, and commitment earned her the respect and admiration of the members of the Board, its staff, and all others associated with its activities; now, therefore, be it

RESOLVED, That the State Board of Behavioral Health and Developmental Services does hereby express its affection and gratitude to Moira Mazzi, for her many contributions to this body as a valued member and good friend; and be it

RESOLVED FURTHER, That this Resolution be made a part of the official minutes of the Board, and that a framed copy thereof be presented to Moira Mazzi, so that all may know of the high regard in which she is held.

NEW BUSINESS: COMMENDING RESOLUTIONS



COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Sandra Price-Stroble

At its regular meeting on Wednesday, September 24, 2025, the State Board of Behavioral Health and Developmental Services unanimously adopted the following resolution:

WHEREAS, Sandra Price-Stroble served the Commonwealth with distinction as a member of the State Board of Behavioral Health and Developmental Services for nearly 12 years, the maximum allowed by law; and

WHEREAS, Sandra Price-Stroble first joined the Board in 2014, filling an unexpired term, and was subsequently appointed to two full four-year terms; and

WHEREAS, Sandra Price-Stroble devoted generously of her time by serving as Vice Chair of the Board as well as chairing the Policy and Evaluation Committee and numerous ad-hoc committees; and

WHEREAS, during her tenure, Sandra Price-Stroble did faithfully endeavor to protect the rights and safety of individuals and their families, and to strengthen Virginia's system of community mental health, developmental, and substance use disorder services; and

WHEREAS, Sandra Price-Stroble's diligence, integrity, and commitment earned her the respect and admiration of the members of the Board, its staff, and all others associated with its activities; now, therefore, be it

RESOLVED, That the State Board of Behavioral Health and Developmental Services does hereby express its affection and gratitude to Sandra Price-Stroble, for her many contributions to this body as a valued member and good friend; and be it

RESOLVED FURTHER, That this Resolution be made a part of the official minutes of the Board, and that a framed copy thereof be presented to Sandra Price-Stroble, so that all may know of the high regard in which she is held.

NEW BUSINESS: COMMENDING RESOLUTIONS



COMMONWEALTH of VIRGINIA

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Varun Choudhary, M.D.

At its regular meeting on Wednesday, September 24, 2025, the State Board of Behavioral Health and Developmental Services unanimously adopted the following resolution:

WHEREAS, Varun Choudhary, M.D., served the Commonwealth with distinction as a member of the State Board of Behavioral Health and Developmental Services from 2018 until 2025; and

WHEREAS, during his tenure, Varun Choudhary did faithfully endeavor to protect the rights and safety of individuals and their families, and to strengthen Virginia's system of community mental health, developmental, and substance use disorder services; and

WHEREAS, Varun Choudhary's diligence, integrity, and commitment earned him the respect and admiration of the members of the Board, its staff, and all others associated with its activities; now, therefore, be it

RESOLVED, That the State Board of Behavioral Health and Developmental Services does hereby express its affection and gratitude to Varun Choudhary, for his many contributions to this body as a valued member and good friend; and be it

RESOLVED FURTHER, That this Resolution be made a part of the official minutes of the Board, and that a framed copy thereof be presented to Varun Choudhary, so that all may know of the high regard in which he is held.

RESOLVED FURTHER, That this Resolution be made a part of the official minutes of the Board, and that a framed copy thereof be presented to Varun Choudhary, M.D., so that all may know of the high regard in which he is held.

DRAFT MINUTES

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Policy and Evaluation Committee

DRAFT Minutes

SEPTEMBER 24, 2025

SOUTHEASTERN VIRGINIA TRAINING CENTER

2100 STEPPINGSTONE SQUARE, CHESAPEAKE, VIRGINIA 23320

This meeting was held in person with electronic or phone connection available.

Members Present: Jane McDonald (virtual), Cindy Lamb, Rebecca Graser

DBHDS Staff Present: Madelyn Lent, Public Policy Manager

Meghan McGuire, Deputy Commissioner, Policy and Public Affairs

Mary Broz-Vaughan, Director Office of Regulatory Affairs, State Board Liaison

Susan Puglisi, Regulatory Research Specialist

Chaye Neal-Jones, Director, Office of Enterprise Management Services (virtual)

Crystal Lipford, Director of Quality and Risk Management, Division of Facility Services (virtual)

Eric Billings, Director of Fiscal Services and Grants Management (virtual)

Rebecca Laubach, Director, Quality Improvement Analytics and Processes (virtual)

I. Call to Order

II. Welcome and Introductions

Jane McDonald called the meeting to order at 8:49 am.

III. Adoption of Agenda, September 24, 2025

Cindy Lamb moved to adopt the agenda. Rebecca Graser seconded. The agenda was adopted unanimously.

IV. Adoption of Minutes, July 9, 2025

Cindy Lamb moved to adopt the agenda. Rebecca Graser seconded. Jane McDonald abstained having not been present at the July 9 meeting. The minutes were adopted.

V. Review Policy Plan for FY2025 - FY2030

Madelyn Lent presented the policy review plan to the Policy Committee.

VI. Presentation of Background Reviews

The committee received background information on the next policies scheduled for periodic review: Policy 3000(CO) 74-10 Department Employee Appointments to Community Services Boards and Policy 1034 (SYS) 05-1 Partnership Agreement. DBHDS staff presented recommendations for revisions in concept for Policy 3000 to replace the term employees with workforce and define the new term to include all classified and wage employees as well as any contractor or subcontractor who has received compensation under a paid contract with DBHDS within the preceding twelve (12) months. The Board directed DBHDS staff to conduct a field review with the Community Services Boards (CSBs) to receive comments on the recommended revision. There were no recommendations for revisions for Policy 1034 and the Committee concluded the periodic review for this policy.

VII. Introduce Draft Revisions

The committee reviewed draft revisions recommended by the Department for Policy 2011 (ADM) 88-3 Naming of Buildings, Rooms, and Other Areas at State Facilities. The draft revisions update and operationalize the policy while maintaining the core requirements. Members questioned how cost of name changes would be accounted for in the decision-making process. It was noted that cost was included as a requirement to be included in the formal proposal developed by the Ad Hoc Committee for review by the facility director, Commissioner, State Board, and Secretary. Staff noted that they would confirm that the recommended revision to replace references to Governor with Secretary was consistent with the code section authorizing the Board to establish a policy to change the names of state facilities prior to the next meeting.

VIII. Presentation of Draft Revisions for Recommendation to the Full Board

The committee reviewed and discussed draft revisions for Policy 4018 (CSB) 86-9 Community Services Board Performance Contracts and the Department's recommendation to rescind Policy 6005 (FIN) 94-2 Retention of Unspent State Funds by Community Services Boards at the July 9th meeting.

The committee reviewed draft technical revisions for Policy 4018 (CSB) 86-9 Community Services Board Performance Contracts. Cindy Lamb motioned to recommend the revisions to the State Board, Rebecca Graser seconded the motion, and the recommendations were adopted unanimously.

The committee discussed DBHDS recommendation to rescind Policy 6005 (FIN) 94-2 Retention of Unspent State Funds by Community Services Boards. The committee reviewed comments received from CSBs through a field review of the recommendation to rescind. The committee reviewed the current performance contract language in Addendum I Appendix C: Unspent Balances Principles and Procedures. Meghan McGuire reviewed the Department's rationale for requesting the rescission of Policy 6005 and responded to committee members' questions. Committee members noted the comments received from the CSBs opposing the recommendation to rescind and determined that they needed more information to inform decision making on the policy. The committee chair asked if there was a motion to recommend that the state board rescind Policy 6005. No motion was made. The committee requested that the policy be placed on the agenda for the next committee meeting for continued discussion. The committee requested information on total unspent balances held by CSBs, how this total is distributed across CSBs, and how the CSBs have utilized these funds. Committee members also requested Department staff draft a recommendation for revision to the policy to be reviewed at the next committee meeting.

IX. Next Quarterly Meeting: December 10, 2025.

X. Adjournment

Cindy Lamb motioned to adjourn the meeting and Rebecca Graser seconded. The meeting was adjourned at 9:47 am.

All current policies of the State Board are here:

<https://dbhds.virginia.gov/about-dbhds/Boards-Councils/state-board-of-BHDS/bhds-policies/>

DRAFT MINUTES

DRAFT MINUTES

State Board of Behavioral Health and Developmental Services

**DINNER MEETING
Tuesday, September 23, 2025**

Western Tidewater Community Services Board (WTCSB)
7025 Harbour View Blvd., Suite 119, Suffolk, VA

MEMBERS PRESENT	Rebecca Graser Cindy Lamb Nina Schroder Tony Vadella
MEMBERS ABSENT	R. Blake Andis Sandy Chung, MD Debbie Marrs Jane McDonald
STAFF PRESENT	Mary Broz-Vaughan, Regulatory Affairs Director / State Board Liaison Madelyn Lent, Public Policy Manager Meghan McGuire, Deputy Commissioner, Policy and Public Affairs

CALL TO ORDER	Finding a quorum of the Board present, Ms. Graser called the dinner meeting to order at 6:10 p.m. Ms. Graser explained the purpose of the informal gathering was to receive information about community programs and services, noting the members would not discuss or transact public business.
PRESENTATION	Executive Director Brandon Rodgers provided an overview of Western Tidewater CSB services and delivered a presentation on community behavioral health clinics.
ADJOURNMENT	The meeting adjourned at 7:40 p.m.

STATE BOARD OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

**Policy and Evaluation Committee
DRAFT AGENDA**

DECEMBER 10, 2025

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

1220 BANK STREET, RICHMOND, VIRGINIA 23221

*This meeting will be held in person with a physical quorum present,
with electronic or phone connection available.*

- I. Call to Order**
- II. Welcome and Introductions (5 min)**
- III. Adoption of Agenda, December 10, 2025**
- IV. Adoption of Minutes, September 24, 2025**
- V. Review Policy Plan for FY2025 - FY2030 (5 min)**

A revision to the policy plan to delay future scheduled reviews by one meeting cycle and adjust the sequence of review for some of the Chapter 1: System Mission and Direction policies to better align reviews of closely related policies will be presented for the committee to vote on adoption.

VI. Introduce Draft Revisions (25 min)

The committee will continue discussion of Policy 3000 (CO) 74-10 Appointments of Department Employees to Community Services Boards. Field review comments received from Community Services Boards on proposed revisions will be presented.

The committee will continue discussion of Policy 6005 (FIN) 94-2 Retention of Unspent State Funds by Community Services Boards. The committee will review data requested by the committee at the September meeting and an initial draft of DBHDS recommended revisions for this policy. Revisions will then be sent to Community Services Boards for field review prior to the April 2026 committee meeting.

VII. Presentation of draft revisions for recommendation to the full board (10 min)

The committee reviewed draft revisions recommended by the Department for Policy 2011 (ADM) 88-3 Naming of Buildings, Rooms, and Other Areas at State Facilities at the September meeting. Revisions will be presented for the committee to vote on recommendation to the full board.

VIII. Next Quarterly Meeting: April 22, 2026.

IX. Adjournment

All current policies of the State Board are here: <https://dbhds.virginia.gov/about-dbhds/Boards-Councils/state-board-of-BHDS/bhds-policies/>.

July 2025 - April 2030

Category	Policy Number	Policy Name	Prior Review Date (month-year)	Next Review Date (month-year)
#2000 (ADM ST BD) --- ADMINISTRATION	2010(ADM)88-2	Policy Development and Education	Jul-21	Jul-25
#2000 (ADM ST BD) --- ADMINISTRATION	2011(ADM)88-3	Naming of Buildings, Rooms and Other Areas at State Facilities	Jul-21	Jul-25
#3000 (C O) --- CENTRAL OFFICE	3000(CO)74-10	Department Employee Appointments to Community Services Boards	Jul-21	Sep-25
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1034(SYS)05-1	Partnership Agreement	Dec-21	Sep-25
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1030(SYS)90-3	Consistent Collection and Utilization of Data in State Facilities and Community Services Boards	Dec-21	Apr-26
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1040(SYS)06-3	Consumer and Family Member Involvement and Participation	Jul-22	Apr-26
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1016(SYS)86-23	Policy Goal of the Commonwealth for a Comprehensive, Community-Based System of Services		Sep-26
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1038(SYS)06-1	The Safety Net of Public Services		Sep-26
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1021(SYS)87-9	Core Services		Dec-26
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1039(SYS)06-2	Availability of Minimum Core Services		Dec-26
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1035(SYS)05-2	Single Point of Entry and Case Management Services		Apr-27

#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1042(SYS)07-1	Primary Health Care		Jul-27
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1008(SYS)86-3	Services for Older Adults with Mental Health or Substance Use Disorders, Intellectual Disability, or Co-Occurring Disorders	Jul-22	Dec-27
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1041(SYS)06-4	Services for Individuals with Mental Health or Substance Use Disorders, Intellectual Disability, or Co-occurring Disorders Who are at Imminent Risk of Becoming Involved with	Oct-22	Apr-28
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1015(SYS)86-22	Services for Individuals with Co-occurring Disorders	Sep-23	Jul-28
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1036(SYS)05-3	Vision Statement	Dec-23	Jul-28
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1044(SYS)12-1	Employment First	Jul-22	Sep-28
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1004(SYS)83-7	Prevention Services	Sep-23	Sep-28
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1023(SYS)89-1	Workforce Cultural and Linguistic Competency	Apr-23	Dec-28
#4000 (CSB) --- COMMUNITY SERVICES BOARDS/COMMUNITY PROGRAMS	4023(CSB)86-24	Housing Supports	Apr-24	Apr-29
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1007(SYS)86-2	Behavioral Health and Developmental Services for Children and Adolescents and Their Families	Apr-24	Apr-29
#4000 (CSB) --- COMMUNITY SERVICES BOARDS/COMMUNITY PROGRAMS	4038(CSB)94-1	Department and CSB Roles in Providing Services to Children Under the Comprehensive Services Act for At-Risk Youth and Families	Apr-24	Jul-29
#5000 (FAC) --- STATE MENTAL HEALTH AND MENTAL RETARDATION FACILITIES	5010(FAC)00-1	State Facility Uniform Clinical and Operational Policies and Procedures	Dec-24	Jul-29

#5000 (FAC) --- STATE MENTAL HEALTH AND MENTAL RETARDATION FACILITIES	5008(FAC)87-12	Accreditation/Certification	Dec-24	Sep-29
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1043(SYS)08-1	Disaster Preparedness	Apr-23	Sep-29
#5000 (FAC) --- STATE MENTAL HEALTH AND MENTAL RETARDATION FACILITIES	5006(FAC)86-29	Razing of Dilapidated Buildings	Oct-24	Dec-29
#4000 (CSB) --- COMMUNITY SERVICES BOARDS/COMMUNITY PROGRAMS	4018(CSB)86-9	Community Services Board Performance Contracts	Apr-25	Apr-29
#4000 (CSB) --- COMMUNITY SERVICES BOARDS/COMMUNITY PROGRAMS	4010(CSB)83-6	Local Match Requirements for Community Services Boards	Oct-24	Jul-29
#6000 (FIN) --- FINANCIAL MANAGEMENT	6005(FIN)94-2	Retention of Unspent State Funds by Community Services Boards	Apr-25	Dec-29
#2000 (ADM ST BD) --- ADMINISTRATION	2010 (ADM ST BD) 10-1	Review and Comment on BHDS Budget Priorities	Oct-24	Apr-30
#1000 (SYS) --- SYSTEM MISSION AND DIRECTION	1028(SYS)90-1	Human Resource Development	Apr-25	Apr-30

POLICY MANUAL

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

POLICY 3000 (CO) 74-10 Appointments of Department Employees to Community Services Boards

Authority	Board Minutes Dated: September 25, 1974 Effective Date: September 25, 1974 <u>Approved by Board Chairman: s/Richard M. Gillis.</u>
References	§ 37.2-203, § 37.2-304, § 37.2-500, § 37.2-501 § 37.2-601, and § 37.2-602 of the Code of Virginia (1950)
Background	Originally, the Board received a number of inquiries about the appointment of an employee of the Department to a community services board. Also, concerns were raised regarding possible perceptions of conflicts of interest if Department employees served on CSBs. In response to these concerns, the Board adopted this policy. Section 37.2-203 of the Code of Virginia authorizes the Board to adopt policies governing the operation of state hospitals, training centers, and community services boards and behavioral health authorities. Section 37.2-304 authorizes the Commissioner to supervise and manage the Department and its state facilities. Sections 37.2-500 and 37.2-601 authorize the establishment of community services boards and behavioral health authorities, hereafter referred to as CSBs. Finally, § 37.2-501 and § 37.2-602 govern the appointment of CSB board members by the governing bodies of the cities and counties that established the CSBs. Those two Code sections do not address appointments of Department employees to CSBs. Consequently, because appointments to CSBs are made by local governments rather than CSBs, those appointments are not under the purview of the Board's policy authority. However, the Board may adopt policy that directs the Department to ensure that its employees do not accept appointments as CSB board members.
Purpose	To prohibit Department employees from accepting appointments as CSB board members.
Policy	It is the policy of the Board that the Department, in order to avoid any appearance

Continued on next page

Policy 3000 (CO) 74-10, Continued

of impropriety or conflict of interest, shall ensure that ~~members of its classified employees~~ *workforce* shall not accept appointments as CSB board members. *For the purposes of this policy, the term workforce references all classified and wage employees as well as any contractor or subcontractor who has received compensation under a paid contract with DBHDS within the preceding twelve (12) months.*

**State Board of Behavioral Health and Developmental Services
Policy Development and Evaluation Committee
December 10, 2025**

COMMENTS ON ONE POLICIES: ONE WINDOW (OCTOBER 31 - NOVEMBER 24)

Stage I:	Initiating Review - Request for Comment
Policy:	Policy 3000 (CO) 74-10 Appointments of Department Employees to Community Services Boards
Window:	October 31 – November 24

Date Rcv'd	Contact	Comment
10/31/2025	David Coe, Executive Director, Colonial Behavioral Health	"I fully support the position that DBHDS employees cannot be allowed to accept appointments to CSB Boards of Directors, and thank you for your restatement of that intention in this Policy Review."
11/11/2025	Anonymous	"When someone on a CSB Board of Directors is an employee, contractor, subcontractor, or a community partner or appointee serving an essential role for DBHDS, it results in a conflict of interest. We fully support this change and advocate that the policy be broadened to include others who directly function within administrative or clinical processes with DBHDS or CSBs."

Updated: 07/26/2011

Updated: 07/17/2019

Updated: ??/??/????

POLICY MANUAL

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

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

Authority	Board Minutes Dated: <u>July 27, 1994</u> Effective Date: <u>July 1, 1994</u> Approved by Board Chairman: <u>James G. Lumpkin</u>
References	<i>Realizing the Vision: Barriers to an Integrated System</i> , Department of Mental Health, Mental Retardation and Substance Abuse Services, January 27, 1993 State Board Policy 4018 (CSB) 86-9 Community Services Performance Contracts Community Services Performance Contract § 37.2-508 and § 37.2-509 of the Code of Virginia (1950)
Supersedes	STATE BOARD POLICY 3002 (CO) 86-16 System-wide Staff Training
Background	Before FY 1995, the Department applied year-end balances of unspent state funds at community services boards and the behavioral health authority, hereafter referred to as CSBs, to the next year's state fund allocations for CSBs so that the state appropriation and balances equaled state awards. If state balances reported in the fall were below the estimates projected in the previous spring's budget deliberations, a deficit could occur. This happened in FY 1993, and a deficit was averted only by a transfer of funds to the CSB appropriation. <i>Realizing the Vision: Barriers to an Integrated System</i>, the Visions Task Force report, recommended preserving any unbudgeted and unspent revenues within the system. ~~The Visions Financial Resources Committee proposed amending § 37.1-199(a) of the Code of Virginia so that CSBs could retain unspent revenues to expand and enhance services. The State Board supported this amendment, but it was not introduced, based on a determination that it could be implemented administratively.~~ Subsequently, the Virginia Association of Community Services Boards and the Department developed a proposal, the basis for this policy, that prevented future deficits, instituted a budget process in which CSB awards equaled the state appropriation, and implemented the Visions recommendation. <i>The Code of Virginia §37.2-508 and §37.2-608 outlines the performance contract as the identified contracting mechanism the Department shall use to develop and initiate negotiation of community services requirements, oversight and monitoring</i>

Continued on next page

of all state-controlled funds awarded to the community services boards.

State Board POLICY 4018 (CSB) 86-9 Community Services Performance Contracts recognizes the community services performance contract as the primary accountability mechanism between the Department and individual CSBs. The performance contract governs unspent balances with detail and enforceability while incorporating substantive protections to both prevent future deficits and limit accrual of funds to support effective and efficient allocations of resources.

Purpose To ~~establish~~ *define* the ability of CSBs to retain balances of unspent state general funds *through the performance contract process.*

Policy It is the policy of the Board that:

- *requirements for unspent fund balances for state general funds must be defined in the performance contract and changes must be negotiated through the Department's performance contract process in collaboration with the CSBs. The performance contract may:*
 - ~~the Department shall~~ allow CSBs to retain balances of unspent state general funds after the end of the fiscal year in which the Department granted those funds *in a reserve fund*;
 - *define the maximum acceptable amount of each unspent state fund balance that a CSB may accumulate in reserve funds and define the maximum total accumulation of state funds in reserve.*
- the Department ~~shall~~ *may* allocate the funds in the CSB state appropriation ~~without~~ applying estimated year-end balances of unspent state general funds to the next year's CSB awards of state general funds;
- ~~based on~~ *Pursuant to* the General Assembly Appropriations Act prohibition against using state funds to supplant the funds provided by local governments for existing services, there should be no reduction of local matching funds as a result of a CSB's retention of any balances of unspent state general funds; and
- ~~if~~ a CSB delivers less than the levels of services in its final approved Community Services Performance Contract, established pursuant to § 37.2-508 of the Code of Virginia and State Board Policy 4018, while generating significant balances of unspent state general funds, it may have to return ~~some~~ *a portion or all* of its balances to the Department or its state fund allocations in the next fiscal year may be reduced.

~~It is also the policy of Board that the Department shall apply procedures, which are authorized by § 37.2-509 of the Code of Virginia and are consistent with those~~

~~in the Community Services Performance Contract, to retrieve unspent state general funds from or reduce future state general fund allocations to a CSB that delivers less than the levels of services in its final approved Performance Contract while generating significant balances of unspent state general funds.~~

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

POLICY MANUAL

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

POLICY 2011 (ADM ST BD) 88-3 Changing the Names of State Facilities

Authority	Board Minutes Dated: <u>June 22, 1988</u> Effective Date: <u>August 24, 1988</u> Approved by Board Chairman: <u>s/James C. Windsor</u>
References	§ 37.2-203 of the Code of Virginia (1950)
Background	The <i>State Board of Behavioral Health and Developmental Services (the “Board”)</i> has a long history of naming buildings at state hospitals and training centers, hereafter referred to as state facilities, operated by the Department. In 1981, the Board asked the Department to propose a statement that would establish the Board’s policy for naming buildings at state facilities and the procedure for implementing that policy. In 1988 the original policy was revised to include rooms and other areas, e.g. recreational areas, under the purview of the policy. <i>In 2025, the policy was revised to modernize language, clarify stakeholder engagement requirements, and align procedures with current best practices in governance, transparency, and community involvement. It also updated timelines, documentation requirements, and responsibilities to ensure consistency across state facilities.</i> <i>Subsection 9 of § 37.2-203 of the Code of Virginia authorizes the Board “to change the names of state facilities.” This policy sets forth the procedures by which such changes may occur.</i>
Purpose	~~To describe the role of the in changing the names of state facilities. To establish the official process for changing the names of state facilities under the jurisdiction of the Board, ensuring decisions are transparent, inclusive, and consistent with statutory authority.~~
Policy	It is the policy of the Board that it may change the name of any state facility ~~as~~

Continued on next page

~~authorized in accordance with the authority granted under § 37.2-203(9) and the following procedures: subsection 9 of § 37.2-203 of the Code of Virginia, and shall do so in accordance with the following procedures.~~

1. Initiation of Renaming

- a. A name change proposal should be considered when one or more of the following apply:
 - i. The existing name is no longer reflective of the facility's mission, services, or population served.
 - ii. The current name is outdated, contains historical associations now judged inappropriate, or causes confusion.
 - iii. To honor an individual (living or deceased) whose contributions to behavioral health, disability services, or the facility / community are outstanding and enduring.
 - iv. Community identity, location, or other geographic naming considerations make a change desirable.
 - v. Other extenuating circumstances as documented and evaluated.
- b. A name change may only be considered when deemed appropriate by the facility director, the Commissioner, and the Secretary of Health and Human Resources (the Secretary).

2. Formation of Ad Hoc Committee

- a. When a name change is deemed appropriate by the facility director, the Commissioner, and the Secretary, the facility director shall appoint an ad hoc committee of at least three members to develop the formal proposal.
- b. The committee shall include the following elements in the proposal:
 - i. Current name and rationale for the renaming proposal
 - ii. Proposed new names, each with a written explanation and justification
 - iii. Input or feedback collected from stakeholders
 - iv. Any cost estimate associated with renaming
 - v. Potential impact on operations, identity, or community perception

3. Facility Director Review

- a. The facility director shall review, approve, or revise the proposal and forward to the Commissioner.

4. Commissioner Review

- a. The Commissioner shall approve, revise, or disapprove the proposal.
 - b. If approved or revised, the Commissioner shall forward the proposal to the Board at least 120 days prior to a regularly scheduled Board meeting.
 - c. If disapproved, the Commissioner shall notify the facility director and provide a summary of the reason for the denial.
-

5. Consultation Period

- a. During the 120-day period, the Commissioner and the Chair of the Board may consult with stakeholders. Stakeholders may include:
 - i. Individuals receiving services
 - ii. Family members
 - iii. Advocacy groups
 - iv. Local governments
 - v. State legislators
 - vi. Others as deemed appropriate

6. Secretary Input

- a. The Commissioner and the Chair shall consult with the Secretary to obtain input on the proposed new name.

7. Board Action

- a. Following the Commissioner's recommendation, the Board will place the renaming proposal on its agenda.
- b. At a regularly scheduled Board meeting, the Board shall consider the recommendations and vote whether to approve the proposed facility name change.

8. Implementation

- a. Upon Board approval, the facility director will develop a timeline for implementing the name change, including:
 - i. Signage replacement
 - ii. Updating documents and websites
 - iii. Communications to internal and external stakeholders

9. Records and Reporting

- a. All proposals, justifications, and decisions shall be documented and retained by DBHDS.
- b. The Commissioner shall report annually to the Board if any renaming activity occurs.

- ~~• The state facility director shall appoint an ad hoc committee of three or more members to develop a list of three recommendations of new names for the facility when it is deemed appropriate by the facility director, the Commissioner, and the Governor to change the name of the state facility.~~
 - ~~• The ad hoc state facility committee shall develop a brief explanation and justification for each of the names it recommends.~~
 - ~~• The state facility director shall review and approve or revise the ad hoc committee's recommendations and forward them to the Commissioner for his review and action.~~
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Policy 2011(ADM) 88-3, Continued

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- ~~• The Commissioner shall approve, revise, or disapprove the recommendations. If he approves or revises them, he shall forward the recommendation or recommendations to the Board at least 120 days prior to a regularly scheduled board meeting.~~
 - ~~• The Commissioner and the Chair of the Board shall discuss the proposed new name to come to agreement on recommendations to send to the Governor. The Commissioner and the Chair may consult with other interested or affected parties, including individuals receiving services, family members, advocacy groups, local governments, and state legislators, about the recommended new name during the 120-day period.~~
 - ~~• The Commissioner and the Chair of the Board shall communicate and consult with the Governor to obtain his input on the proposed new name.~~
 - ~~• The Board shall consider the recommendation and take action on the recommendation to change the name of the state facility at a regularly scheduled board meeting.~~
-

UNFINISHED BUSINESS

Consideration of technical amendments recommended by Policy and Evaluation Committee

Included in Agenda Packet:

- Policy 4018 (CSB) 86-9 – Community Services Board Performance Contracts

POLICY MANUAL

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

POLICY 4018 (CSB) 86-9 Community Services Performance Contracts

Authority Board Minutes Date: October 22, 1986
Effective Date: November 19, 1986
Approved by Board Chairman: s/James C. Windsor

References Report of the Commission on Mental Health and Mental Retardation, 1980
Final Report on Core Services and Formula Funding, 1983
§ 37.2-508 and § 37.2-608 of the Code of Virginia
Current Core Services Taxonomy
Current Community Services Performance Contract
STATE BOARD POLICY 1030 (SYS) 90-3 Consistent Collection and Use of
Data About Individuals and Services

Background The Commission on Mental Health and Mental Retardation identified a need for increased accountability in the community services board system. In its Final Report on Core Services and Formula Funding, the Department proposed developing a performance contracting system to address this need. This system would be based on contractual arrangements between the Department and individual community services boards or the behavioral health authority, hereafter referred to as CSBs, within the core services framework. The General Assembly accepted this report in 1984.

The Department developed the first community services performance contract in 1983 with extensive participation from CSBs and piloted the implementation of performance contracts with some CSBs in 1985. The Department and the Virginia Association of Community Services Boards revised the first core services taxonomy and the first performance contract in 1988. These documents continue to evolve in response to the changing needs of individuals receiving services and the new priorities and directions of the services system.

An original purpose of this policy was the elimination of the program application then submitted by CSBs. This application was a detailed line item budget that focused on revenues and expenditures rather than on services and individuals receiving services. The 1990 review of this policy revealed that 26 CSBs had

eliminated dual submission of an application and a performance contract. By 1992, the Department no longer used the program application, greatly reducing paperwork for CSBs. The shift from a budget-focused program application to a performance contract focused on services and individuals receiving services was the first of three major developments in the evolution of increased CSB accountability.

The House Joint Resolution 240/225 Joint Subcommittee, chaired by Senator Joseph V. Gartlan, Jr. and Delegate Franklin P. Hall, studied the services system in the mid-1990s and rewrote most of Chapter 10 in Title 37.1 of the Code of Virginia, the CSB statute, in House Bill (HB) 428 (1998). This bill reflected the first comprehensive review and major revision of Chapter 10 since the original legislation was enacted in 1968. HB 428 formally recognized the performance contract as the primary accountability and funding mechanism between the Department and CSBs. The bill identified three types of CSBs, which clarified relationships and accountability between CSBs and their local governments. The bill also identified CSBs as the single points of entry into publicly funded mental health, developmental, and substance use disorder services. HB 428 was the second major development in the evolution of increased CSB accountability to the Department and to the local governments that established CSBs. In its 2005 session, the General Assembly ~~revised~~ *recodified* Title 37.1 and, in § 37.2-508 and § 37.2-608, continued its recognition of the performance contract as the primary accountability and funding mechanism between the Department and CSBs. *In 2012 these code sections were amended by HB 552 and HB 1295. HB 552 was an omnibus bill that replaced terminology used to reference people with developmental disabilities throughout the Code of Virginia. HB 1295 modified requirements for contract renewal across multiple areas of the code from annual to at least annually.*

The Joint Legislative Audit and Review Commission published a report in 2022 on CSB Behavioral Health Services, and the Behavioral Health Commission published a report in 2023 on STEP-VA Implementation and Performance Monitoring. Both reports included recommendations for modifying performance contract requirements. The General Assembly amended code requirements for performance contracts in § 37.2-508 and § 37.2-608 in the 2023 legislative session enhancing requirements for state oversight of services and contract enforcement. The General Assembly also established additional agency reporting requirements on performance contracts in the 2024-2026 biennial budget. These changes allow the Department to have consistent monitoring of CSB performance and enforcement of performance contract requirements

The performance contract consists of three documents. The performance contract itself contains a standard contract body and numerous exhibits, including specific information about services provided and individuals receiving services through the contract and various continuous quality improvement performance expectations and measures. The Central Office, State Facility, and Community

Services Board Partnership Agreement, recognized and supported in STATE BOARD POLICY 1034 (SYS) 05-1, reflects the fundamental, positive evolution in the relationship between CSBs and the Department to a more collegial partnership. The CSB Administrative Requirements document contains externally imposed requirements and some long term, relatively unchanging Department requirements that CSBs and the Department must meet. The last two documents are incorporated into and made a part of the performance contract itself by reference.

~~The Community Consumer Submission (CCS), discussed in STATE BOARD POLICY 1030 (SYS) 90-3, is the third major development in the evolution of CSB accountability. Previously, CSBs provided only aggregate data about individuals receiving services through the Community Automated Reporting System (CARS). With the advent the CCS in FY 2004, CSBs began reporting demographic and clinical data about individuals and data about the services they received to the Department in each program area (mental health, developmental, and substance use disorder services).~~

Purpose

Recognize the community services performance contract as the primary accountability mechanism between the Department and individual CSBs.

Policy

It is the policy of the Board that the Department and each CSB shall enter into a community services performance contract for the purpose of funding services provided directly or contractually by the CSB in a manner that

- ensures accountability to the Department;
- assures quality of care for individuals receiving services;
- promotes a fully collaborative partnership process through which CSBs, the Department's central office, and state facilities make decisions and resolve problems at the level closest to the issue or situation whenever possible; and
- implements the vision, articulated in STATE BOARD POLICY 1036 (SYS) 05-3, of a system of quality recovery-oriented services and supports that respects the rights and values of individuals with mental illnesses, intellectual disability, other developmental disabilities who are eligible for or are receiving Medicaid developmental disability waiver services, or substance use disorders. The system is driven by individuals receiving services and promotes self-determination, empowerment, recovery, resilience, health and overall wellness, and the highest possible level of participation by individuals receiving services in all aspects of community life, including work, school, family, and other meaningful relationships.

It also is the policy of the Board that the performance contract shall be the primary accountability and funding mechanism for a CSB with the Department. The contract shall define the CSB's responsibilities and identify the core services the CSB will provide and their costs by the categories and subcategories of core

services, defined in the current ~~core~~ services taxonomy, for each program area (mental health, developmental, and substance use disorder services). The contract also shall include all of the funds that the CSB expects to receive for services.

Further, it is the policy of the Board that a CSB shall provide periodic reports to the Department on the accomplishment of its contract objectives, responsibilities, and requirements using the ~~CARS, CCS, and other~~ *data* mechanisms developed collaboratively by the Department and CSBs, as specified in the performance contract.

It also is the policy of the Board that the performance contract shall be the primary accountability and funding mechanism for the Department with a CSB. The contract shall define the Department's responsibilities and specify the amounts of funds the Department will provide to support the services shown in the performance contract.

Further, it is the policy of the Board that the Department shall monitor a CSB's accomplishment of its contract objectives, responsibilities, and requirements through periodic reports submitted by the CSB using the ~~CARS, CCS, and other~~ *data reporting* mechanisms developed collaboratively by the Department and CSBs, as specified in the performance contract.

Finally, it is the policy of the Board that the Department shall provide feedback to the CSB and its board of directors about the CSB's accomplishment of its contract objectives, responsibilities, and requirements.

REGULATORY BUSINESS

Emergency/NOIRA Action | Align Licensing Regulations with Redesigned Medicaid Service: Coordinated Specialty Care (CSC)

Included in Agenda Packet:

- DRAFT Agency Background Document (TH-05)
- DRAFT Amendments to DBHDS Licensing Regulations (12VAC35-105)

Background:

Virginia's behavioral health system is undergoing a multi-phased, interagency process of transformation to enhance the service delivery system. As part of this transformative effort, the General Assembly amended the 2024-26 appropriation act ([Item 293 B](#)) directing the board to align DBHDS Licensing Regulations with the modifications being made to Medicaid behavioral health services.

To comply with the legislative mandate, the board must amend the regulations to ensure consistency with the following newly funded Medicaid services:

- Community Psychiatric Support and Treatment (CPST)¹;
- **Coordinated Specialty Care (CSC)**; and
- Mental Health Clubhouse Services, entitled Recovery and Empowerment Center (REC).

The authorizing budget language requires the board's emergency regulations to become effective by February 6, 2026. (A standard regulatory action to establish permanent regulations will follow this emergency action.)

→ *Refer to this flowchart for more information about the emergency regulatory process:* <https://www.townhall.virginia.gov/um/chartemergencystate.pdf>

Justification:

The goal of CSC is to provide comprehensive and recovery-oriented treatment for individuals experiencing a first episode of psychosis. CSC aims to improve the quality of life and social and clinical outcomes for individuals served by offering a team-based approach that includes collaborative treatment planning, individual and family therapy, medication management, and support for education and employment goals.

This action will improve access to a continuum of high-quality behavioral health services for Virginians and ensure CSC providers adhere to a base level of model fidelity. Consistency between DBHDS licensing regulations and DMAS modifications to behavioral health services is important for licensed providers as well as for individuals receiving services and their families.

Action Needed:

Authorize an Emergency/NOIRA action to align the Licensing Regulations with redesigned Medicaid services for Coordinated Specialty Care (CSC) and to initiate the process for permanent regulations.

¹ Emergency/NOIRA for CPST adopted by the board at its September 24, 2025, meeting.


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Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services (DBHDS)
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC35-105
VAC Chapter title(s)	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (12VAC35-105)
Action title	Alignment with Medicaid behavioral health services redesign: Coordinated Specialty Care (CSC)
Date this document prepared	November 19, 2025

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

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of the subject matter, intent, and goals 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 or changes. If applicable, generally describe the existing regulation.

[Item 293 B](#) of the 2024-2026 Appropriations Act directs the State Board of Behavioral Health and Developmental Services to promulgate emergency regulations that align its provider licensing regulations with the modifications being made to Medicaid behavioral health services pursuant to Item 288 XX. [Item 288 XX](#) states, in relevant part:

Effective July 1, 2024, the Department of Medical Assistance Services (DMAS) shall have the authority to modify Medicaid behavioral health services such that: (1) legacy services that predate the current service delivery system, including Mental Health Skill Building, Psychosocial Rehabilitation, Intensive In Home

Services, and Therapeutic Day Treatment are phased out; (2) legacy youth services are replaced with the implementation of tiered community based supports for youth and families with and at-risk for behavioral health disorders appropriate for delivery in homes and schools, (3) legacy services for adults are replaced with a comprehensive array of psychiatric rehabilitative services for adults with Serious Mental Illness (SMI), including community-based and center-based services such as independent living and resiliency supports, community support teams, and psychosocial rehabilitation services, (4) legacy Targeted Case Management- SMI and Targeted Case Management- Serious Emotional Disturbance (SED) are replaced with Tiered Case Management Services.

To comply with the General Assembly mandates, the State Board shall adopt emergency actions that restructure DBHDS Licensing Regulations to align with the following newly funded Medicaid behavioral health categories: Community Psychiatric Support and Treatment (CPST); Coordinated Specialty Care (CSC); and Mental Health Clubhouse Services (Clubhouse).

This regulatory action amends the DBHDS Licensing Regulations to establish the newly licensed service of CSC. (The Board adopted an Emergency/NOIRA action for the CPST service at its September 24, 2025, meeting.)

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.

Board – State Board of Behavioral Health and Developmental Services
CSC – Coordinated Specialty Care
DBHDS – Department of Behavioral Health and Developmental Services
DMAS – Department of Medical Assistance Services

Mandate and Impetus (Necessity for Emergency)

Explain why this rulemaking is an emergency situation in accordance with § 2.2-4011 A and B of the Code of Virginia. In doing so, either:

- a) Indicate whether the Governor's Office has already approved the use of emergency regulatory authority for this regulatory change.*
- b) Provide specific citations to Virginia statutory law, the appropriation act, federal law, or federal regulation that require that a regulation be effective in 280 days or less from its enactment.*

As required by § 2.2-4011, also describe the nature of the emergency and of the necessity for this regulatory change. In addition, delineate any potential issues that may need to be addressed as part of this regulatory change.

The General Assembly amended the appropriation act ([Item 293 B](#)) to direct the State Board of Behavioral Health and Developmental Services to promulgate emergency regulations to "align licensing regulations with the modifications being made to Medicaid behavioral health services" in collaboration with DMAS.

The authorizing budget language requires the board's emergency regulations to become effective within 280 days of the budget's final adoption on May 2, 2025. (A regulatory action to establish permanent regulations will follow this emergency action.)

Legal Basis

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

The State Board of Behavioral Health and Developmental Services was directed by the General Assembly through the 2024-26 appropriation act to promulgate emergency regulations that align its provider licensing regulations with the modifications being made to Medicaid behavioral health services. [Item 293 B of the 2024-2026 Budget Bill](#) mandates the changes within this regulatory action (as well as the Recovery and Empowerment Center emergency action and the CPST action already adopted).

Section 37.2-203 of the Code of Virginia gives the board 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 board voted to adopt this regulatory action at its meeting on _____.

Purpose

Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.

The purpose of this regulatory action is to comply with the legislative mandate by aligning DBHDS licensing regulations with ongoing interagency efforts to enhance Virginia's behavioral health services system. In particular, the changes in this regulatory action establish the newly licensed service of CSC.

As a newly funded Medicaid behavioral health category, the goal of CSC is to provide comprehensive and recovery-oriented treatment for individuals experiencing a first episode of psychosis. CSC aims to improve the quality of life and social and clinical outcomes for individuals served by offering a team-based approach that includes collaborative treatment planning, individual and family therapy, medication management, and support for education and employment goals.

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) Definitions necessary for the integration of CSC into the Licensing Regulations;
- 2) Admission criteria for CSC;
- 3) Discharge criteria for CSC;
- 4) Minimum requirements for CSC treatment teams and staffing; and
- 5) Minimum requirements for CSC service delivery.

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 transformation to enhance the service delivery system. This requires coordination among agencies with responsibilities for licensing, funding, and oversight behavioral health services in the Commonwealth.

The primary advantages of this regulatory action include (1) improving access to a continuum of high-quality behavioral health services for Virginians; (2) ensuring CSC providers adhere to a base level of model fidelity; and (3) reducing administrative burden by aligning provider licensing regulations with Medicaid service expectations.

There are no known disadvantages to the public or the Commonwealth.

Alternatives to Regulation

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

There are no alternatives to the regulatory changes contained herein that could achieve the essential purpose of this action, which itself is mandated by the General Assembly.

The amendments are limited to those that are necessary to ensure consistency between DBHDS licensing regulations and DMAS modifications to Medicaid behavioral health services. Misalignment between the two would be problematic for licensed providers of behavioral health services, including small business providers, as well as for individuals receiving services and their families.

Periodic Review and Small Business Impact Review Announcement

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

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

The Department of Behavioral Health and Developmental Services is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, and (iii) the potential impacts of the regulation.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: <https://townhall.virginia.gov>. Comments may also be submitted by mail or email to Susan Puglisi, 1220 Bank Street, Richmond Virginia, 23219, or susan.puglisi@dbhds.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will not be held following the publication of the proposed stage of this regulatory action.

Detail of Changes

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

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

Table 1: Changes to Existing VAC Chapter(s)

Current 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.		Definitions for the Licensing Regulations.	Addition of the following terms: <u>"Coordinated specialty care" or "CSC"</u> means an evidence-based treatment approach that supports the recovery of adolescents and young adults experiencing an initial onset of psychosis. CSC provides coordinated, targeted treatment in the early stages of mental illness through integrated medical, psychological, and rehabilitative interventions. <u>"CSC rehabilitation skill-building"</u> means facilitating wellness and autonomy through the restoration of skills, as set forth in the plan of care, in symptom management, interpersonal relationships, communication, problem solving, coping skills, and community integration.

		<u>"Designated employee" means a provider's named employee or contractor who is at least 18 years of age and who has met the appropriate prerequisites as specified in 12VAC35-105.</u> <u>"Health literacy support" means both (i) medication administration by staff working within the scope of their practice and (ii) support regarding mental health and associated health risks, monitoring for adverse side effects or results of that medication, support regarding the role of prescription medications and their effects, including side effects, and the importance of compliance and adherence. Services are provided with family or caregivers when they are for the direct benefit of the individual.</u> <u>"LMHP-resident in psychology" or "LMHP-RP" means an individual in a residency as that term is defined in 18VAC125-20-10 for clinical psychologists. An LMHP-RP shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65. LMHP-RPs also include licensed psychological practitioners working under supervision of a licensed clinical psychologist in accordance with 18VAC125-20-58 and 18VAC125-20-59.</u> <u>"Psychotherapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.</u> Edits to the term: <u>"Credentialed addiction treatment professional" means a person who</u>

			possesses one of the following credentials issued by the appropriate health regulatory board: (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) a licensed nurse practitioner or a licensed physician assistant with experience or training in addiction medicine; (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical social worker; (vi) a licensed professional counselor; (vii) a licensed nurse practitioner with experience or training in psychiatry or mental health; (viii) a licensed marriage and family therapist; (ix) a licensed substance abuse treatment practitioner; (x) a resident who is under the supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and is registered with the Virginia Board of Counseling; (xi) a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology (18VAC125-20-10); or (xii) a supervisee in social work who is under the supervision of a licensed clinical social worker and is registered with the Virginia Board of Social Work (18VAC140-20-10); or (xiii) a licensed <u>psychological practitioner working under supervision of a licensed clinical psychologist in accordance with 18VAC125-20-58 and 18VAC125-20-59.</u> Likely impact: Clearer regulations. Alignment with Medicaid service changes and current evidence-based practices and terminology to provide person-centered treatment.
12VAC35-105-30. Licenses.		Lists those services which require to be licensed by DBHDS.	Addition of the license type: Coordinated specialty care. Likely impact: Clearer regulations. Alignment with Medicaid service changes and current evidence-based practices and terminology to provide person-centered treatment.

	12VAC35-105-1426. Admission Criteria		Intent: Provide clear admission requirements within CSC programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1427. Discharge criteria.		Intent: Provide clear discharge requirements within CSC programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1428. Service delivery		Intent: Provide clear service delivery requirements within CSC programs. Impact: Robust, effective mental health treatment within the Commonwealth.
	12VAC35-105-1429. Treatment team and staffing.		Intent: Provide clear requirements to providers of CSC services specifically related to personnel. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.

Project 8524 - Emergency/NOIRA

Department of Behavioral Health And Developmental Services

Coordinated Specialty Care (CSC)

12VAC35-105-20. Definitions.

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

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

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

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

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

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

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

"ASAM" means the American Society of Addiction Medicine.

"Assertive community treatment service" or "ACT" means a self-contained interdisciplinary community-based team of medical, behavioral health, and rehabilitation professionals who use a

team approach to meet the needs of an individual with severe and persistent mental illness. ACT teams:

1. Provide person-centered services addressing the breadth of an individual's needs, helping the individual achieve his personal goals;
2. Serve as the primary provider of all the services that an individual receiving ACT services needs;
3. Maintain a high frequency and intensity of community-based contacts;
4. Maintain a very low individual-to-staff ratio;
5. Offer varying levels of care for all individuals receiving ACT services and appropriately adjust service levels according to each individual's needs over time;
6. Assist individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles, such as worker, family member, resident, spouse, tenant, or friend;
7. Carry out planned assertive engagement techniques, including rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques;
8. Monitor the individual's mental status and provide needed supports in a manner consistent with the individual's level of need and functioning;
9. Deliver all services according to a recovery-based philosophy of care; and
10. Promote self-determination, respect for the individual receiving ACT as an individual in such individual's own right, and engage peers in promoting recovery and regaining meaningful roles and relationships in the community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Community-based crisis stabilization" means services that are short term and designed to support an individual and the individual's natural support system following contact with an initial crisis response service or as a diversion to a higher level of care. Providers deliver community-based crisis stabilization services in an individual's natural environment and provide referrals and linkage to other community-based services at the appropriate level of care. Interventions may include mobile crisis response, brief therapeutic and skill-building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization

of the crisis, and coordination of follow-up services. Coordination of specialized services to address the needs of co-occurring developmental disabilities and substance use disorders are also available through this service. Services include advocacy and networking to provide linkages and referrals to appropriate community-based services and assist the individual and the individual's family or caregiver in accessing other benefits or assistance programs for which the individual may be eligible. Community-based crisis stabilization is a non-center, community-based service. The goal of community-based crisis stabilization services is to stabilize the individual within the community and support the individual or the individual's support system (i) as part of an initial mobile crisis response; (ii) during the period between an initial mobile crisis response and entry into an established follow-up service at the appropriate level of care; (iii) as a transitional step-down from a higher level of care if the next level of care service is identified but not immediately available for access; or (iv) as a diversion to a higher level of care.

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

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

"Conveyance" means a motor vehicle that serves as the mobile component of a mobile MAT program.

"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.

→ "Coordinated specialty care" or "CSC" means an evidence-based treatment approach that supports the recovery of adolescents and young adults experiencing an initial onset of psychosis. CSC provides coordinated, targeted treatment in the early stages of mental illness through integrated medical, psychological, and rehabilitative interventions.

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

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

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



under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology (18VAC125-20-10); or (xii) a supervisee in social work who is under the supervision of a licensed clinical social worker and is registered with the Virginia Board of Social Work (18VAC140-20-10); or (xiii) a licensed psychological practitioner working under supervision of a licensed clinical psychologist in accordance with 18VAC125-20-58 and 18VAC125-20-59.

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

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

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

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

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

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



"CSC rehabilitation skill-building" means facilitating wellness and autonomy through the restoration of skills, as set forth in the plan of care, in symptom management, interpersonal relationships, communication, problem solving, coping skills, and community integration.

"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.

→ "Designated employee" means a provider's named employee or contractor who is at least 18 years of age and who has met the appropriate prerequisites as specified in 12VAC35-105.

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

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

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

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

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

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

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

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

"Group home or community residential service" means a congregate service providing 24-hour supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living for individuals whose

individualized services plan identifies the need for the specific types of services available in this setting.

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

→ "Health literacy support" means both (i) medication administration by staff working within the scope of their practice and (ii) support regarding mental health and associated health risks, monitoring for adverse side effects or results of that medication, support regarding the role of prescription medications and their effects, including side effects, and the importance of compliance and adherence. Services are provided with family or caregivers when they are for the direct benefit of the individual.

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

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

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

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

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

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

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

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

"Intellectual disability" means a disability originating before 18 years of age, characterized concurrently by (i) significant subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with

accepted professional practice that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

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

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

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

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

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

→ "LMHP-resident in psychology" or "LMHP-RP" means an individual in a residency as that term is defined in 18VAC125-20-10 for clinical psychologists. An LMHP-RP shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65. LMHP-RPs also include licensed psychological practitioners working under supervision of a licensed clinical psychologist in accordance with 18VAC125-20-58 and 18VAC125-20-59.

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

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

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

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

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

managed by a physician who is responsible for diagnosis, treatment, and treatment plan decisions in collaboration with the individual.

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

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

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

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

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

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

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

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

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

"Mental health outpatient service" means treatment provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Mental health outpatient services may include diagnosis and evaluation,

screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory, and other ancillary services, medical services, and medication services. Mental health outpatient service specifically includes:

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

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

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

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

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

"Mobile medication-assisted treatment program" or "mobile MAT program" means a MAT operating from a motor vehicle or conveyance that serves as a mobile component to a licensed MAT location registered with the U.S. Drug Enforcement Administration as required by 21 CFR 1301.11 et seq.

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

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

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

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

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

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

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

→ "Psychotherapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.

"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 the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Qualified mental health professional-trainee" or "QMHP-T" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Qualified paraprofessional in mental health" or "QPPMH" means a person who meets at least one of the following criteria: (i) is registered with the United States Psychiatric Association (USPRA) as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) has an associate degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling,

vocational rehabilitation, human services counseling) and at least one year of experience providing direct services to individuals with a diagnosis of mental illness; (iii) is licensed as an occupational therapy assistant, and supervised by a licensed occupational therapist, with at least one year of experience providing direct services to individuals with a diagnosis of mental illness; or (iv) has a minimum of 90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP providing services to individuals with mental illness and at least one year of experience, including the 12 weeks of supervised experience.

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

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

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

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

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

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

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

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

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

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

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

1. Mechanical restraint means the use of a mechanical device that cannot be removed by the individual to restrict the individual's freedom of movement or functioning of a limb or portion of an individual's body when that behavior places him or others at imminent risk.
2. Pharmacological restraint means the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that individual's behavior places him or others at imminent risk and the administered medication is not a standard treatment for the individual's medical or psychiatric condition.
3. Physical restraint, also referred to as manual hold, means the use of a physical intervention or hands-on hold to prevent an individual from moving his body when that individual's behavior places him or others at imminent risk.

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

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

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

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

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

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

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

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

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

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

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

1. A serious injury;
2. An individual who is or was missing;
3. An emergency room visit;
4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services, except that a psychiatric admission in accordance with an individual's wellness plan shall not constitute an unplanned admission for the purposes of this chapter;
5. Choking incidents that require direct physical intervention by another person;
6. Ingestion of any hazardous material; or
7. A diagnosis of:
 - a. A decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer;
 - b. A bowel obstruction; or
 - c. Aspiration pneumonia.

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

1. Any death of an individual;
2. A sexual assault of an individual; or
3. A suicide attempt by an individual admitted for services, other than licensed emergency services, that results in a hospital admission.

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

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

"Shall" means an obligation to act is imposed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12VAC35-105-30. 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:

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1. Assertive community treatment (ACT);
 2. Case management;
 3. Clinically managed high-intensity residential care or Level of care 3.5;
 4. Clinically managed low-intensity residential care or Level of care 3.1;
 5. Clinically managed population specific high-intensity residential or Level of care 3.3;
 6. Community gero-psychiatric residential;
 7. Community-based crisis stabilization;
 8. Coordinated specialty care;
 - ~~8-9.~~ Crisis receiving center;
 - ~~9-10.~~ Crisis stabilization unit;
 - ~~10-11.~~ Day support;
 - ~~11-12.~~ Day treatment, including therapeutic day treatment for children and adolescents;
 - ~~12-13.~~ Group home and community residential;
 - ~~13-14.~~ ICF/IID;
 - ~~14-15.~~ Inpatient psychiatric;
 - ~~15-16.~~ Intensive in-home;
 - ~~16-17.~~ Medically managed intensive inpatient service or Level of care 4.0;
 - ~~17-18.~~ Medically monitored intensive inpatient treatment or Level of care 3.7;
 - ~~18-19.~~ Medication assisted opioid treatment;
 - ~~19-20.~~ Mental health community support;
 - ~~20-21.~~ Mental health intensive outpatient;
 - ~~21-22.~~ Mental health outpatient;
 - ~~22-23.~~ Mental health partial hospitalization;
 - ~~23-24.~~ Psychosocial rehabilitation;
 - ~~24-25.~~ REACH CTH;
 - ~~25-26.~~ REACH mobile crisis response;
 - ~~26-27.~~ Residential treatment;
 - ~~27-28.~~ Respite care;
 - ~~28-29.~~ Sponsored residential home;
 - ~~29-30.~~ Substance abuse intensive outpatient;
 - ~~30-31.~~ Substance abuse outpatient;

- ~~31-32.~~ Substance abuse partial hospitalization;
- ~~32-33.~~ Supervised living residential; and
- ~~33-34.~~ Supportive in-home.

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

12VAC35-105-1426. Admission Criteria.

A. Before a CSC provider may admit an individual to the service, the individual shall meet the criteria for admission as defined by this chapter and the provider's policies.

B. The policy regarding admission to CSC, shall at a minimum, meet the requirements of 12VAC35-105-650 and the assessment required by that section shall:

1. Be conducted by a LMHP, LMHP-R, LMHP-RP or LMHP-S. Assessments completed by a LMHP-R, LMHP-RP or LMHP-S shall be signed by a LMHP;
2. Be conducted in person in the individual's home or another location of the individual's choice;
3. Document that the individual:
 - a. Is between the ages of 15 and 35 at admission;
 - b. Exhibited psychotic symptoms for less than five years at admission;
 - c. Has a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, other specified schizophrenia spectrum, affective disorder with psychosis, bipolar disorder with psychotic features, major depression with psychotic features, or other psychotic disorder. Individuals may also have a co-occurring diagnosis of a substance use disorder or developmental disability; and
 - d. Is experiencing symptoms of a mental, behavioral, or emotional illness that results in functional impairments in major life activities. Such symptoms may include auditory or visual hallucinations, delusions, or a thought disorder that causes significant disruptions in at least one of the following areas: (i) educational functioning, (ii) occupational functioning, (iii) relationships with family members, or (iv) building a social support network.

12VAC35-105-1427. Discharge criteria.

Before a CSC provider may discharge an individual, the individual shall meet the criteria for discharge as defined by this chapter and the provider's policies, which shall meet all the requirements of 12VAC35-105-693. The provider's policy regarding discharge shall require that an individual be discharged when one of the following conditions is met:

1. The individual has successfully completed the CSC program and has transitioned to a lower level of care adequate to support recovery;
2. The individual is unable to achieve the goals of treatment but could progress with a different type of treatment;
3. The individual has achieved the original treatment goals but has developed new treatment challenges that can only be adequately addressed in a different type of treatment; or
4. The individual chooses to be discharged from the program or has not participated in treatment for six months.

12VAC35-105-1428. Service delivery.

A. A CSC program shall meet the following programmatic requirements in accordance with the individual's assessment and ISP.

1. Treatment planning may be developed through a team approach, but the ISP shall be signed and overseen by an LMHP.
2. Psychiatric services to include a comprehensive psychiatric evaluation, medication prescription monitoring, and contact with the individual. The psychiatric evaluation shall be completed as soon as possible but no later than 30 days after admission.
 - i. Psychiatric services shall be provided by a psychiatrist, a psychiatric nurse practitioner, a nurse practitioner, or a physician assistant working under the supervision of a psychiatrist.
 - ii. Contact with the individual shall occur at least twice a month for the first six months and then taper in frequency as appropriate for the individual served. Contact with the individual shall be based on the individual's needs as documented within the individual's ISP but shall occur at least monthly.
3. Psychotherapy provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.
4. Family education and support provided by any team member acting within the scope of their practice.
5. Health Literacy Support. The medication administration component shall be performed by an RN or LPN. The support component shall be performed by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner, occupational therapist, CSAC, CSAC-S, RN, or LPN.
6. Rehabilitation skill-building by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, occupational therapist, CSAC, CSAC-S, or registered PRS.
7. Care coordination by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, CSAC, CSAC-S, RN, LPN, or registered PRS.
8. Crisis support provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, or QMHP-T.
 - i. Crisis support shall be available 24 hours a day, seven days a week.
 - ii. Crisis support shall not solely include referral to a crisis provider (CRC, CSU, or community-based crisis stabilization, including mobile crisis response) as a means of addressing the crisis.
 - iii. Crisis support shall include the development of the individual's crisis mitigation plan.
9. Peer recovery support services by a registered PRS.

B. A CSC program shall participate in the completion of quality service reviews conducted by DBHDS.

C. A CSC program shall furnish information and documentation on request and in the form requested by DBHDS.

12VAC35-105-1429. Treatment team and staffing.

A. CSC providers shall have sufficient staffing composition to meet the varying needs of individuals served by the provider as required by this section. CSC services shall be delivered by a multidisciplinary team made up of staff who fulfill the following roles:

1. Team leader;
2. Psychiatric provider;
3. Therapist;

4. Family education and support specialist;
5. Care coordinator;
6. Supported employment specialist;
7. Supported education specialist; and
8. Community education and outreach specialist.

B. Each CSC provider shall meet the following minimum position requirements:

1. Team leader who is a designated employee and LMHP with at least three years of experience in the provision of mental health services.
 - a. The team leader shall be a full-time employee or contractor.
 - b. The team leader shall oversee all aspects of team operation.
 - c. The team leader shall routinely provide direct services to individuals in the community.
 - d. The team leader shall monitor, oversee, and supervise the team-based process.
2. Psychiatric provider who is a designated employee and a psychiatrist, psychiatric nurse practitioner, or nurse practitioner with sufficient training and mental health experience.
 - a. The psychiatric provider shall be available to the team to provide assessments and medication management.
 - b. The psychiatric provider shall serve as fully integrated team member who attends clinical team meetings.
3. An additional clinician who is a LMHP, LMHP-R, LMHP-RP, or LMHP-S. The clinician shall provide psychotherapy.
4. A registered peer recovery support specialist who is a designated employee.
5. General clinical staff as appropriate to meet the needs of individuals served. Additional staff may include QMHPs, QMHP-Ts, CSACs, CSAC-Ss, occupational therapists, RNs, and LPNs.
6. At least one of the CSC provider team members shall have training working with individuals with substance use disorders.
7. All team members shall complete initial and annual training approved by DBHDS in core and evidence-based practices that support high-fidelity CSC practice. Documentation of completion of initial training shall be provided to the department at the time of application for a full license.

REGULATORY BUSINESS

Emergency/NOIRA Action | Align Licensing Regulations with Redesigned Medicaid Service: Recovery and Empowerment Center (Mental Health Clubhouse Services)

Included in Agenda Packet:

- DRAFT Agency Background Document (TH-05)
- DRAFT Amendments to DBHDS Licensing Regulations (12VAC35-105)

Background:

Virginia's behavioral health system is undergoing a multi-phased, interagency process of transformation to enhance the service delivery system. As part of this transformative effort, the General Assembly amended the 2024-26 appropriation act ([Item 293 B](#)) directing the board to align DBHDS Licensing Regulations with the modifications being made to Medicaid behavioral health services.

To comply with the legislative mandate, the board must amend the regulations to ensure consistency with the following newly funded Medicaid services:

- Community Psychiatric Support and Treatment (CPST)¹;
- Coordinated Specialty Care (CSC); and
- Mental Health Clubhouse Services, entitled **Recovery and Empowerment Center**.

The authorizing budget language requires the board's emergency regulations to become effective by February 6, 2026. (A standard regulatory action to establish permanent regulations will follow this emergency action.)

→ *Refer to this flowchart for more information about the emergency regulatory process:* <https://www.townhall.virginia.gov/um/chartemergencystate.pdf>

Justification:

The goal of Recovery and Empowerment Center (REC) is to support the recovery of individuals living with serious mental illness by creating a community-based environment that fosters social connection, meaningful engagement, and skill development.

This action will improve access to a continuum of high-quality behavioral health services for Virginians and ensure REC providers adhere to a base level of model fidelity. Consistency between DBHDS licensing regulations and DMAS modifications to behavioral health services is important for licensed providers as well as for individuals receiving services and their families.

Action Requested:

Authorize an Emergency/NOIRA action to align the Licensing Regulations with redesigned Medicaid services for Recovery and Empowerment Center (REC) and to initiate the process for permanent regulations.

¹ Emergency/NOIRA for CPST adopted by the board at its September 24, 2025, meeting.


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Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services (DBHDS)
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC35-105
VAC Chapter title(s)	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (12VAC35-105)
Action title	Alignment with Medicaid behavioral health services redesign: Recovery and Empowerment Center (REC)
Date this document prepared	November 10, 2025

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

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of the subject matter, intent, and goals 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 or changes. If applicable, generally describe the existing regulation.

[Item 293 B](#) of the 2024-2026 Appropriations Act directs the State Board of Behavioral Health and Developmental Services to promulgate emergency regulations that align its provider licensing regulations with the modifications being made to Medicaid behavioral health services pursuant to Item 288 XX. [Item 288 XX](#) states, in relevant part:

Effective July 1, 2024, the Department of Medical Assistance Services (DMAS) shall have the authority to modify Medicaid behavioral health services such that: (1) legacy services that predate the current service delivery system, including Mental Health Skill Building, Psychosocial Rehabilitation, Intensive In Home

Services, and Therapeutic Day Treatment are phased out; (2) legacy youth services are replaced with the implementation of tiered community based supports for youth and families with and at-risk for behavioral health disorders appropriate for delivery in homes and schools, (3) legacy services for adults are replaced with a comprehensive array of psychiatric rehabilitative services for adults with Serious Mental Illness (SMI), including community-based and center-based services such as independent living and resiliency supports, community support teams, and psychosocial rehabilitation services, (4) legacy Targeted Case Management- SMI and Targeted Case Management- Serious Emotional Disturbance (SED) are replaced with Tiered Case Management Services.

To comply with the General Assembly mandates, the State Board shall adopt emergency actions that restructure DBHDS Licensing Regulations to align with the following newly funded Medicaid behavioral health categories: Community Psychiatric Support and Treatment (CPST); Coordinated Specialty Care (CSC); and Mental Health Clubhouse Services (Clubhouse).

This regulatory action amends the DBHDS Licensing Regulations to establish the newly licensed service to align with Clubhouse, which in Virginia will be entitled Recovery and Empowerment Center (REC). (The Board adopted an Emergency/NOIRA action for the CPST service at its September 24, 2025, meeting.)

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.

Board – State Board of Behavioral Health and Developmental Services
DBHDS – Department of Behavioral Health and Developmental Services
DMAS – Department of Medical Assistance Services
REC – Recovery and Empowerment Center

Mandate and Impetus (Necessity for Emergency)

Explain why this rulemaking is an emergency situation in accordance with § 2.2-4011 A and B of the Code of Virginia. In doing so, either:

- a) Indicate whether the Governor's Office has already approved the use of emergency regulatory authority for this regulatory change.*
- b) Provide specific citations to Virginia statutory law, the appropriation act, federal law, or federal regulation that require that a regulation be effective in 280 days or less from its enactment.*

As required by § 2.2-4011, also describe the nature of the emergency and of the necessity for this regulatory change. In addition, delineate any potential issues that may need to be addressed as part of this regulatory change.

The General Assembly amended the appropriation act ([Item 293 B](#)) to direct the State Board of Behavioral Health and Developmental Services to promulgate emergency regulations to "align licensing regulations with the modifications being made to Medicaid behavioral health services" in collaboration with DMAS.

The authorizing budget language requires the board's emergency regulations to become effective within 280 days of the budget's final adoption on May 2, 2025. (A regulatory action to establish permanent regulations will follow this emergency action.)

Legal Basis

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

The State Board of Behavioral Health and Developmental Services was directed by the General Assembly through the 2024-26 appropriation act to promulgate emergency regulations that align its provider licensing regulations with the modifications being made to Medicaid behavioral health services. [Item 293 B of the 2024-2026 Budget Bill](#) mandates the changes within this regulatory action (as well as the Coordinated Specialty Care emergency action and the CPST action already adopted).

Section 37.2-203 of the Code of Virginia gives the board 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 board voted to adopt this regulatory action at its meeting on _____.

Purpose

Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.

The purpose of this regulatory action is to comply with the legislative mandate by aligning DBHDS licensing regulations with ongoing interagency efforts to enhance Virginia's behavioral health services system. In particular, the changes in this regulatory action establish the newly licensed service to align with Clubhouse, which in Virginia will be entitled Recovery and Empowerment Center (REC).

As a newly funded Medicaid behavioral health category, the goal of REC is to support the recovery of individuals living with serious mental illness by creating a community-based environment that fosters social connection, meaningful engagement, and skill development.

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) Definitions necessary for the integration of REC into the Licensing Regulations;
- 2) Admission criteria for REC;
- 3) Discharge criteria for REC;
- 4) Service delivery requirements for REC;
- 5) Minimum requirements for REC staffing; and
- 6) REC physical environment standards.

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 transformation to enhance the service delivery system. This requires coordination among agencies with responsibilities for licensing, funding, and oversight behavioral health services in the Commonwealth.

The primary advantages of this regulatory action include (1) improving access to a continuum of high-quality behavioral health services for Virginians; (2) ensuring Recovery and Empowerment Center providers adhere to a base level of model fidelity; and (3) reducing administrative burden by aligning provider licensing regulations with Medicaid service expectations.

There are no known disadvantages to the public or the Commonwealth.

Alternatives to Regulation

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

There are no alternatives to the regulatory changes contained herein that could achieve the essential purpose of this action, which itself is mandated by the General Assembly.

The amendments are limited to those that are necessary to ensure consistency between DBHDS licensing regulations and DMAS modifications to Medicaid behavioral health services. Misalignment between the two would be problematic for licensed providers of behavioral health services, including small business providers, as well as for individuals receiving services and their families.

Periodic Review and Small Business Impact Review Announcement

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

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

The Department of Behavioral Health and Developmental Services is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, and (iii) the potential impacts of the regulation.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: <https://townhall.virginia.gov>. Comments may also be submitted by mail or email to Susan Puglisi, 1220 Bank Street, Richmond Virginia, 23219, or susan.puglisi@dbhds.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will not be held following the publication of the proposed stage of this regulatory action.

Detail of Changes

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

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

Table 1: Changes to Existing VAC Chapter(s)

Current 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.		Definitions for the Licensing Regulations.	Addition of the following terms: <u>"Member" means an individual who participates in Recovery and Empowerment Center services.</u> <u>"Recovery and Empowerment Center" means evidence-based practices that provide side-by-side engagement between members and staff in supporting restoration of skills in symptom management, interpersonal relationships, communication, problem solving, coping skills, and community integration for members living with mental illness. Each Recovery and Empowerment Center provider shall allow members opportunities for skills development, improved wellness, and achieving person-centered goals identified in the individualized services plan. Interventions are designed to</u>

			<u>alleviate emotional or behavioral symptoms associated with a mental illness with the goal of reintegrating the member into the community and increasing social connectedness beyond a clinical setting. Recovery and Empowerment Centers emphasize long-term support and provide a supportive environment for members with serious mental illness to thrive in their recovery journeys, regardless of how long they are engaged in daily activities.</u> <u>"Work-ordered day" means the structure of day-to-day activity within Recovery and Empowerment Center services. A work-ordered day means that members collaborate with staff as colleagues to perform critical tasks for the Recovery and Empowerment Center community. Members and staff share responsibility for running every aspect of the Recovery and Empowerment Center environment, such as filing, maintenance, and participation in consensus-based decision-making regarding all important matters related to the Recovery and Empowerment Center operations.</u> Likely impact: Clearer regulations. Alignment with Medicaid service changes and current evidence-based practices and terminology to provide person-centered treatment.
12VAC35-105-30. Licenses.		Lists those services which require to be licensed by DBHDS.	Addition of the license type: Recovery and Empowerment Center Likely impact: Clearer regulations. Alignment with Medicaid service changes and current evidence-based practices and terminology to provide person-centered treatment.
	12VAC35-105-1055. Admission		Intent: Provide clear admission requirements within REC programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1060. Discharge		Intent: Provide clear discharge requirements within REC programs.

			Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1070. Service delivery		Intent: Provide clear service delivery requirements within REC programs. Impact: Robust, effective mental health treatment within the Commonwealth.
	12VAC35-105-1080. Staffing requirements		Intent: Provide clear requirements to providers of REC services specifically related to personnel. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.
	12VAC35-105-1090. Physical environment		Intent: Provide clear physical environment requirements within REC programs. Impact: Robust, effective mental health treatment within the Commonwealth that is appropriately administered.

Project 8525 - Emergency/NOIRA

Department of Behavioral Health And Developmental Services

Recovery and Empowerment Center (Clubhouse)

12VAC35-105-20. Definitions.

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

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

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

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

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

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

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

"ASAM" means the American Society of Addiction Medicine.

"Assertive community treatment service" or "ACT" means a self-contained interdisciplinary community-based team of medical, behavioral health, and rehabilitation professionals who use a

team approach to meet the needs of an individual with severe and persistent mental illness. ACT teams:

1. Provide person-centered services addressing the breadth of an individual's needs, helping the individual achieve his personal goals;
2. Serve as the primary provider of all the services that an individual receiving ACT services needs;
3. Maintain a high frequency and intensity of community-based contacts;
4. Maintain a very low individual-to-staff ratio;
5. Offer varying levels of care for all individuals receiving ACT services and appropriately adjust service levels according to each individual's needs over time;
6. Assist individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles, such as worker, family member, resident, spouse, tenant, or friend;
7. Carry out planned assertive engagement techniques, including rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques;
8. Monitor the individual's mental status and provide needed supports in a manner consistent with the individual's level of need and functioning;
9. Deliver all services according to a recovery-based philosophy of care; and
10. Promote self-determination, respect for the individual receiving ACT as an individual in such individual's own right, and engage peers in promoting recovery and regaining meaningful roles and relationships in the community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Community-based crisis stabilization" means services that are short term and designed to support an individual and the individual's natural support system following contact with an initial crisis response service or as a diversion to a higher level of care. Providers deliver community-based crisis stabilization services in an individual's natural environment and provide referrals and linkage to other community-based services at the appropriate level of care. Interventions may include mobile crisis response, brief therapeutic and skill-building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization

of the crisis, and coordination of follow-up services. Coordination of specialized services to address the needs of co-occurring developmental disabilities and substance use disorders are also available through this service. Services include advocacy and networking to provide linkages and referrals to appropriate community-based services and assist the individual and the individual's family or caregiver in accessing other benefits or assistance programs for which the individual may be eligible. Community-based crisis stabilization is a non-center, community-based service. The goal of community-based crisis stabilization services is to stabilize the individual within the community and support the individual or the individual's support system (i) as part of an initial mobile crisis response; (ii) during the period between an initial mobile crisis response and entry into an established follow-up service at the appropriate level of care; (iii) as a transitional step-down from a higher level of care if the next level of care service is identified but not immediately available for access; or (iv) as a diversion to a higher level of care.

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

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

"Conveyance" means a motor vehicle that serves as the mobile component of a mobile MAT program.

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

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

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

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

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

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

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

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

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

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

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

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

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

"Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or a combination of mental and physical

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

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

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

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

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

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

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

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

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

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

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

"Individual" or "individual receiving services" means a current direct recipient of public or private mental health, developmental, or substance abuse treatment, rehabilitation, or habilitation services and includes the terms "consumer," "patient," "resident," "recipient," or "client". When the

term is used in this chapter, the requirement applies to every individual receiving licensed services from the provider.

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

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

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

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

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

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

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

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

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

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

certification regulations for an intermediate care facility for individuals with intellectual disability and persons with related conditions and that addresses the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, providing active treatment as defined in 42 CFR 435.1010 and 42 CFR 483.440.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

→ "Member" means an individual who participates in Recovery and Empowerment Center services.

"Mental Health Community Support Service" or "MCHSS" means the provision of recovery-oriented services to individuals with long-term, severe mental illness. MCHSS 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. MCHSS may be provided in any setting in which the individual's needs can be addressed, skills training applied, and recovery experienced.

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

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

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

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

coordinated, structured, and interdisciplinary ambulatory treatment within a stable environment that is of greater intensity than intensive outpatient, but of lesser intensity than inpatient.

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

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

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

"Mobile medication-assisted treatment program" or "mobile MAT program" means a MAT operating from a motor vehicle or conveyance that serves as a mobile component to a licensed MAT location registered with the U.S. Drug Enforcement Administration as required by 21 CFR 1301.11 et seq.

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

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

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

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

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

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

who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601, and 54.1-3701 of the Code of Virginia.

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

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

"Qualified mental health professional" or "QMHP" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Qualified mental health professional-trainee" or "QMHP-T" means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

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

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

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

→ "Recovery and Empowerment Center" means evidence-based practices that provide side-by-side engagement between members and staff in supporting restoration of skills in symptom management, interpersonal relationships, communication, problem solving, coping skills, and community integration for members living with mental illness. Each Recovery and Empowerment Center provider shall allow members opportunities for skills development, improved wellness, and achieving person-centered goals identified in the individualized services plan. Interventions are designed to alleviate emotional or behavioral symptoms associated with a mental illness with the goal of reintegrating the member into the community and increasing social connectedness beyond a clinical setting. Recovery and Empowerment Centers emphasize long-term support and provide a supportive environment for members with serious mental illness to thrive in their recovery journeys, regardless of how long they are engaged in daily activities.

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

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

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

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

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

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

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

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

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

1. Mechanical restraint means the use of a mechanical device that cannot be removed by the individual to restrict the individual's freedom of movement or functioning of a limb or portion of an individual's body when that behavior places him or others at imminent risk.
2. Pharmacological restraint means the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that individual's behavior places him or others at imminent risk and the administered medication is not a standard treatment for the individual's medical or psychiatric condition.
3. Physical restraint, also referred to as manual hold, means the use of a physical intervention or hands-on hold to prevent an individual from moving his body when that individual's behavior places him or others at imminent risk.

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

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

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

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

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

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

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

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

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

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

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

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

1. A serious injury;
2. An individual who is or was missing;
3. An emergency room visit;
4. An unplanned psychiatric or unplanned medical hospital admission of an individual receiving services other than licensed emergency services, except that a psychiatric admission in accordance with an individual's wellness plan shall not constitute an unplanned admission for the purposes of this chapter;
5. Choking incidents that require direct physical intervention by another person;
6. Ingestion of any hazardous material; or
7. A diagnosis of:
 - a. A decubitus ulcer or an increase in severity of level of previously diagnosed decubitus ulcer;
 - b. A bowel obstruction; or
 - c. Aspiration pneumonia.

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

1. Any death of an individual;
2. A sexual assault of an individual; or
3. A suicide attempt by an individual admitted for services, other than licensed emergency services, that results in a hospital admission.

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

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

"Shall" means an obligation to act is imposed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

→ "Work-ordered day" means the structure of day-to-day activity within Recovery and Empowerment Center services. A work-ordered day means that members collaborate with staff as colleagues to perform critical tasks for the Recovery and Empowerment Center community. Members and staff share responsibility for running every aspect of the Recovery and Empowerment Center environment, such as filing, maintenance, and participation in consensus-based decision-making regarding all important matters related to the Recovery and Empowerment Center operations.

"Written," "writing," and "in writing" include any representation of words, letters, symbols, numbers, or figures, whether (i) printed or inscribed on a tangible medium or (ii) stored in an electronic or other medium and retrievable in a perceivable form and whether an electronic

signature authorized by Chapter 42.1 (§ 59.1-479 et seq.) of Title 59.1 of the Code of Virginia is or is not affixed.

12VAC35-105-30. Licenses.

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

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

1. Assertive community treatment (ACT);
2. Case management;
3. Clinically managed high-intensity residential care or Level of care 3.5;
4. Clinically managed low-intensity residential care or Level of care 3.1;
5. Clinically managed population specific high-intensity residential or Level of care 3.3;
6. Community gero-psychiatric residential;
7. Community-based crisis stabilization;
8. Crisis receiving center;
9. Crisis stabilization unit;
10. Day support;
11. Day treatment, including therapeutic day treatment for children and adolescents;
12. Group home and community residential;
13. ICF/IID;
14. Inpatient psychiatric;
15. Intensive in-home;
16. Medically managed intensive inpatient service or Level of care 4.0;
17. Medically monitored intensive inpatient treatment or Level of care 3.7;
18. Medication assisted opioid treatment;
19. Mental health community support;
20. Mental health intensive outpatient;
21. Mental health outpatient;
22. Mental health partial hospitalization;
23. Psychosocial rehabilitation;
24. REACH CTH;
25. REACH mobile crisis response;
- 26. Recovery and Empowerment Center;
- ~~26-27.~~ Residential treatment;
- ~~27-28.~~ Respite care;
- ~~28-29.~~ Sponsored residential home;
- ~~29-30.~~ Substance abuse intensive outpatient;
- ~~30-31.~~ Substance abuse outpatient;
- ~~31-32.~~ Substance abuse partial hospitalization;
- ~~32-33.~~ Supervised living residential; and
- ~~33-34.~~ 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 2

Recovery and Empowerment Center

12VAC35-105-1055. Admission.

Before a Recovery and Empowerment Center provider may admit a member to the service, the member shall meet the criteria for admission as defined by this chapter and the provider's policies. The policy regarding admission to a Recovery and Empowerment Center shall at a minimum meet the requirements of 12VAC35-105-650 and the assessment by that section shall:

1. Be completed in person by a LMHP, LMHP-R, LMHP-S, or LMHP-RP no more than 30 days prior to admission. The assessment shall be completed in the member's home or another location of the member's choice. Assessments completed by a LMHP-R, LMHP-S, or LMHP-RP require a co-signature by a LMHP.
2. Document a DSM diagnosis that is consistent with a serious mental illness.
3. Document that the member does not pose a significant and current threat to the general safety of the Recovery and Empowerment Center community.

12VAC35-105-1060. Discharge.

Before a Recovery and Empowerment Center provider may discharge a member, the member shall meet the criteria for discharge as defined by this chapter and the provider's policies, which shall meet all the requirements of 12VAC35-105-693. The provider's policy regarding discharge shall at a minimum also meet one of the following requirements:

1. The member no longer meets admission criteria.
2. The member has successfully met the specific goals outlined in the treatment plan for discharge.
3. The member requires a more intensive level of care or service.
4. The member no longer needs the service.

12VAC35-105-1070. Service delivery.

A Recovery and Empowerment Center shall meet the following programmatic requirements:

1. General. The Recovery and Empowerment Center shall be member-run with voluntary participation.
 - a. Reassessments shall be performed annually until discharge.
 - b. Service planning shall be conducted in collaboration with the member by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, or QMHP-T.
 - c. The program shall create and implement an outreach policy to contact members who are not attending.
2. Crisis support. Crisis support shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, or RPRS.
 - a. Crisis support shall include the development of a crisis mitigation plan and connecting the member to other behavioral health services.
 - b. Crisis support shall be available in person during Recovery and Empowerment Center hours of operation.

3. Work-ordered day. The Recovery and Empowerment Center shall be open at a minimum five days a week for five hours each day and shall offer a schedule of structured activities.

a. The provider shall establish a policy governing how the Recovery and Empowerment Center will offer and support a work-ordered day. The policy shall specify the work units and associated activities the provider will offer to carry out the work of the Recovery Empowerment Center which may include administration, governance, programming, physical site maintenance, food service, human resources, and center development.

b. Work shall be generated exclusively by the Recovery and Empowerment Center. Work for outside individuals and agencies shall not be permitted except through the offered employment programs.

c. Members shall not be paid for Recovery and Empowerment Center work. There shall not be artificial reward systems for Recovery and Empowerment Center work.

d. The Recovery and Empowerment Center shall be organized into one or more work units. Unit meetings shall be held to organize and plan the work of the day.

4. Transitional employment. The Recovery and Empowerment Center provider shall offer a transitional employment program to provide opportunities for members to experience job placements in the labor market.

a. The Recovery and Empowerment Center shall not provide employment to members through in-house businesses, segregated Recovery and Empowerment Center enterprises, or sheltered workshops.

b. The Recovery and Empowerment Center shall establish a policy documenting how the provider will encourage and support attendance, address member absences, and ensure coverage of all placements.

c. Placement opportunities shall continue to be available regardless of the level of success in previous placements.

d. There shall be no transitional employment placements within the Recovery and Empowerment Center. Members shall attend and participate at the employer's place of business.

e. Members shall be paid the prevailing wage rate but at least minimum wage, directly by the employer.

5. Supported and independent employment. The Recovery and Empowerment Center provider shall offer a supported employment program.

a. Within the supported employment program, staff shall maintain and document a relationship with the member and the member's employer.

b. Members and staff shall work in partnership to determine and document the type, frequency, and location of desired supports.

6. Supportive education. The Recovery and Empowerment Center provider shall establish a policy regarding supportive education. The policy shall:

a. Document how the provider will support members in taking advantage of educational opportunities in the community; and

b. State whether the provider will offer an in-house education program. If the provider does provide an in-house education program, the policy must describe how the program will utilize the teaching and tutoring skills of the Recovery and Empowerment Center's members.

7. Rehabilitative skill building. Rehabilitative skill building shall be provided in person by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, BHT, or RPRS. Rehabilitative skill building will assist members with learning the skills necessary to seek and obtain employment, to pursue their educational goals, to find housing opportunities, and to reintegrate into their community.

8. Care coordination. Care coordination shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, or RPRS.

12VAC35-105-1080. Staffing requirements.

A Recovery and Empowerment Center provider shall meet the following minimum position requirements:

1. A clinical director who is a LMHP.

a. The clinical director shall complete Clubhouse International training or a substantially equivalent program approved by DBHDS in evidence-based practices that support high-fidelity psychosocial rehabilitation services.

b. The clinical director shall be responsible for operation of the Recovery and Empowerment Center services and environment including the authorization and oversight of ISPs.

2. A program director who is a LMHP, LMHP-R, LMHP-RP, LMHP-S, or QMHP. The program director shall complete Clubhouse International training or a substantially equivalent program approved by DBHDS in evidence-based practices that support high-fidelity psychosocial rehabilitation services.

3. Additional staff as appropriate to meet the needs of individuals served. Additional staff may include LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHPs, QMHP-Ts, PRSs, and BHTs.

4. The Recovery and Empowerment Center clinical director, program director, staff, members, and other appropriate persons shall participate in a Recovery and Empowerment Center training program.

12VAC35-105-1090. Physical environment.

A. The Recovery and Empowerment Center shall have its own physical space. The Recovery and Empowerment Center space shall be separate and distinct from all other provider services.

B. The Recovery and Empowerment Center shall have an administrative office which houses personnel and member records. Due to confidentiality requirements the administrative office shall only be accessible to staff.

C. Every other area of the Recovery and Empowerment Center shall be accessible to all members and staff.

D. The Recovery and Empowerment Center shall have spaces which can provide privacy when needed.

REGULATORY BUSINESS

Proposed Actions | Regulatory Restructuring

Included in Agenda Packet:

- Virginia Regulatory Town Hall Notices
- Public Comments Received on NOIRA
- DRAFT Text:
 - o General Rules and Regulations for Licensing Providers (12VAC35-270)
 - o Residential and Inpatient Services (12VAC35-272)
 - o NonCenter-Based Services (12VAC35-274)
 - o Center-Based Services (12VAC35-276)
 - o Crisis Services (12VAC35-278)
 - o Case Management Services (12VAC35-280)
- “Crosswalk” Chart

Background:

At its April meeting, the Board authorized a Notice of Intended Regulatory Action (NOIRA) to restructure the licensing regulations by:

1. Repealing the existing Children’s Residential Regulations ([12VAC35-46](#)) and the general Licensing Regulations ([12VAC35-105](#)), and
2. Replacing them with one overarching General Chapter applicable to all providers and five (5) service-specific chapters: Residential, Center-Based, NonCenter-Based, Case Management, and Crisis.

Refer to this flowchart for more information about the three-stage process:

<https://townhall.virginia.gov/um/chartstandardbasic.pdf>

Staff Notes:

- Each chapter is the subject of its own standard three-stage action; however, all six will proceed simultaneously in coordination with the repeal/replace action.
- The NOIRA comment period closed with 37 comments from **16 unique commenters**.

Justification:

Initially drafted as a comprehensive regulatory overhaul, this project has been underway since 2019, in response to feedback from providers about the Licensing Regulations being lengthy and cumbersome. In the intervening years, many substantive provisions became effective through separate actions (e.g. legislative mandates, regulatory reform initiatives). Therefore, this proposed action is scaled back from the prior “overhaul” to focus on making the regulations easier to navigate. Proposed changes incorporate significant stakeholder feedback and reflect technical assistance from a panel of subject matter experts.

Action Needed:

Adopt the Proposed Regulations.

Next Steps:

Staff will submit regulatory package for Proposed Stage review and publication.



Agency

Department of Behavioral Health and Developmental Services

Board

State Board of Behavioral Health and Developmental Services

Chapter

General Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services **[12 VAC 35 - 270]**
(Under Development)

Action: Regulatory Restructuring - General Chapter (Part 1 of 7)

Action 6755

General Information

Action Summary	In 2017, the Department of Behavioral Health and Developmental Services (DBHDS) conducted a periodic review of the Licensing Regulations. During that review, the Office of Regulatory Affairs (ORA) conducted extensive research on how other states structure their Licensing Regulations. The department also considered comments from internal subject matter experts, providers, and sister agencies when recommending the new licensing structure. As a result of that review, DBHDS determined the regulations should be amended and broken into service-specific chapters. Therefore, DBHDS will repeal the existing Children's Residential and Licensing Regulations, replacing them with one overarching General Chapter applicable to all providers and five (5) service-specific chapters: Residential, Center-Based, NonCenter-Based, Case Management, and Crisis. This methodology allows more detailed service-specific regulations where appropriate and offers more clarity for providers regarding exactly which provisions of the licensing regulations apply to their services. This action will enact the overarching General Provisions chapter. Regulatory provisions from 12VAC35-105 have been pulled into this chapter and updated as appropriate.
Chapters Affected	Only affects this chapter.
Executive Branch Review	This action will go through the normal Executive Branch Review process.
RIS Project	Yes [7101]
New Periodic Review	This action will not be used to conduct a new periodic review.

Stages

Stages associated with this regulatory action.

Stage ID	Stage Type	Status
<u>10768</u>	NOIRA	Stage complete. Comment period ended 09/24/2025.

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Agency

Department of Behavioral Health and Developmental Services

Board

State Board of Behavioral Health and Developmental Services

Chapter

General Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services [[12 VAC 35 - 270](#)]
(Under Development)

Action: Regulatory Restructuring - General Chapter (Part 1 of 7)

Notice of Intended Regulatory Action (NOIRA)

Action 6755 / Stage 10768

Documents

Preliminary Draft Text	None submitted	
<u>Agency Background Document</u>	4/28/2025	
<u>Governor's Review Memo</u>	7/22/2025	

Status

DPB Review	Submitted on 4/28/2025 Review Completed: 5/9/2025
Secretary Review	Secretary of Health and Human Resources Review Completed: 7/9/2025
Governor's Review	ORM Review Completed: 7/22/2025 Governor Review Completed: 7/22/2025 Result: Approved
Virginia Registrar	Submitted on 7/23/2025 <u>The Virginia Register of Regulations</u> Publication Date: 8/25/2025 <u>Volume: 42 Issue: 1</u>
Comment Period	<u>Ended 9/24/2025</u> <u>11 comments</u>

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Agency

Department of Behavioral Health and Developmental Services

Board

State Board of Behavioral Health and Developmental Services

Chapter

Regulations for Residential and Inpatient Services [12 VAC 35 - 272]

Action: Regulatory Restructuring - Residential Services (Part 2 of 7)

Action 6756

General Information

Action Summary	In 2017, the Department of Behavioral Health and Developmental Services (DBHDS) conducted a periodic review of the Licensing Regulations. During that review, the Office of Regulatory Affairs (ORA) conducted extensive research on how other states structure their Licensing Regulations. The department also considered comments from internal subject matter experts, providers, and sister agencies when recommending the new licensing structure. As a result of that review, DBHDS determined the regulations should be amended and broken into service-specific chapters. Therefore, DBHDS will repeal the existing Children's Residential and Licensing Regulations, replacing them with one overarching General Chapter applicable to all providers and five (5) service-specific chapters: Residential, Center-Based, NonCenter-Based, Case Management, and Crisis. This methodology allows more detailed service-specific regulations where appropriate and offers more clarity for providers regarding exactly which provisions of the licensing regulations apply to their services. This action will enact the Residential service-specific chapter. Regulatory provisions from 12VAC35-105 and 12VAC35-46 have been pulled into this chapter and updated as appropriate.
Chapters Affected	Only affects this chapter.
Executive Branch Review	This action will go through the normal Executive Branch Review process.
RIS Project	Yes [8086]
New Periodic Review	This action will not be used to conduct a new periodic review.

Stages

Stages associated with this regulatory action.

Stage ID	Stage Type	Status
<u>10769</u>	NOIRA	Stage complete. Comment period ended 09/24/2025.

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Agency Department of Behavioral Health and Developmental Services

Board State Board of Behavioral Health and Developmental Services

Chapter Regulations for Residential and Inpatient Services [[12 VAC 35 - 272](#)]

Action: Regulatory Restructuring - Residential Services (Part 2 of 7)

Notice of Intended Regulatory Action (NOIRA)

Action 6756 / Stage 10769

Documents

Preliminary Draft Text	None submitted	
 <u>Agency Background Document</u>	4/28/2025	
 <u>Governor's Review Memo</u>	7/22/2025	

Status

DPB Review	Submitted on 4/28/2025 Review Completed: 5/9/2025
Secretary Review	Secretary of Health and Human Resources Review Completed: 7/9/2025
Governor's Review	ORM Review Completed: 7/22/2025 Governor Review Completed: 7/22/2025 Result: Approved
Virginia Registrar	Submitted on 7/23/2025 <u>The Virginia Register of Regulations</u> Publication Date: 8/25/2025  <u>Volume: 42 Issue: 1</u>
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Department of Behavioral Health and Developmental Services

Board

State Board of Behavioral Health and Developmental Services

Chapter

Regulations for NonCenter-Based Services [12 VAC 35 - 274] (Under Development)

Action: Regulatory Restructuring - NonCenter-Based Services (Part 3 of 7)

Action 6760

General Information

Action Summary	In 2017, the Department of Behavioral Health and Developmental Services (DBHDS) conducted a periodic review of the Licensing Regulations. During that review, the Office of Regulatory Affairs (ORA) conducted extensive research on how other states structure their Licensing Regulations. The department also considered comments from internal subject matter experts, providers, and sister agencies when recommending the new licensing structure. As a result of that review, DBHDS determined the regulations should be amended and broken into service-specific chapters. Therefore, DBHDS will repeal the existing Children's Residential and Licensing Regulations, replacing them with one overarching General Chapter applicable to all providers and five (5) service-specific chapters: Residential, Center-Based, NonCenter-Based, Case Management, and Crisis. This methodology allows more detailed service-specific regulations where appropriate and offers more clarity for providers regarding exactly which provisions of the licensing regulations apply to their services. This action will enact the NonCenter-Based service-specific chapter. Regulatory provisions from 12VAC35-105 have been pulled into this chapter and updated as appropriate.
Chapters Affected	Only affects this chapter.
Executive Branch Review	This action will go through the normal Executive Branch Review process.
RIS Project	Yes [8154]
New Periodic Review	This action will not be used to conduct a new periodic review.

Stages

Stages associated with this regulatory action.

Stage ID	Stage Type	Status
<u>10774</u>	NOIRA	Stage complete. Comment period ended 09/24/2025.

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Agency Department of Behavioral Health and Developmental Services

Board State Board of Behavioral Health and Developmental Services

Chapter Regulations for NonCenter-Based Services [12 VAC 35 - 274] (Under Development)

Action: Regulatory Restructuring - NonCenter-Based Services (Part 3 of 7)

Notice of Intended Regulatory Action (NOIRA)

Action 6760 / Stage 10774

Documents

Preliminary Draft Text	None submitted	
 Agency Background Document	5/1/2025	
 Governor's Review Memo	7/22/2025	

Status

DPB Review	Submitted on 5/1/2025 Review Completed: 5/12/2025
Secretary Review	Secretary of Health and Human Resources Review Completed: 7/9/2025
Governor's Review	ORM Review Completed: 7/22/2025 Governor Review Completed: 7/22/2025 Result: Approved
Virginia Registrar	Submitted on 7/23/2025 <u>The Virginia Register of Regulations</u> Publication Date: 8/25/2025  <u>Volume: 42 Issue: 1</u>
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Agency

Department of Behavioral Health and Developmental Services

Board

State Board of Behavioral Health and Developmental Services

Chapter

Regulations for Center-Based Services [[12 VAC 35 - 276](#)] (Under Development)

Action: Regulatory Restructuring- Center-Based Services (Part 4 of 7)

Action 6761

General Information

Action Summary	In 2017, the Department of Behavioral Health and Developmental Services (DBHDS) conducted a periodic review of the Licensing Regulations. During that review, the Office of Regulatory Affairs (ORA) conducted extensive research on how other states structure their Licensing Regulations. The department also considered comments from internal subject matter experts, providers, and sister agencies when recommending the new licensing structure. As a result of that review, DBHDS determined the regulations should be amended and broken into service-specific chapters. Therefore, DBHDS will repeal the existing Children's Residential and Licensing Regulations, replacing them with one overarching General Chapter applicable to all providers and five (5) service-specific chapters: Residential, Center-Based, NonCenter-Based, Case Management, and Crisis. This methodology allows more detailed service-specific regulations where appropriate and offers more clarity for providers regarding exactly which provisions of the licensing regulations apply to their services. This action will enact the Center-Based service-specific chapter. Regulatory provisions from 12VAC35-105 have been pulled into this chapter and updated as appropriate.
Chapters Affected	Only affects this chapter.
Executive Branch Review	This action will go through the normal Executive Branch Review process.
RIS Project	Yes [8128]
New Periodic Review	This action will not be used to conduct a new periodic review.

Stages

Stages associated with this regulatory action.

Stage ID	Stage Type	Status
10775	NOIRA	Stage complete. Comment period ended 09/24/2025.

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Agency

Department of Behavioral Health and Developmental Services

Board

State Board of Behavioral Health and Developmental Services

Chapter

Regulations for Center-Based Services [[12 VAC 35 - 276](#)] (Under Development)

Action: Regulatory Restructuring- Center-Based Services (Part 4 of 7)

Notice of Intended Regulatory Action (NOIRA)

Action 6761 / Stage 10775

Documents

Preliminary Draft Text	None submitted	
 <u>Agency Background Document</u>	5/1/2025	
 <u>Governor's Review Memo</u>	7/22/2025	

Status

DPB Review	Submitted on 5/1/2025 Review Completed: 5/12/2025
Secretary Review	Secretary of Health and Human Resources Review Completed: 7/9/2025
Governor's Review	ORM Review Completed: 7/22/2025 Governor Review Completed: 7/22/2025 Result: Approved
Virginia Registrar	Submitted on 7/23/2025 <u>The Virginia Register of Regulations</u> Publication Date: 8/25/2025  <u>Volume: 42 Issue: 1</u>
Comment Period	<u>Ended 9/24/2025</u> <u>6 comments</u>

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Agency Department of Behavioral Health and Developmental Services

Board State Board of Behavioral Health and Developmental Services

Chapter Regulations for Crisis Services [[12 VAC 35 - 278](#)]

Action: Regulatory Restructuring - Crisis Services (Part 5 of 7)

Action 6767

General Information

Action Summary	In 2017, the Department of Behavioral Health and Developmental Services (DBHDS) conducted a periodic review of the Licensing Regulations. During that review, the Office of Regulatory Affairs (ORA) conducted extensive research on how other states structure their Licensing Regulations. The department also considered comments from internal subject matter experts, providers, and sister agencies when recommending the new licensing structure. As a result of that review, DBHDS determined the regulations should be amended and broken into service-specific chapters. Therefore, DBHDS will repeal the existing Children's Residential and Licensing Regulations, replacing them with one overarching General Chapter applicable to all providers and five (5) service-specific chapters: Residential, Center-Based, NonCenter-Based, Case Management, and Crisis. This methodology allows more detailed service-specific regulations where appropriate and offers more clarity for providers regarding exactly which provisions of the licensing regulations apply to their services. This action will enact the Crisis service-specific chapter. Regulatory provisions from 12VAC35-105 have been pulled into this chapter and updated as appropriate.
Chapters Affected	Only affects this chapter.
Executive Branch Review	This action will go through the normal Executive Branch Review process.
RIS Project	Yes [8115]
New Periodic Review	This action will not be used to conduct a new periodic review.

Stages

Stages associated with this regulatory action.

Stage ID	Stage Type	Status
10782	NOIRA	Stage complete. Comment period ended 09/24/2025.

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Agency Department of Behavioral Health and Developmental Services

Board State Board of Behavioral Health and Developmental Services

Chapter Regulations for Crisis Services [[12 VAC 35 - 278](#)]

Action: Regulatory Restructuring - Crisis Services (Part 5 of 7)

Notice of Intended Regulatory Action (NOIRA)

Action 6767 / Stage 10782

Documents

Preliminary Draft Text	None submitted	
 <u>Agency Background Document</u>	5/5/2025	
 <u>Governor's Review Memo</u>	7/22/2025	

Status

DPB Review	Submitted on 5/5/2025 Review Completed: 5/14/2025
Secretary Review	Secretary of Health and Human Resources Review Completed: 7/9/2025
Governor's Review	ORM Review Completed: 7/22/2025 Governor Review Completed: 7/22/2025 Result: Approved
Virginia Registrar	Submitted on 7/23/2025 <u>The Virginia Register of Regulations</u> Publication Date: 8/25/2025  <u>Volume: 42 Issue: 1</u>
Comment Period	<u>Ended 9/24/2025</u> <u>6 comments</u>

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Agency

Department of Behavioral Health and Developmental Services

Board

State Board of Behavioral Health and Developmental Services

Chapter

Regulations for Case Management Services **[12 VAC 35 - 280]**

Action: Regulatory Restructuring - Case Management Services (Part 6 of 7)

Action 6768

General Information

Action Summary	In 2017, the Department of Behavioral Health and Developmental Services (DBHDS) conducted a periodic review of the Licensing Regulations. During that review, the Office of Regulatory Affairs (ORA) conducted extensive research on how other states structure their Licensing Regulations. The department also considered comments from internal subject matter experts, providers, and sister agencies when recommending the new licensing structure. As a result of that review, DBHDS determined the regulations should be amended and broken into service-specific chapters. Therefore, DBHDS will repeal the existing Children's Residential and Licensing Regulations, replacing them with one overarching General Chapter applicable to all providers and five (5) service-specific chapters: Residential, Center-Based, NonCenter-Based, Case Management, and Crisis. This methodology allows more detailed service-specific regulations where appropriate and offers more clarity for providers regarding exactly which provisions of the licensing regulations apply to their services. This action will enact the Case Management service-specific chapter. Regulatory provisions from 12VAC35-105 have been pulled into this chapter and updated as appropriate.
Chapters Affected	Only affects this chapter.
Executive Branch Review	This action will go through the normal Executive Branch Review process.
RIS Project	Yes [8174]
New Periodic Review	This action will not be used to conduct a new periodic review.

Stages

Stages associated with this regulatory action.

Stage ID	Stage Type	Status
<u>10783</u>	NOIRA	Stage complete. Comment period ended 09/24/2025.

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Agency Department of Behavioral Health and Developmental Services

Board State Board of Behavioral Health and Developmental Services

Chapter Regulations for Case Management Services [12 VAC 35 - 280]

Action: Regulatory Restructuring - Case Management Services (Part 6 of 7)

Notice of Intended Regulatory Action (NOIRA)

Action 6768 / Stage 10783

Documents

Preliminary Draft Text	None submitted	
 Agency Background Document	5/5/2025	
 Governor's Review Memo	7/22/2025	

Status

DPB Review	Submitted on 5/5/2025 Review Completed: 5/14/2025
Secretary Review	Secretary of Health and Human Resources Review Completed: 7/9/2025
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Agency

Department of Behavioral Health and Developmental Services

Board

State Board of Behavioral Health and Developmental Services

Chapter

Regulations for Children's Residential Facilities [12 VAC 35 - 46]

Action: Regulatory Restructuring - Repeal and Replace (Part 7 of 7)

Action 6769

General Information

Action Summary

In 2017, the Department of Behavioral Health and Developmental Services (DBHDS) conducted a periodic review of the Licensing Regulations. During that review, the Office of Regulatory Affairs (ORA) conducted extensive research on how other states structure their Licensing Regulations. The department also considered comments from internal subject matter experts, providers, and sister agencies when recommending the new licensing structure. As a result of that review, DBHDS determined the regulations should be amended and broken into service-specific chapters. Therefore, this action would repeal the existing Children's Residential and Licensing Regulations, replacing them with one overarching General Chapter applicable to all providers and five (5) service-specific chapters: Residential, Center-Based, NonCenter-Based, Case Management, and Crisis. This methodology allows more detailed service-specific regulations where appropriate and offers more clarity for providers regarding exactly which provisions of the licensing regulations apply to their services. This action will repeal the existing Children's Residential and Licensing Regulations once the new restructured chapters are in place.

Chapters Affected

	VAC	Chapter Name	Action Type
Primary	12 VAC 35-46	Regulations for Children's Residential Facilities	Repeal Entire Regulation
Other chapters			
	12 VAC 35 - 105	Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services	Repeal Entire Regulation

Executive Branch Review

This action will go through the normal Executive Branch Review process.

RIS Project

Yes [7294]

New Periodic Review

This action will not be used to conduct a new periodic review.

Stages

Stages associated with this regulatory action.

Stage ID	Stage Type	Status
10786	NOIRA	Stage complete. Comment period ended 09/24/2025.



Agency Department of Behavioral Health and Developmental Services

Board State Board of Behavioral Health and Developmental Services

Chapter Regulations for Children's Residential Facilities [12 VAC 35 - 46]

Action: Regulatory Restructuring - Repeal and Replace (Part 7 of 7)

Notice of Intended Regulatory Action (NOIRA)

Action 6769 / Stage 10786

Documents

Preliminary Draft Text	None submitted	
 Agency Background Document	5/6/2025	
 Governor's Review Memo	7/22/2025	

Status

DPB Review	Submitted on 5/6/2025 Review Completed: 5/12/2025
Secretary Review	Secretary of Health and Human Resources Review Completed: 7/9/2025
Governor's Review	ORM Review Completed: 7/22/2025 Governor Review Completed: 7/22/2025 Result: Approved
Virginia Registrar	Submitted on 7/23/2025 <u>The Virginia Register of Regulations</u> Publication Date: 8/25/2025  <u>Volume: 42 Issue: 1</u>
Comment Period	<u>Ended 9/24/2025</u> <u>1 comments</u>

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ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
Jessica Bryant, CIBH	CIBH Comment on Regulation Overhaul In response to the Notice of Intended Regulatory Action (NOIRA) for the <i>Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services, 12 VAC 35-105-10, et seq</i>, please reconsider the proposed action of separating regulations into a general chapter and service specific chapters. With pending regulation and service changes related to the Behavioral Health Redesign, the proposed action would not be in alignment with the ending of certain services and establishing of other services in the Redesign model. We should be moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign.	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Jonina (Nina) Moskowitz, Psy.D., LCP	SOAR365 agrees with DBHDS's plan to shift to a General Provisions Chapter and a series of service-type specific chapters. 2025's regulatory reduction successfully removed requirements identified as going beyond the scope of the Office of Licensing; this approach should be continued. In addition, changes should avoid creating administrative burdens that detract from service provision or the ability to hire staff. Clarification is needed related to Respite services not provided in an individual's home. The definition of Residential Services does not include respite services; prior drafts of both the Center-based and Residential Services chapters include Respite. There should be no distinction between the requirements for adults and for minors receiving this service. While they should be served separately,	Thank you for your support. The regulatory provisions which were reduced in 2025 were not eliminated because they were outside of the scope of the authority of the Office of Licensing. Reductions were made at the direction of the Office of the Governor through Executive Directive 1. The eliminated provisions were within the authority of the Department; however, they were removed to reduce burden and streamline regulations. All regulatory reductions resulting from Executive Directive 1 have been incorporated into the Regulatory Restructuring drafts. Respite services provided in an individual's home shall be located within the NonCenter Based chapter. Those respite services provided within a respite center will be located and governed by the Center-Based chapter. Those respite services provided within a group home or a residential service setting shall be located and governed by the Residential chapter. The Department has considered the commenter's notes regarding placing respite

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	the intention and delivery of the service are the same – to provide relief for a care giver while providing for the needs of the individuals. Placing respite services for youth under the requirements of Children's Residential Services would result in establishing a series of irrelevant, prohibitive requirements (e.g., involvement of the Interstate Compact administrator, placement agreements, educational planning, mental health services, PT/OT/Speech & Language therapy, many aspects of case management services, allowance, dental treatment information, etc.) Licensing regulations should not specify that services are only available to "unpaid" caregivers as reimbursement is beyond the scope of the Office of Licensing. Introducing secondary screenings for individuals who have been on waitlists makes sense. However, the extent of the documentation for a secondary screening should be taken into consideration in a manner that reflects the varying services and situations. For example, being on a waitlist for two weeks is not equivalent for a person seeking group home services as for someone seeking medically managed intensive inpatient services. Prior drafts set an expectation for providers to test employees' knowledge and/or competence on ISPs of the persons they service. Documentation of this was expected to be retained within the personnel file. DBHDS's response to prior public comment included the idea of a verbal quiz and	services for youth under the requirements of the Children's Residential Services and in the current draft has made edits, so respite is not required to comply with irrelevant provisions. The Department is unsure what the commenter is referencing. The current draft states that <u>"Respite care' means providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular caregiver."</u> The definition, service description etc. does not refer to "unpaid" caregivers. The latest draft of the Residential chapter does not have a secondary screening. Rather, the draft requires that providers review all elements of the screening at the time of initial assessment and update as necessary. Therefore, individuals who have not been on a waitlist for a long period of time may not require updates to screening information. The current draft retains the requirement that employees or contractors who are responsible for implementing the ISP demonstrate a working knowledge of the objectives and strategies contained within the current ISP. However, the requirement of the provider testing this knowledge has been removed from the latest draft. The

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)
STAGE: NOIRA

Commenter	Comment	Agency Response
	minimized the concerns inherent in this expectation, including: • Documentation of knowledge of people's ISPs in personnel files requires the inclusion of confidential information about participants in a personnel file. This is entirely inappropriate. • The time it would take to complete this activity will inherently decrease the amount of time employees have to actually provide services. • Some service providers hold independent licenses. One aspect of holding such a license is the expectation that a person will know and understand the ISPs of persons served. It is burdens such as this that contribute to people such as physicians, nurses, and licensed providers of mental health services to avoid work in Licensed services. Is it appropriate to quiz a licensed psychiatrist on plans? Is it good use of their time to do this for caseloads of 100 -200 people? • One "easy solution" for providers would be to avoid changing people's plans, despite other regulatory requirements and the best interests of individuals. • Another "easy solution" to ensure staff members know the content of plans is to limit the content of plans and to repeat this	Department believes this edit will address the commenter's concerns.

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)
STAGE: NOIRA

Commenter	Comment	Agency Response
	across individuals receiving the service as much as possible. This cookie cutter approach would be another indicator that the intention of this has backfired. • This time-consuming, labor-intensive concept will ultimately <i>detract</i> from providers' ability to ensure quality and quantity of services. Providers are facing staffing crises in hiring direct support professionals, support coordinators, behavioral health case managers, licensed clinicians, nurses, and psychiatrists. Requirements such as this further undermine the service delivery system. In light of the nature and intent of Respite service, is there a need for a quarterly progress review? Often, people only make use of the service for a few days in a quarter. If there is a true need for this review, align with DMAS and require a quarterly progress review only if the individual made use of the service during the quarter. Maintain awareness that individuals served may be slow to make progress. While quarterly conversations at the provider level may make sense, convening a team each quarter where a person has not made progress on one or more objectives has the potential to become burdensome and demoralizing for individuals. A more person-centered approach would be to ask the person if they would like a meeting of all treatment team members to discuss how to proceed.	The Department will take the commenter's concerns into consideration. The requirement for convening a team to meet to review goals and objectives only exists for those goals and objectives that were not accomplished by the identified target date. Therefore, this requirement would not apply each quarter. Moreover, this is an existing regulatory requirement.

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	Requiring consistent format for progress notes across all locations of a service, for each discipline involved is understandable. Requiring consistent format across all services and hence all disciplines does not reflect the varying expectations for members of a team. For example, in some services, a specified plan for objectives to address in the next encounter (e.g., outpatient therapy), whereas this may not be a match for other services (e.g., a residential program's shift notes). Ensure regulations do not set expectations that employees will provide interventions outside of their scope. For example, in many services, it is not appropriate for the provider to communicate the results of medical examinations to providers – that is the responsibility of the treating physician. While community participation is important, Residential Respite services should be exempt from requiring this. The service is intended to provide relief to caregivers, not to build additional skills.	The Department has edited the requirement regarding consistency of progress notes to address the commenter's concerns. The latest draft requires consistency of progress notes across a service that than across all services. It seems the commenter is referring to section 12VAC35-272-120 "Health care policy". This provision requires that the provider have a health care policy which describes how and to what extent <u>"The provider will communicate the results of physical examinations, medical assessment, and diagnostic test, treatments, or examinations conducted by the provider to the individual and the individual's authorized representative, as appropriate."</u> Therefore the draft does not require the provider to communicate any medical examination results but rather create and implement a policy that describes to what extent the provider will communicate medical examination results. The Department shall take the commenter's concerns into consideration.
Allison Meyer GPCS	Consolidate regulatory actions Please consider consolidating regulatory actions on Licensing regulations. DBHDS is trying to separate regulations into a general chapter and service specific chapters which no longer all align with other efforts to end certain services and establish others as	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	part of Behavioral Health Redesign with DMAS. This is inefficient and confusing. We should be moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign.	separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Nicole Lewis, Southside Behavioral Health	Comment on Proposed Overhaul of DBHDS Licensing Regulations I appreciate the opportunity to provide feedback on the proposal to repeal 12VAC35-46 and 12VAC35-105 and restructure the Department of Behavioral Health and Developmental Services licensing regulations into a general chapter with multiple service-specific chapters. Concerns: 1. Fragmentation of Regulations Splitting licensing rules into six separate chapters may create unnecessary confusion for providers and staff. Many providers operate across multiple service types (residential, crisis, case management, etc.), which will force them to cross-reference several chapters rather than using one integrated framework. This increases the risk of misinterpretation, inconsistency, and regulatory burden without clear benefit.	Thank you for your comment. 1. Initially drafted as a comprehensive regulatory overhaul, this action is a project DBHDS has been undertaking carefully since 2019, in response to feedback from providers about the Licensing Regulations being lengthy and cumbersome. Providers have stated that it is often difficult to determine which provisions apply to them, so the restructuring is intended to make it easier to navigate the Licensing Regulations and to clarify service specific requirements. DBHDS convened Regulatory Advisory Panels and circulated initial draft language for public comment in 2019, 2021, and 2022. However, since issuing those General Notices, many substantive provisions in the initial overhaul drafts became effective through separate actions (e.g. legislative mandates, ED 1 reductions). Therefore, this Regulatory Restructuring action is scaled back from the prior overhaul drafts. Provisions common to all services are centrally located in the General Chapter and not repeated across chapters.

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	2. Timing with DMAS Behavioral Health Redesign The Department of Medical Assistance Services (DMAS) is still in the process of redesigning behavioral health services. The DBHDS licensing overhaul appears disconnected from this redesign effort. If the two processes move forward on separate timelines, providers will face overlapping but unaligned changes to regulations and service definitions. This timing could cause duplication, inefficiency, and added compliance costs during an already unstable transition period. 3. Regulatory Overload for Providers The system has seen a wave of new initiatives: Marcus Alert, crisis service transformation, new performance contract requirements, DBHDS risk management memos, and pending updates on case management. Adding a full licensing restructure at the same time may overwhelm providers and divert resources away from quality improvement and direct care. 4. No Planned Public Hearing Given the scale of this change, not holding a public hearing reduces transparency and limits meaningful input from those most impacted. Providers, families, and advocates deserve the opportunity for live	2. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters. 3. The intent of the Regulatory Restructuring action is to make it easier for providers to navigate the Licensing Regulations and to clarify service specific requirements. 4. DBHDS has provided multiple opportunities for stakeholder input and participation throughout the course of this project (i.e. Regulatory Advisory Panels; General Notices with comment periods) and will continue to do so with public comment periods at the proposed and final stages of the regulatory process. Public hearings are proceedings to receive testimony only; they do not allow two-way

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	discussion and feedback before a decision is made. Recommendations: • Consolidate the Process: Align the DBHDS licensing overhaul with DMAS Behavioral Health Redesign so that regulations and services are integrated into a single, coordinated framework. • Phase Changes Gradually: Consider targeted updates to address urgent gaps (e.g., new service types) but delay full restructuring until DMAS redesign details are finalized. • Maintain a Central Framework: If DBHDS proceeds with service-specific chapters, ensure there is one consolidated reference guide or integrated portal that shows how requirements interact across service types. • Add a Public Hearing: Provide stakeholders the opportunity to discuss these changes openly before they move forward. • Conduct Impact Analysis: Before adoption, DBHDS should assess the administrative and financial impact on providers, particularly smaller CSBs and community agencies already under resource strain. Conclusion: While the goal of clarity and service-specific detail is understood, moving forward now	discussion. No responses to comments, questions, or concerns can be provided at a public hearing. • DBHDS and DMAS are separate agencies and must each conduct independent regulatory actions for the combined effort of the Behavioral Health Redesign. (Also refer to response #2.) • Thank you for your recommendation; the Department shall take it into consideration. • As with any regulatory change the Department shall provide training and resources to educate providers. • The regulatory action will provide additional opportunities for public comment at the proposed and final stages. • A financial impact analysis is required of every regulatory action. The required economic impact analysis for this action is a part of the regulatory package. Thank you for your input. The Department intends to move forward with this Regulatory Restructuring action in order to make the Licensing Regulations easier for providers to

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	with this broad regulatory overhaul risks creating confusion, duplication, and instability across the system. A more coordinated, phased approach that aligns with DMAS redesign would better serve providers, individuals, and the Commonwealth.	navigate and to clarify service-specific provisions.
Lynn Brackenridge, Allegheny Highlands Community Services	Regulatory actions Thank you for the opportunity to post comments. Please consider consolidating regulatory actions on Licensing regulations. Separating regulations in a general chapter may/will be confusing. DBHDS and DMAS partnering together to have one uniform process in overhauling regulations will be beneficial for all.	Thank you for your comment. DBHDS and DMAS are separate agencies and must both conduct separate regulatory actions for the combined effort of the Behavioral Health Redesign. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Mount Rogers Community Services	comments Our agency has concerns about moving forward with an overhaul of the regulations, particularly given the many changes underway at the Department of Medical Assistance (DMAS). The DMAS redesign changes are significant, and moving forward simultaneously could create confusion and inconsistency for providers. This would place an added burden on agencies and staff who are already working hard to learn and adapt to the coming DMAS changes. We believe it would be most effective to allow DMAS redesign to be finalized before undertaking additional regulatory overhauls. If DBHDS does decide to continue with revisions at this time, we respectfully request that the new regulations be aligned with DMAS and the MCO's to ensure consistency across agencies.	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)
STAGE: NOIRA

Commenter	Comment	Agency Response
Anonymous	Comment on Proposed Licensing Restructure As a provider committed to trauma-informed, person-centered care across both adult and children's services, I respectfully urge DBHDS to reconsider the decision to merge regulatory oversight for these distinct populations under a single Residential Services chapter. While I appreciate the intent to streamline and clarify licensing expectations, combining children's and adult regulations introduces unnecessary complexity and operational risk. These populations differ significantly in developmental needs, legal protections, supervision requirements, and therapeutic approaches. Merging them into one chapter—however well-intentioned—creates ambiguity for providers, especially those serving both groups. Key concerns include: • Policy Clarity: Providers must now parse which provisions apply to children, adults, or both—without the benefit of separate chapters. This increases the risk of misinterpretation and noncompliance. • Staff Training Burden: Training must now be bifurcated internally, with staff needing to distinguish between overlapping but divergent standards within a single regulatory document. • Audit Vulnerability: Licensing specialists may interpret provisions differently depending on population served, creating inconsistency and confusion during audits. • ISP and Service Planning: Children's services often require more intensive coordination with guardians, schools, and legal systems. Adult services emphasize autonomy and recovery. These distinctions deserve regulatory separation. • Trauma-Informed Practice:	Thank you for your comment. The Department recognizes that adults and children are distinct populations with differing needs. Although the Children's Residential regulations will be located within the Residential chapter, they will be clearly distinguishable and set aside within a separate Part. Therefore, parsing which provisions apply to adults and children will not be necessary. The Department has done as the commenter has suggested and created a clearly demarcated subsection (a separate Part) for children's residential services to ensure the clarity of the newly restructured regulations.

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	Children and adults experience and respond to trauma differently. Regulatory language should reflect these nuances explicitly, not implicitly. I strongly recommend reinstating separate chapters for Children's Residential Services and Adult Residential Services, or at minimum, embedding clearly demarcated subsections within the Residential chapter that distinctly address each population. Doing so would preserve clarity, reduce administrative burden, and better support providers in delivering safe, dignified, and developmentally appropriate care. Thank you for your consideration.	
Valerie Patton, Prince William County Community Services Board	Comment on Overhaul of DBHDS Regulations The DBHDS plan to separate the Licensing Regulations into a general chapter and separate service-specific chapters does not align with the DMAS Behavioral Health Redesign efforts. PWC CSB supports moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign.	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Jessica Bryant, CIBH	CIBH Comment on Regulation Overhaul In response to the Notice of Intended Regulatory Action (NOIRA) for the <i>Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services, 12 VAC 35- 105-10, et seq</i>, please reconsider the proposed action of separating regulations into a general chapter and service specific chapters. With pending regulation and service changes related to the Behavioral Health Redesign, the proposed action action would not be in	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	alignment with the ending of certain services and establishing of other services in the Redesign model. We should be moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign.	
Loudoun County MHSADS	Support of licensing regulation overhaul We support DBHDS's intent to structure the licensing regulations into separate chapters. We are supportive of proposed actions Virginia's behavioral health and developmental disability services for long-term modernization. We urge DBHDS to be mindful when creating the chapters to clearly distinguish between services that may fall under two categories (for example crisis residential services which are both residential and crisis). The NOIRA bulletin mentions reviews that have occurred as far back as 2017. We urge DBHDS to thoughtfully review the previous drafts shared with the public. Many codes and regulations have changed between 2017 and 2025 and the some of the content in the draft regulations and comments from 2019 and 2021 may be obsolete.	Thank you for your support. The Department has continuously updated the Regulatory Restructuring drafts since the project's inception in 2019, incorporating changes from both the Virginia Code and regulations.
Dana Dewing, HRCSB	Concerns with Overhaul of DBHDS Licensing Regs Before moving forward with overhauling the licensing regulations, DBHDS should assess the administrative burden and financial impact on providers, who are already under resource strain. The greatest concern is that DBHDS is proposing regulation changes at the same time DMAS is proposing the BH Redesign. These plans would not be in alignment with each other, creating confusion and inconsistency. If these two	Thank you for your comment. A financial impact analysis is required of every regulatory action. The required economic impact analysis for this action is a part of the regulatory package. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	proposals move forward separately, the regulations will be overlapping yet unaligned. This a big problem. Please consider the timing.	new services as a part of that effort will be incorporated into the new restructured licensing chapters.
RBHA	regulatory action concerns DBHDS is proposing major regulation changes at the same time that DMAS is proposing BH redesign. These actions occurring at the same time without being in alignment will create additional administrative and financial burdens on providers who are already under resource strain. It will also create inconsistency and inefficiency. Please consider the timing of this initiative so one process can be established to overhaul the regulations while taking into account the BH redesign.	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Valerie Carney	Comments & Questions on General Chapter Overhaul VAC35-106-30.C.3 States that the non-residential providers license identifies the maximum capacity of enrolled individuals the provider may serve. I don't see that on our license - will this be added? 12VAC35-106-250 - Are these requirements for contents of personnel files intended for all provider staff or just those working in direct support roles? 12VAC35-106-290.B.2.a Are all providers staff required to be CPR certified including those who work in Administrative roles? Are all direct support staff required to be CPR certified?	VAC35-106-30-C.3. Within the current Regulatory Restructuring drafts the elements required by the license addendum provision are the same elements within the existing 12VAC35-105-30 C. which states, "For residential and inpatient services, the license identifies the number of individuals each residential location may serve at a given time." The current draft of the General chapter requires the following personnel information for all provider staff: <u>1. Individual identifying information; 2. Verified education history if specific education is a requirement within the employee's job description or a legal requirement; 3. Employment or training history; and 4. A record of disciplinary action taken by the provider, if any.</u> All employee and contractor training is required to be <u>"as appropriate according to each employee's or contractor's function or job-specific responsibilities."</u> Therefore, not all staff are required to be CPR certified. The draft does require, <u>"There shall be at least one employee or contractor on duty at each location at all times during service hours who holds a current certificate issued by the</u>

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	12VAC35-106-290.B.2.b Is medical administration training required for all direct support staff - even those who do not administer medication?	<u>American Red Cross, the American Heart Association, or comparable authority in standard first aid and cardiopulmonary resuscitation (CPR)."</u> As noted above all training should be "<u>as appropriate according to each employee's or contractor's function or job-specific responsibilities.</u>"
Jonina (Nina) Moskowitz on behalf of SOAR 365	SOAR365 agrees with DBHDS's plan to shift to a General Provisions Chapter and a series of service-type specific chapters. 2025's regulatory reduction successfully removed requirements identified as going beyond the scope of the Office of Licensing; this approach should be continued. In addition, changes should avoid creating administrative burdens that detract from service provision or the ability to hire staff. Clarification is needed related to Respite services not provided in an individual's home. The definition of Residential Services does not include respite services; prior drafts of both the Center-based and Residential Services chapters include Respite. There should be no distinction between the requirements for adults and for minors receiving this service. While they should be served separately, the intention and delivery of the service are the same – to provide relief for a care giver while providing for the needs of the individuals. Placing respite services for youth under the requirements of Children's Residential Services would result in establishing a series of irrelevant, prohibitive requirements (e.g., involvement of the Interstate Compact administrator, placement agreements, educational planning,	Thank you for your support. The regulatory provisions which were reduced in 2025 were not eliminated because they were outside of the scope of the authority of the Office of Licensing. Reductions were made at the direction of the Office of the Governor through Executive Directive 1. The eliminated provisions were within the authority of the Department; however, they were removed to reduce burden and streamline regulations. All regulatory reductions resulting from Executive Directive 1 have been incorporated into the Regulatory Restructuring drafts. Respite services provided in an individual's home shall be located within the NonCenter Based chapter. Those respite services provided within a respite center will be located and governed by the Center-Based chapter. Those respite services provided within a group home or a residential service setting shall be located and governed by the Residential chapter. The Department has considered the commenter's notes regarding placing respite services for youth under the requirements of the Children's Residential Services and in the current draft has made edits, so respite is not required to comply with irrelevant provisions.

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STAGE: NOIRA

Commenter	Comment	Agency Response
	mental health services, PT/OT/Speech & Language therapy, many aspects of case management services, allowance, dental treatment information, etc.) Licensing regulations should not specify that services are only available to “unpaid” caregivers as reimbursement is beyond the scope of the Office of Licensing. Ensure the regulations and CONNECT are aligned. Specifically, the use of an on-line system eliminates the need for Corrective Action Plans to be signed. For some modifications, the date within CONNECT defaults to 45 days and cannot be shortened, although the regulatory requirement is for 30 days’ notice. A previously proposed definition of a succession plan seems most applicable to providers owned by a single individual. While planning for unexpected changes in leadership, this definition should be more widely applicable across types of providers and, therefore, not require the signature of the “license holder.” If there is a specific concern, consider requiring a corporate will for single ownership providers. While records should be available for DBHDS staff to review in a timely manner and considerations for historical records is appreciated, similar considerations may be needed for providers operating across a large geographic area, where more than two hours may be required to gather and transport	The Department is unsure what the commenter is referencing. The current draft states that <u>“Respite care’ means providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual’s family, guardian, or regular caregiver.”</u> The definition, service description etc. does not refer to “unpaid” caregivers. The requirement for signed corrective action plans was removed during the regulatory reduction associated with Executive Directive 1. All changes made due to the regulatory reduction efforts have been incorporated into the Regulatory Restructuring drafts. Additionally, there will be an extensive overhaul of CONNECT requirements to align with the Regulatory Restructuring. The Department shall take this comment into consideration. Thank you for your comment.

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STAGE: NOIRA

Commenter	Comment	Agency Response
	information (such as HR files) to a program site. There should be recognition that not all violations of regulations involve a systemic deficiency and, therefore, not all violations require systemic corrections. Evaluate the use and the merits of the requirement to submit a revised corrective action plan when a previous plan, on its own, is insufficient. Previous drafts included a new requirement to notify DBHDS of “any changes that cause a provider to be unable to provide services to any individual for a significant period of time.” As written, the expectation was unclear. Does this refer to an inability to serve any people, in which case the request is logical, or does this refer to a provider’s inability to serve a particular individual? If the latter, is the more ethical expectation to have a provider refer an individual to another program if unable to meet a person’s needs for an extended period? Would that not fall within exclusion and discharge criteria within the program description? Previous iterations discussed the need for the executive director/administrator or their designee to be on the premises during regular business hours and that each site must have an appointed designee who has access to all files on site. While there is no disagreement that someone with decision-making authority must be readily available and that files should be accessible to the Department, this expectation fails to take reasonably common scenarios into account, such as leadership retreats, provider trainings, times when all group	The Department realizes that not all violations require systemic changes to be made and a CAP would simply need to note that the violation was not systemic in nature. However, systemic changes can be made to ensure that even isolated incidents are not repeated. This language was entered due to circumstances where providers lose program staff that are necessary to fulfill certain individuals’ ISP requirements. In these instances, the provider may choose to discharge the individual or may request a variance until appropriate staff are hired. However, the Department needs to be aware of the change and be involved in the course of action to address the change. Licensing Specialists frequently encounter providers who state no one on the premises has decision-making authority or access to files necessary to perform inspections, and the necessary point of contact is also unable to be reached via cell phone. This provision is necessary to ensure that the Department can continue to perform meaningful unannounced site visits.

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	home residents are away from home during the day. Similarly, separation of duties may make it unwise for one person to have access to all types of files. This requirement does not consider how modern technology (i.e., cell phones) increases the availability of leadership. Consider approaching this differently. When establishing the requirements for the executive director or administrator, take into consideration the wide variety of providers, some of which also house programs that do not fall under the purview of the Office of Licensing and are different in nature. One option would be to allow for both an executive director and an administrator, who between them cover the responsibilities outlined in a previous draft. This would also allow for the administrator to have relevant education and experience, whereas an executive director may have a background in business, public, or health care administration. Evidence of a valid driver's license for employees who transport individuals is logical. Specifying that this must be a Virginia driver's license is limiting. Providers may be located near other states, Virginia is home to a high number of military families who may have official residency in another state, and licenses from other states, as well as international licenses are accepted in Virginia. Allow for more than 14 – 15 business days to train new employees in behavior intervention policies and procedures, including those related to restrictive interventions and physical restraint. Like First Aid and CPR, these courses require trainers with specific certification. In addition, these trainers must come from	The Department has expanded the field of qualifications for executive directors or administrators in the current draft and has removed the requirement that employees have a Virginia Driver's License. Behavior intervention policies and procedures are too important to allow 30 business days to pass prior to an employee to be trained appropriately. The Department believes the timeline provided within the draft is reasonable and protects individuals served as well as employees.

ACTION: Regulatory Restructuring – General Chapter (Part 1 of 7)
STAGE: NOIRA

Commenter	Comment	Agency Response
	within the provider's organization. It is difficult for providers to provide these trainings (often requiring two full days) multiple times within one month. A 30-business day timeframe is more reasonable. Setting an expectation that the provider will notify the Department of substantive changes to policies creates an unnecessary burden for both providers and the Department, without benefit to individuals served. It is well within the scope of a Licensing Specialist to review any policies required under these regulations during site visits or to request specific policies as germane to specific events (e.g., corrective actions, investigations). In previous drafts, the section on transportation was highly prescriptive and may be able to be scaled back. Regarding on-going checks of driving records, include the option of DMV Driver Alert, which allows a provider to receive notification of related violations. Those providers would not need to demonstrate the latest check of a sample of employees' driving records. Eliminate expectations to conduct root cause analyses related to thresholds. They have proven to be of little value; training from the Eunice Kennedy Shriver Center advised against this approach. It is sufficient to state that Licensed providers are required to comply with the Human Rights Regulations (12VAC35-115) without including restatement of the details of those regulations. Avoid adding duplicative requirements (e.g., reporting the use of seclusion or restraint that does not involve a Level II or Level III serious incident to both departments), having two compliant processes (it would be a	This provision ensures that the Department has the most up to date copies of policies and procedures for unannounced site visits. The provision does not require Department approval prior to implementation, simply notification. The Department has made several edits to the section on Transportation. The requirements regarding root cause analyses related to thresholds are existing regulatory requirements and remain unchanged in the Regulatory Restructuring drafts. The Department does utilize cross references where appropriate; however, some providers have expressed frustration and difficulty using cross-references and prefer restating requirements in text. The Department will reconsider the use of cross references and whether they should be reinserted rather than the restatement of requirements. The proposed "Licensing Complaint process" the commenter references is removed from the latest draft.

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STAGE: NOIRA

Commenter	Comment	Agency Response
	rare complaint that does not involve a Human Right), or setting of any requirements that are more appropriately within the domain of the Human Rights Regulations (e.g., access to computers and the internet). Of note, providing computer and internet access “at the individual’s request” may pose a conflict for some providers as DMAS expects to see how the use of these connects to the service being provided vs. on demand access and use. Similarly, these regulations might state that providers are required to comply with the Americans with Disabilities Act (although even that is a given), without additional details. Remove the requirement to have CPR face guards or masks in First Aid kits. Multiple sources indicate that mouth-to-mouth is not indicated, and many trainings no longer include this component.	The Department has moved the computer and internet access provision to service-specific chapters in order to address the commenter’s concerns. As with any regulatory change the Department shall provide training and resources to educate providers once the draft regulations are ready to take effect. Compliance with the Americans with Disability Act is an existing regulatory requirement located within 12VAC35-105-150 (3) (b). The Department will consider the commenter’s notes regarding CPR face guards or masks.

ACTION: Regulatory Restructuring – Residential Services (Part 2 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
Jessica Bryant, CIBH	CIBH Comment on Regulation Overhaul In response to the Notice of Intended Regulatory Action (NOIRA) for the <i>Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services, 12 VAC 35-105-10, et seq</i>, please reconsider the proposed action of separating regulations into a general chapter and service specific chapters. With pending regulation and service changes related to the Behavioral Health Redesign, the proposed action would not be in alignment with the ending of certain services and establishing of other services in the Redesign model. We should be moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign.	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Jonina (Nina) Moskowitz, Psy.D., LCP	SOAR365 agrees with DBHDS's plan to shift to a General Provisions Chapter and a series of service-type specific chapters. 2025's regulatory reduction successfully removed requirements identified as going beyond the scope of the Office of Licensing; this approach should be continued. In addition, changes should avoid creating administrative burdens that detract from service provision or the ability to hire staff. Clarification is needed related to Respite services not provided in an individual's home. The definition of Residential Services does not include respite services; prior drafts of both the Center-based and Residential Services chapters include Respite. There should be no distinction between the requirements for adults and for minors receiving this service. While they should be served separately, the intention and delivery of the	Thank you for your support. The regulatory provisions which were reduced in 2025 were not eliminated because they were outside of the scope of the authority of the Office of Licensing. Reductions were made at the direction of the Office of the Governor through Executive Directive 1. The eliminated provisions were within the authority of the Department; however, they were removed to reduce burden and streamline regulations. All regulatory reductions resulting from Executive Directive 1 have been incorporated into the Regulatory Restructuring drafts. Respite services provided in an individual's home shall be located within the NonCenter Based chapter. Those respite services provided within a respite center will be located and governed by the Center-Based chapter. Those respite services provided within a group home or a residential service setting shall be located and governed by the Residential chapter. The Department has considered the commenter's notes regarding placing respite

ACTION: Regulatory Restructuring – Residential Services (Part 2 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	service are the same – to provide relief for a care giver while providing for the needs of the individuals. Placing respite services for youth under the requirements of Children's Residential Services would result in establishing a series of irrelevant, prohibitive requirements (e.g., involvement of the Interstate Compact administrator, placement agreements, educational planning, mental health services, PT/OT/Speech & Language therapy, many aspects of case management services, allowance, dental treatment information, etc.) Licensing regulations should not specify that services are only available to "unpaid" caregivers as reimbursement is beyond the scope of the Office of Licensing. Introducing secondary screenings for individuals who have been on waitlists makes sense. However, the extent of the documentation for a secondary screening should be taken into consideration in a manner that reflects the varying services and situations. For example, being on a waitlist for two weeks is not equivalent for a person seeking group home services as for someone seeking medically managed intensive inpatient services. Prior drafts set an expectation for providers to test employees' knowledge and/or competence on ISPs of the persons they service. Documentation of this was expected to be retained within the personnel file. DBHDS's response to prior public comment included the idea of a verbal quiz and	services for youth under the requirements of the Children's Residential Services and in the current draft has made edits, so respite is not required to comply with irrelevant provisions. The Department is unsure what the commenter is referencing. The current draft states that <u>"Respite care' means providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular caregiver."</u> The definition, service description etc. does not refer to "unpaid" caregivers. The latest draft of the Residential chapter does not have a secondary screening. Rather, the draft requires that providers review all elements of the screening at the time of initial assessment and update as necessary. Therefore, individuals who have not been on a waitlist for a long period of time may not require updates to screening information. The current draft retains the requirement that employees or contractors who are responsible for implementing the ISP demonstrate a working knowledge of the objectives and strategies contained within the current ISP. However, the requirement of the provider testing this knowledge has been removed from the latest draft. The Department believes this edit will address the commenter's concerns.

ACTION: Regulatory Restructuring – Residential Services (Part 2 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	minimized the concerns inherent in this expectation, including: • Documentation of knowledge of people's ISPs in personnel files requires the inclusion of confidential information about participants in a personnel file. This is entirely inappropriate. • The time it would take to complete this activity will inherently decrease the amount of time employees have to actually provide services. • Some service providers hold independent licenses. One aspect of holding such a license is the expectation that a person will know and understand the ISPs of persons served. It is burdensome such as this that contribute to people such as physicians, nurses, and licensed providers of mental health services to avoid work in Licensed services. Is it appropriate to quiz a licensed psychiatrist on plans? Is it good use of their time to do this for caseloads of 100 -200 people? • One "easy solution" for providers would be to avoid changing people's plans, despite other regulatory requirements and the best interests of individuals. • Another "easy solution" to ensure staff members know the content of plans is to limit the content of plans and to repeat this across	

ACTION: Regulatory Restructuring – Residential Services (Part 2 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	individuals receiving the service as much as possible. This cookie cutter approach would be another indicator that the intention of this has backfired. • This time-consuming, labor-intensive concept will ultimately <i>detract</i> from providers' ability to ensure quality and quantity of services. Providers are facing staffing crises in hiring direct support professionals, support coordinators, behavioral health case managers, licensed clinicians, nurses, and psychiatrists. Requirements such as this further undermine the service delivery system. In light of the nature and intent of Respite service, is there a need for a quarterly progress review? Often, people only make use of the service for a few days in a quarter. If there is a true need for this review, align with DMAS and require a quarterly progress review only if the individual made use of the service during the quarter. Maintain awareness that individuals served may be slow to make progress. While quarterly conversations at the provider level may make sense, convening a team each quarter where a person has not made progress on one or more objectives has the potential to become burdensome and demoralizing for individuals. A more person-centered approach would be to ask the person if they would like a meeting of all treatment team members to discuss how to proceed.	The Department will take the commenter's concerns into consideration. The requirement for convening a team to meet to review goals and objectives only exists for those goals and objectives that were not accomplished by the identified target date. Therefore, this requirement would not apply each quarter. Moreover, this is an existing regulatory requirement.

ACTION: Regulatory Restructuring – Residential Services (Part 2 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	Requiring consistent format for progress notes across all locations of a service, for each discipline involved is understandable. Requiring consistent format across all services and hence all disciplines does not reflect the varying expectations for members of a team. For example, in some services, a specified plan for objectives to address in the next encounter (e.g., outpatient therapy), whereas this may not be a match for other services (e.g., a residential program's shift notes). Ensure regulations do not set expectations that employees will provide interventions outside of their scope. For example, in many services, it is not appropriate for the provider to communicate the results of medical examinations to providers – that is the responsibility of the treating physician. While community participation is important, Residential Respite services should be exempt from requiring this. The service is intended to provide relief to caregivers, not to build additional skills.	The Department has edited the requirement regarding consistency of progress notes to address the commenter's concerns. The latest draft requires consistency of progress notes across a service that than across all services. It seems the commenter is referring to section 12VAC35-272-120 "Health care policy". This provision requires that the provider have a health care policy which describes how and to what extent "<u>The provider will communicate the results of physical examinations, medical assessment, and diagnostic test, treatments, or examinations conducted by the provider to the individual and the individual's authorized representative, as appropriate.</u>" Therefore the draft does not require the provider to communicate any medical examination results but rather create and implement a policy that describes to what extent the provider will communicate medical examination results. The Department shall take the commenter's concerns into consideration.

ACTION: Regulatory Restructuring – NonCenter-Based Services (Part 3 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
DH	In Favor In favor of the structure change to promote improved accessibility and relatedness to the applicable service category	Thank you for your support.
Allison Meyer, GPCS	Consolidate regulatory actions Please consider consolidating regulatory actions on Licensing regulations. DBHDS is trying to separate regulations into a general chapter and service specific chapters which no longer all align with other efforts to end certain services and establish others as part of Behavioral Health Redesign with DMAS. This is inefficient and confusing. We should be moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign.	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Nicole Lewis, Southside Behavioral Health	Comment on Proposed Overhaul of DBHDS Licensing Regulations I appreciate the opportunity to provide feedback on the proposal to repeal 12VAC35-46 and 12VAC35-105 and restructure the Department of Behavioral Health and Developmental Services licensing regulations into a general chapter with multiple service-specific chapters. Concerns: Fragmentation of Regulations Splitting licensing rules into six separate chapters may create unnecessary confusion for providers and staff. Many providers operate across multiple service types (residential, crisis, case management, etc.), which will force them to cross-reference several chapters rather than using one integrated framework. This increases the risk of misinterpretation, inconsistency, and	Thank you for your comment. Initially drafted as a comprehensive regulatory overhaul, this action is a project DBHDS has been undertaking carefully since 2019, in response to feedback from providers about the Licensing Regulations being lengthy and cumbersome. Providers have stated that it is often difficult to determine which provisions apply to them, so the restructuring is intended to make it easier to navigate the Licensing Regulations and to clarify service specific requirements. DBHDS convened Regulatory Advisory Panels and circulated initial draft language for public comment in

ACTION: Regulatory Restructuring – NonCenter-Based Services (Part 3 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	regulatory burden without clear benefit. 2. Timing with DMAS Behavioral Health Redesign The Department of Medical Assistance Services (DMAS) is still in the process of redesigning behavioral health services. The DBHDS licensing overhaul appears disconnected from this redesign effort. If the two processes move forward on separate timelines, providers will face overlapping but unaligned changes to regulations and service definitions. This timing could cause duplication, inefficiency, and added compliance costs during an already unstable transition period. 3. Regulatory Overload for Providers The system has seen a wave of new initiatives: Marcus Alert, crisis service transformation, new performance contract requirements, DBHDS risk management memos, and pending updates on case management. Adding a full licensing restructure at the same time may overwhelm providers and divert resources away from	2019, 2021, and 2022. However, since issuing those General Notices, many substantive provisions in the initial overhaul drafts became effective through separate actions (e.g. legislative mandates, ED 1 reductions). Therefore, this Regulatory Restructuring action is scaled back from the prior overhaul drafts. Provisions common to all services are centrally located in the General Chapter and not repeated across chapters. 2. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters. 3. The intent of the Regulatory Restructuring action is to make it easier for providers to navigate the Licensing Regulations and to clarify service-specific requirements.

ACTION: Regulatory Restructuring – NonCenter-Based Services (Part 3 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	quality improvement and direct care. 4. No Planned Public Hearing Given the scale of this change, not holding a public hearing reduces transparency and limits meaningful input from those most impacted. Providers, families, and advocates deserve the opportunity for live discussion and feedback before a decision is made. Recommendations: • Consolidate the Process: Align the DBHDS licensing overhaul with DMAS Behavioral Health Redesign so that regulations and services are integrated into a single, coordinated framework. • Phase Changes Gradually: Consider targeted updates to address urgent gaps (e.g., new service types) but delay full restructuring until DMAS redesign details are finalized. • Maintain a Central Framework: If DBHDS proceeds with service-specific chapters, ensure there is one consolidated reference guide or integrated portal that shows how requirements interact across service types. • Add a Public Hearing: Provide stakeholders the opportunity to discuss these changes openly before they move forward.	4. DBHDS has provided multiple opportunities for stakeholder input and participation throughout the course of this project (i.e. Regulatory Advisory Panels; General Notices with comment periods) and will continue to do so with public comment periods at the proposed and final stages of the regulatory process. Public hearings are proceedings to receive testimony only; they do not allow two-way discussion. No responses to comments, questions, or concerns can be provided at a public hearing. • DBHDS and DMAS are separate agencies and must each conduct independent regulatory actions for the combined effort of the Behavioral Health Redesign. (Also refer to response #2.) • Thank you for your recommendation; the Department shall take it into consideration. • As with any regulatory change the Department shall provide training and resources to educate providers. • The regulatory action will provide additional opportunities for public comment at the proposed and final stages.

ACTION: Regulatory Restructuring – NonCenter-Based Services (Part 3 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	• Conduct Impact Analysis: Before adoption, DBHDS should assess the administrative and financial impact on providers, particularly smaller CSBs and community agencies already under resource strain. Conclusion: While the goal of clarity and service-specific detail is understood, moving forward now with this broad regulatory overhaul risks creating confusion, duplication, and instability across the system. A more coordinated, phased approach that aligns with DMAS redesign would better serve providers, individuals, and the Commonwealth.	• A financial impact analysis is required of every regulatory action. The required economic impact analysis for this action is a part of the regulatory package. Thank you for your input. The Department intends to move forward with this Regulatory Restructuring action in order to make the Licensing Regulations easier for providers to navigate and to clarify service-specific provisions.
Valerie Patton, Prince William County Community Services Board	Comment on Overhaul of DBHDS Regulations The DBHDS plan to separate the Licensing Regulations into a general chapter and separate service-specific chapters does not align with the DMAS Behavioral Health Redesign efforts. PWC CSB supports moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign.	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Jessica Bryant, CIBH	CIBH Comment on Regulation Overhaul In response to the Notice of Intended Regulatory Action (NOIRA) for the <i>Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services, 12 VAC 35-105-10, et seq</i>, please reconsider the proposed action of separating regulations into a general chapter and service specific chapters. With pending regulation and service changes related to the Behavioral	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.

ACTION: Regulatory Restructuring – NonCenter-Based Services (Part 3 of 7)**STAGE:** NOIRA

Commenter	Comment	Agency Response
	Health Redesign, the proposed action would not be in alignment with the ending of certain services and establishing of other services in the Redesign model. We should be moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign	

ACTION: Regulatory Restructuring – Center-Based Services (Part 4 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
Allison Meyer, GPCS	Consolidate regulatory actions Please consider consolidating regulatory actions on Licensing regulations. DBHDS is trying to separate regulations into a general chapter and service specific chapters which no longer all align with other efforts to end certain services and establish others as part of Behavioral Health Redesign with DMAS. This is inefficient and confusing. We should be moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign.	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Nicole Lewis, Southside Behavioral Health	Comment on Proposed Overhaul of DBHDS Licensing Regulations I appreciate the opportunity to provide feedback on the proposal to repeal 12VAC35-46 and 12VAC35-105 and restructure the Department of Behavioral Health and Developmental Services licensing regulations into a general chapter with multiple service-specific chapters. Concerns: 1. Fragmentation of Regulations Splitting licensing rules into six separate chapters may create unnecessary confusion for providers and staff. Many providers operate across multiple service types (residential, crisis, case management, etc.), which will force them to cross-reference several chapters rather than using one integrated framework. This increases the risk of misinterpretation, inconsistency, and regulatory burden without clear benefit.	Thank you for your comment. 1. Initially drafted as a comprehensive regulatory overhaul, this action is a project DBHDS has been undertaking carefully since 2019, in response to feedback from providers about the Licensing Regulations being lengthy and cumbersome. Providers have stated that it is often difficult to determine which provisions apply to them, so the restructuring is intended to make it easier to navigate the Licensing Regulations and to clarify service-specific requirements. DBHDS convened Regulatory Advisory Panels and circulated initial draft language for public comment in 2019, 2021, and 2022. However, since issuing those General Notices, many substantive provisions in the initial overhaul drafts became effective through separate actions

ACTION: Regulatory Restructuring – Center-Based Services (Part 4 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	2. Timing with DMAS Behavioral Health Redesign The Department of Medical Assistance Services (DMAS) is still in the process of redesigning behavioral health services. The DBHDS licensing overhaul appears disconnected from this redesign effort. If the two processes move forward on separate timelines, providers will face overlapping but unaligned changes to regulations and service definitions. This timing could cause duplication, inefficiency, and added compliance costs during an already unstable transition period. 3. Regulatory Overload for Providers The system has seen a wave of new initiatives: Marcus Alert, crisis service transformation, new performance contract requirements, DBHDS risk management memos, and pending updates on case management. Adding a full licensing restructure at the same time may overwhelm providers and divert resources away from quality improvement and direct care. 4. No Planned Public Hearing Given the scale of this	(e.g. legislative mandates, ED 1 reductions). Therefore, this Regulatory Restructuring action is scaled back from the prior overhaul drafts. Provisions common to all services are centrally located in the General Chapter and not repeated across chapters. 2. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters. 3. The intent of the Regulatory Restructuring action is to make it easier for providers to navigate the Licensing Regulations and to clarify service-specific requirements. 4. DBHDS has provided multiple opportunities for stakeholder input and participation throughout the

ACTION: Regulatory Restructuring – Center-Based Services (Part 4 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	change, not holding a public hearing reduces transparency and limits meaningful input from those most impacted. Providers, families, and advocates deserve the opportunity for live discussion and feedback before a decision is made. Recommendations: • Consolidate the Process: Align the DBHDS licensing overhaul with DMAS Behavioral Health Redesign so that regulations and services are integrated into a single, coordinated framework. • Phase Changes Gradually: Consider targeted updates to address urgent gaps (e.g., new service types) but delay full restructuring until DMAS redesign details are finalized. • Maintain a Central Framework: If DBHDS proceeds with service-specific chapters, ensure there is one consolidated reference guide or integrated portal that shows how requirements interact across service types. • Add a Public Hearing: Provide stakeholders the opportunity to discuss these changes openly before they move forward. • Conduct Impact Analysis: Before adoption, DBHDS should assess the administrative and financial impact on providers, particularly smaller CSBs	course of this project (i.e. Regulatory Advisory Panels; General Notices with comment periods) and will continue to do so with public comment periods at the proposed and final stages of the regulatory process. Public hearings are proceedings to receive testimony only; they do not allow two-way discussion. No responses to comments, questions, or concerns can be provided at a public hearing. • DBHDS and DMAS are separate agencies and must each conduct independent regulatory actions for the combined effort of the Behavioral Health Redesign. (Also refer to response #2.) • Thank you for your recommendation; the Department shall take it into consideration. • As with any regulatory change the Department shall provide training and resources to educate providers. • The regulatory action will provide additional opportunities for public comment at the proposed and final stages. • A financial impact analysis is required of every regulatory action. The required economic impact analysis for this action is a part of the regulatory package.

ACTION: Regulatory Restructuring – Center-Based Services (Part 4 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	and community agencies already under resource strain. Conclusion: While the goal of clarity and service-specific detail is understood, moving forward now with this broad regulatory overhaul risks creating confusion, duplication, and instability across the system. A more coordinated, phased approach that aligns with DMAS redesign would better serve providers, individuals, and the Commonwealth.	Thank you for your input. The Department intends to move forward with this Regulatory Restructuring action in order to make the Licensing Regulations easier for providers to navigate and to clarify service-specific provisions.
Valerie Patton, Prince William County Community Services Board	Comment on Overhaul of DBHDS Regulations The DBHDS plan to separate the Licensing Regulations into a general chapter and separate service-specific chapters does not align with the DMAS Behavioral Health Redesign efforts. PWC CSB supports moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign.	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Jessica Bryant, CIBH	CIBH Comment on Regulation Overhaul In response to the Notice of Intended Regulatory Action (NOIRA) for the <i>Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services, 12 VAC 35-105-10, et seq</i>, please reconsider the proposed action of separating regulations into a general chapter and service specific chapters. With pending regulation and service changes related to the Behavioral Health Redesign, the proposed action would not be in alignment with the ending of certain services and establishing of other services in the Redesign model. We should be moving forward with	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.

ACTION: Regulatory Restructuring – Center-Based Services (Part 4 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign.	
Joan Rodgers, Fairfax-Falls Church Community Services Board	Restructure of DBHDS licensing regulations Thank you for the opportunity to provide feedback on the restructuring of the DBHDS licensing regulations into a general chapter with multiple service-specific chapters. I would like to submit the following concerns: Fragmentation: splitting licensing rules into six categories may create confusion for providers operating across multiple service types. Staff will need to cross-reference multiple sources, increasing the risk of inconsistency and compliance errors. Regulatory Overload: CSBs are already implementing major initiatives, including Marcus Alert, crisis service transformation, new performance contract requirements, and overwhelming providers and diverting resources away from care. Transparency: The absence of a public hearing limits meaningful stakeholder engagement on changes of this scale.	Initially drafted as a comprehensive regulatory overhaul, this action is a project DBHDS has been undertaking carefully since 2019, in response to feedback from providers about the Licensing Regulations being lengthy and cumbersome. Providers have stated that it is often difficult to determine which provisions apply to them, so the restructuring is intended to make it easier to navigate the Licensing Regulations and to clarify service-specific requirements. DBHDS convened Regulatory Advisory Panels and circulated initial draft language for public comment in 2019, 2021, and 2022. However, since issuing those General Notices, many substantive provisions in the initial overhaul drafts became effective through separate actions (e.g., legislative mandates, ED 1 reductions). Therefore, this Regulatory Restructuring action is scaled back from the prior overhaul drafts. Provisions common to all services are centrally located in the General Chapter and not repeated across chapters. The intent of the Regulatory Restructuring action is to make it easier for providers to navigate the Licensing Regulations and to clarify service-specific requirements DBHDS has provided multiple opportunities for stakeholder input and participation throughout the course of this project (i.e., Regulatory Advisory Panels; General Notices with comment periods) and will continue to do so with public comment periods at the proposed and final stages of the regulatory process. Public hearings are proceedings to receive testimony only; they do not allow two-way discussion. No responses to comments, questions, or concerns can be provided at a public hearing.

ACTION: Regulatory Restructuring – Center-Based Services (Part 4 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	Recommendations Phase-In Changes: address urgent gaps first, delaying full restructuring until the system stabilizes. Provide a Central Reference: if separate chapters are adopted, create a consolidated tool to show how requirements interact. Hold a Public Hearing: allow providers, families, and advocates to give direct input. Impact Analysis: Assess the administrative and financial burdens on CSBs and other community providers While clarity is important, moving forward now with a broad restructuring risks duplications and instability, particularly with the massive DMAS changes and the need for those changes to properly align with DBHDS regulations, as they often do not. A phased, coordinated approach would better serve providers, individuals, and the Commonwealth.	Thank you for your recommendation; the Department shall take it into consideration. As with any regulatory change the Department shall provide training and resources to educate providers. The regulatory action will provide additional opportunities for public comment at the proposed and final stages. A financial impact analysis is required of every regulatory action. The required economic impact analysis for this action is a part of the regulatory package. Thank you for your input. The Department intends to move forward with this Regulatory Restructuring action in order to make the Licensing Regulations easier for providers to navigate and to clarify service-specific provisions.
Valerie Carney	Center Based Regulations Update Questions/Comments In the definitions section of the Center Based updated regulations in the Provider definition the term mental retardation is used - followed by intellectual disability in parenthesis. I understand that it is reflecting the Code of Virginia definition - but can we please advocate to have the Code of Virginia definition updated?? 12VAC35-109-60 references standardized state assessment tools. Where can we access these?	Thank you for your comment. This was an error within a previous draft. The term “mental retardation” is not utilized within the Code or within the regulations. Standardized state assessment tools will be available on the DBHDS Office of Licensing website when the restructured regulations are enacted.

ACTION: Regulatory Restructuring – Center-Based Services (Part 4 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	12VAC35-109=70 The section discussion alternate services seems like excessive documentation when working with and individual seeking center based day support. Is this intended for all center based services? 12VAC35-109-B.14 Doesn't seem pertinent to most Center Based Day Support plans. 12VAC35-109-80.E 1 & 2 Training and review of individual service plans is very important and something we do at regular team meetings. But if I am reading paragraph 2 correctly - we are expected to develop tests specific to each individual training plan and maintain copies of these tests? Everytime we admit a new individual? For every staff member that will work with them or be in rotation for coverage? This really sounds excessive. Over managing an already administratively burdened group of people. 12VAC35-109-90F.4.b&c Center based day support initial planning isn't typically focused on discharge planning. Center based day support is generally long term, with discharge planning discussed when appropriate by the team. Why add this measure before it is appropriate for the individual? I value the work done to separate the the regulations into chapter that are more organized and meaningful - but it seems like Group Day Support is so different from other Center Based providers, that maybe a little more division would help. Great job over all - with updates that were needed.	The language the commenter is referring to is a current requirement listed within 12VAC35-105-660 (D) and will continue to be a requirement moving forward. The commenter has omitted the subsection notation so the Department is unable to respond. If the commenter can provide clarification the Department will respond. The current draft retains the requirement that employees or contractors who are responsible for implementing the ISP demonstrate a working knowledge of the objectives and strategies contained within the current ISP. However, the requirement of the provider testing this knowledge has been removed from the latest draft. The Department believes this edit will address the commenter's concerns. For individuals receiving developmental disability services, a discharge plan and length of stay will look different, but those individuals should still have these aspects reflected within the ISP. Thank you for your support.
SOAR365	SOAR365 agrees with DBHDS's plan to shift to a General Provisions Chapter and a series of service-type specific chapters. 2025's	Thank you for your support. The regulatory provisions which were reduced in 2025 were not eliminated because they were outside of the scope of the authority of the Office of

ACTION: Regulatory Restructuring – Center-Based Services (Part 4 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	regulatory reduction successfully removed requirements identified as going beyond the scope of the Office of Licensing; this approach should be continued. In addition, changes should avoid creating administrative burdens that detract from service provision or the ability to hire staff. Clarification is needed related to Respite services not provided in an individual's home. The definition of Residential Services does not include respite services; prior drafts of both the Center-based and Residential Services chapters include Respite. There should be no distinction between the requirements for adults and for minors receiving this service. While they should be served separately, the intention and delivery of the service are the same – to provide relief for a care giver while providing for the needs of the individuals. Placing respite services for youth under the requirements of Children's Residential Services would result in establishing a series of irrelevant, prohibitive requirements (e.g., involvement of the Interstate Compact administrator, placement agreements, educational planning, mental health services, PT/OT/Speech & Language therapy, many aspects of case management services, allowance, dental treatment information, etc.) Licensing regulations should not specify that services are only available to "unpaid" caregivers as reimbursement is beyond the scope of the Office of Licensing. Center based day support services are defined as programming for <i>adults</i> with a developmental disability. As there is a license for center-based day support for youth	Licensing. Reductions were made at the direction of the Office of the Governor through Executive Directive 1. The eliminated provisions were within the authority of the Department; however, they were removed to reduce burden and streamline regulations. All regulatory reductions resulting from Executive Directive 1 have been incorporated into the Regulatory Restructuring drafts. Respite services provided in an individual's home shall be located within the NonCenter Based chapter. Those respite services provided within a respite center will be located and governed by the Center-Based chapter. Those respite services provided within a group home or a residential service setting shall be located and governed by the Residential chapter. The Department has considered the commenter's notes regarding placing respite services for youth under the requirements of the Children's Residential Services and in the current draft has made edits, so respite is not required to comply with irrelevant provisions. The Department is unsure what the commenter is referencing. The current draft states that <u>"Respite care' means providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular caregiver."</u> The definition, service description etc. does not refer to "unpaid" caregivers.

ACTION: Regulatory Restructuring – Center-Based Services (Part 4 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	the definition should be updated to match. Thank you for specifying the number of years of experience that may be substituted for education when defining a QDDP. Shift the focus from “the service provided” to the “the population receiving the service.” While there may be a preference to have, for example, prior day support experience within a day support setting, a narrow focus will eliminate qualified applicants (e.g., a support coordinator or group home staff member) from obtaining a position as a QDDP. This also holds true for supervisory staff. In addition, there is a dilemma in expecting someone to have several years’ experience providing direction, direct supervision, and monitoring of a service to qualify as a QDDP and the requirement for supervisors of DD services to be QDDPs. Moving forward people will not be able to acquire the required experiences; this comes across as though the actual intention is to phase out allowing experience to be substituted for education. Screening information should include current medications and current dosages. Information about recent changes and discontinued medications may be helpful but should not be required in all settings. Introducing secondary screenings for individuals who have been on waitlists makes sense. However, the extent of the documentation for a secondary screening should take into consideration the varying services and situations. For example, being on a waitlist for two weeks is not equivalent for a person seeking substance abuse intensive outpatient services as for	The Department will take the commenter’s concern into consideration. Thank you for your support. The Department will take the commenter’s concerns into consideration. The Department will take the commenter’s concerns into consideration. The latest draft of the Center-Based chapter does not have a secondary screening. Rather, the draft requires that providers review all elements of the screening at the time of initial assessment and update as necessary. Therefore, individuals who have not been on a waitlist for a long period of time may not require updates to screening information.

ACTION: Regulatory Restructuring – Center-Based Services (Part 4 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	someone seeking day support services. Prior drafts set an expectation for providers to test employees' knowledge and/or competence on ISPs of persons served. Documentation of this was expected to be retained within the personnel file. DBHDS's response to prior public comment included the idea of a verbal quiz and minimized the concerns inherent in this expectation, including: • Documentation of knowledge of people's ISPs in personnel files requires the inclusion of confidential information about participants in a personnel file. This is entirely inappropriate. • The time it would take to complete this activity will inherently decrease the amount of time employees have to actually provide services. • Some service providers hold independent licenses. One aspect of holding such a license is the expectation that a person will know and understand the ISPs of persons served. It is burdens such as this that contribute to people such as physicians, nurses, and licensed providers of mental health services to avoid work in Licensed services. Is it appropriate to quiz a licensed psychiatrist on plans? Is it good use of their time to do this for caseloads of 100 -200 people?	The current draft retains the requirement that employees or contractors responsible for implementing the ISP demonstrate a working knowledge of the objectives and strategies contained within the current ISP. However, the requirement of the provider testing this knowledge has been removed from the latest draft. The Department believes this edit will address the commenter's concerns.

ACTION: Regulatory Restructuring – Center-Based Services (Part 4 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	- One “easy solution” for providers would be to avoid changing people’s plans, despite other regulatory requirements and the best interests of individuals. - Another “easy solution” to ensure staff members know the content of plans is to limit the content of plans and to repeat this across individuals receiving the service as much as possible. This cookie cutter approach would be another indicator that the intention of this has backfired. - This time-consuming, labor-intensive concept will ultimately <i>detract</i> from providers’ ability to ensure quality and quantity of services. Providers are facing staffing crises in hiring direct support professionals, support coordinators, behavioral health case managers, licensed clinicians, nurses, and psychiatrists. Requirements such as this further undermine the service delivery system. In light of the nature and intent of Respite service, is there a need for a quarterly progress review? Often, people only make use of the service for a few days in a quarter. If there is a true need for this review, align with DMAS and require a quarterly progress review only if the individual made use of the service during the quarter. Maintain awareness that individuals served may be slow to make progress. While quarterly	The Department will take the commenter’s concerns into consideration. The requirement for convening a team to meet to review goals and objectives only exists for those goals and objectives that

ACTION: Regulatory Restructuring – Center-Based Services (Part 4 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	conversations at the provider level may make sense, convening a team each quarter where a person has not made progress on one or more objectives has the potential to become burdensome and demoralizing for individuals. A more person-centered approach would be to ask the person if they would like a meeting of all treatment team members to discuss how to proceed. Requiring consistent format for progress notes across all locations of a service, for each discipline involved is understandable. Requiring consistent format across all services and hence all disciplines does not reflect the varying expectations for members of a team. For example, in some services, a specified plan for objectives to address in the next encounter (e.g., outpatient therapy), whereas this may not be a match for other services (e.g., a residential program's shift notes). Ensure regulations do not set expectations that employees will provide interventions outside of their scope. For example, in many services, it is not appropriate for the provider to communicate the results of medical examinations to providers – that is the responsibility of the treating physician.	were not accomplished by the identified target date. Therefore, this requirement would not apply each quarter. Moreover, this is an existing regulatory requirement. The Department has edited the requirement regarding consistency of progress notes to address the commenter's concerns. The latest draft requires consistency of progress notes across a service rather than across all services. It seems the commenter is referring to section 12VAC35-272-120 "Health care policy." This provision requires that the provider have a health care policy which describes how and to what extent "<u>The provider will communicate the results of physical examinations, medical assessment, and diagnostic test, treatments, or examinations conducted by the provider to the individual and the individual's authorized representative, as appropriate.</u>" Therefore, the draft does not require the provider to communicate any medical examination results but rather create and implement a policy that describes to what extent the provider will communicate medical examination results.

ACTION: Regulatory Restructuring – Crisis Services (Part 5 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
Anonymous	24/7 NURSING RCSU DOES NOT NEED 24/7 nursing (LPN/RN). Please explain why 24/7 nursing is needed when nurses can not diagnose or treat clients. On call provider should be readily available for consult if needed.	Thank you for your comment. The current regulatory requirement for 24/7 nursing is aligned with Medicaid standards (as seen in the DMAS Comprehensive Crisis Services manual on page 28: MHS - Appendix G (updated 11.15.24) Final.pdf) and will continue to be a requirement moving forward.
Chris Santarsiero, Connections Health Solutions	SUPPORT 12VAC35-278 Thank you to DBHDS for this regulatory package that ensures that every person will receive nationally recognized and high quality “no-wrong door” community-based crisis services. When Connections Health Solutions, an experienced crisis services provider in other locations, successfully bid on a contract to provide a comprehensive crisis program for both children and adults in Prince William County, the regulatory barriers to operating our model in Virginia was burdensome and uncertain. In the 2024 session of the General Assembly, not only were we successful in resolving the issues found in the Code of Virginia related to the storage and administration of medication, but the barriers found in the Licensing and Human Rights regulations were also addressed. We support the proposed regulations are not only designed to provide guidance and direction to the providers of services, but also to offer protections and assurance of best practice to the recipients of those services. These regulations do both!	Thank you for your support.
Allison Meyer, GPCS	Consolidate regulatory actions Please consider consolidating regulatory actions on Licensing regulations. DBHDS is trying to separate regulations into a general chapter and service specific	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are

ACTION: Regulatory Restructuring – Crisis Services (Part 5 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	chapters which no longer all align with other efforts to end certain services and establish others as part of Behavioral Health Redesign with DMAS. This is inefficient and confusing. We should be moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign.	outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Nicole Lewis, Southside Behavioral Health	Comment on Proposed Overhaul of DBHDS Licensing Regulations I appreciate the opportunity to provide feedback on the proposal to repeal 12VAC35-46 and 12VAC35-105 and restructure the Department of Behavioral Health and Developmental Services licensing regulations into a general chapter with multiple service-specific chapters. Concerns: 1. Fragmentation of Regulations Splitting licensing rules into six separate chapters may create unnecessary confusion for providers and staff. Many providers operate across multiple service types (residential, crisis, case management, etc.), which will force them to cross-reference several chapters rather than using one integrated framework. This increases the risk of misinterpretation, inconsistency, and regulatory burden without clear benefit.	Thank you for your comment. 1. Initially drafted as a comprehensive regulatory overhaul, this action is a project DBHDS has been undertaking carefully since 2019, in response to feedback from providers about the Licensing Regulations being lengthy and cumbersome. Providers have stated that it is often difficult to determine which provisions apply to them, so the restructuring is intended to make it easier to navigate the Licensing Regulations and to clarify service-specific requirements. DBHDS convened Regulatory Advisory Panels and circulated initial draft language for public comment in 2019, 2021, and 2022. However, since issuing those General Notices, many substantive provisions in the initial overhaul drafts became effective through separate actions (e.g. legislative mandates, ED 1 reductions). Therefore, this Regulatory Restructuring action is scaled back from the prior overhaul drafts. Provisions common to all services are centrally located in the

ACTION: Regulatory Restructuring – Crisis Services (Part 5 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	2. Timing with DMAS Behavioral Health Redesign The Department of Medical Assistance Services (DMAS) is still in the process of redesigning behavioral health services. The DBHDS licensing overhaul appears disconnected from this redesign effort. If the two processes move forward on separate timelines, providers will face overlapping but unaligned changes to regulations and service definitions. This timing could cause duplication, inefficiency, and added compliance costs during an already unstable transition period. 3. Regulatory Overload for Providers The system has seen a wave of new initiatives: Marcus Alert, crisis service transformation, new performance contract requirements, DBHDS risk management memos, and pending updates on case management. Adding a full licensing restructure at the same time may overwhelm providers and divert resources away from quality improvement and direct care. 4. No Planned Public Hearing Given the scale of this change, not holding a public hearing reduces transparency and limits meaningful input from those most impacted. Providers, families, and advocates deserve the	General Chapter and not repeated across chapters. 2. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters. 3. The intent of the Regulatory Restructuring action is to make it easier for providers to navigate the Licensing Regulations and to clarify service specific requirements. 4. DBHDS has provided multiple opportunities for stakeholder input and participation throughout the course of this project (i.e. Regulatory Advisory Panels; General Notices with comment periods) and will continue to do so with public comment periods at the proposed and final stages of the regulatory process. Public hearings are

ACTION: Regulatory Restructuring – Crisis Services (Part 5 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	opportunity for live discussion and feedback before a decision is made. Recommendations: • Consolidate the Process: Align the DBHDS licensing overhaul with DMAS Behavioral Health Redesign so that regulations and services are integrated into a single, coordinated framework. • Phase Changes Gradually: Consider targeted updates to address urgent gaps (e.g., new service types) but delay full restructuring until DMAS redesign details are finalized. • Maintain a Central Framework: If DBHDS proceeds with service-specific chapters, ensure there is one consolidated reference guide or integrated portal that shows how requirements interact across service types. • Add a Public Hearing: Provide stakeholders the opportunity to discuss these changes openly before they move forward. • Conduct Impact Analysis: Before adoption, DBHDS should assess the administrative and financial impact on providers, particularly smaller CSBs and community agencies already under resource strain. Conclusion: While the goal of clarity and service-specific detail is	proceedings to receive testimony only; they do not allow two-way discussion. No responses to comments, questions, or concerns can be provided at a public hearing. • DBHDS and DMAS are separate agencies and must each conduct independent regulatory actions for the combined effort of the Behavioral Health Redesign. (Also refer to response #2.) • Thank you for your recommendation; the Department shall take it into consideration. • As with any regulatory change the Department shall provide training and resources to educate providers. • The regulatory action will provide additional opportunities for public comment at the proposed and final stages. • A financial impact analysis is required of every regulatory action. The required economic impact analysis for this action is a part of the regulatory package. Thank you for your input. The Department intends to move forward with this Regulatory Restructuring action in order to make the

ACTION: Regulatory Restructuring – Crisis Services (Part 5 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	understood, moving forward now with this broad regulatory overhaul risks creating confusion, duplication, and instability across the system. A more coordinated, phased approach that aligns with DMAS redesign would better serve providers, individuals, and the Commonwealth.	Licensing Regulations easier for providers to navigate and to clarify service-specific provisions.
Valerie Patton, Prince William County Community Services Board	Comment on Overhaul of DBHDS Regulations The DBHDS plan to separate the Licensing Regulations into a general chapter and separate service-specific chapters does not align with the DMAS Behavioral Health Redesign efforts. PWC CSB supports moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Jessica Bryant, CIBH	CIBH Comment on Regulation Overhaul In response to the Notice of Intended Regulatory Action (NOIRA) for the <i>Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services, 12 VAC 35-105-10, et seq</i>, please reconsider the proposed action of separating regulations into a general chapter and service specific chapters. With pending regulation and service changes related to the Behavioral Health Redesign, the proposed action would not be in alignment with the ending of certain services and establishing of other services in the Redesign model. We should be moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.

ACTION: Regulatory Restructuring – Case Management (Part 6 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
Allison Meyer, GPCS	Consolidate regulatory actions Please consider consolidating regulatory actions on Licensing regulations. DBHDS is trying to separate regulations into a general chapter and service specific chapters which no longer all align with other efforts to end certain services and establish others as part of Behavioral Health Redesign with DMAS. This is inefficient and confusing. We should be moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign.	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Nicole Lewis, Southside Behavioral Health	Comment on Proposed Overhaul of DBHDS Licensing Regulations I appreciate the opportunity to provide feedback on the proposal to repeal 12VAC35-46 and 12VAC35-105 and restructure the Department of Behavioral Health and Developmental Services licensing regulations into a general chapter with multiple service-specific chapters. Concerns: 1. Fragmentation of Regulations Splitting licensing rules into six separate chapters may create unnecessary confusion for providers and staff. Many providers operate across multiple service types (residential, crisis, case management, etc.), which will force them to cross-reference several chapters rather than using one integrated framework. This increases the risk of misinterpretation, inconsistency, and regulatory burden without clear benefit.	Thank you for your comment. 1. Initially drafted as a comprehensive regulatory overhaul, this action is a project DBHDS has been undertaking carefully since 2019, in response to feedback from providers about the Licensing Regulations being lengthy and cumbersome. Providers have stated that it is often difficult to determine which provisions apply to them, so the restructuring is intended to make it easier to navigate the Licensing Regulations and to clarify service specific requirements. DBHDS convened Regulatory Advisory Panels and circulated initial draft language for public comment in 2019, 2021, and 2022. However, since issuing those General Notices, many substantive provisions in the initial overhaul drafts became effective through separate actions(e.g. legislative mandates, ED

ACTION: Regulatory Restructuring – Case Management (Part 6 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	2. Timing with DMAS Behavioral Health Redesign The Department of Medical Assistance Services (DMAS) is still in the process of redesigning behavioral health services. The DBHDS licensing overhaul appears disconnected from this redesign effort. If the two processes move forward on separate timelines, providers will face overlapping but unaligned changes to regulations and service definitions. This timing could cause duplication, inefficiency, and added compliance costs during an already unstable transition period. 3. Regulatory Overload for Providers The system has seen a wave of new initiatives: Marcus Alert, crisis service transformation, new performance contract requirements, DBHDS risk management memos, and pending updates on case management. Adding a full licensing restructure at the same time may overwhelm providers and divert resources away from quality improvement and direct care. 4. No Planned Public Hearing Given the scale of this change, not holding a	1 reductions). Therefore, this Regulatory Restructuring action is scaled back from the prior overhaul drafts. Provisions common to all services are centrally located in the General Chapter and not repeated across chapters. 2. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters. 3. The intent of the Regulatory Restructuring action is to make it easier for providers to navigate the Licensing Regulations and to clarify service specific requirements. 4. DBHDS has provided multiple opportunities for stakeholder input and participation throughout the course of this project (i.e. Regulatory

ACTION: Regulatory Restructuring – Case Management (Part 6 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	public hearing reduces transparency and limits meaningful input from those most impacted. Providers, families, and advocates deserve the opportunity for live discussion and feedback before a decision is made. Recommendations: • Consolidate the Process: Align the DBHDS licensing overhaul with DMAS Behavioral Health Redesign so that regulations and services are integrated into a single, coordinated framework. • Phase Changes Gradually: Consider targeted updates to address urgent gaps (e.g., new service types) but delay full restructuring until DMAS redesign details are finalized. • Maintain a Central Framework: If DBHDS proceeds with service-specific chapters, ensure there is one consolidated reference guide or integrated portal that shows how requirements interact across service types. • Add a Public Hearing: Provide stakeholders the opportunity to discuss these changes openly before they move forward. • Conduct Impact Analysis: Before adoption, DBHDS should assess the administrative and financial impact on providers, particularly smaller CSBs	Advisory Panels; General Notices with comment periods) and will continue to do so with public comment periods at the proposed and final stages of the regulatory process. Public hearings are proceedings to receive testimony only; they do not allow two-way discussion. No responses to comments, questions, or concerns can be provided at a public hearing. • DBHDS and DMAS are separate agencies and must each conduct independent regulatory actions for the combined effort of the Behavioral Health Redesign. (Also refer to response #2.) • Thank you for your recommendation; the Department shall take it into consideration. • As with any regulatory change the Department shall provide training and resources to educate providers. • The regulatory action will provide additional opportunities for public comment at the proposed and final stages. • A financial impact analysis is required of every regulatory action. The required economic impact analysis for this action is a part of the regulatory package.

ACTION: Regulatory Restructuring – Case Management (Part 6 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	and community agencies already under resource strain. Conclusion: While the goal of clarity and service-specific detail is understood, moving forward now with this broad regulatory overhaul risks creating confusion, duplication, and instability across the system. A more coordinated, phased approach that aligns with DMAS redesign would better serve providers, individuals, and the Commonwealth.	Thank you for your input. The Department intends to move forward with this Regulatory Restructuring action in order to make the Licensing Regulations easier for providers to navigate and to clarify service-specific provisions.
Jessica Bryant, CIBH	CIBH Comment on Regulation Overhaul In response to the Notice of Intended Regulatory Action (NOIRA) for the <i>Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services, 12 VAC 35-105-10, et seq</i>, please reconsider the proposed action of separating regulations into a general chapter and service specific chapters. With pending regulation and service changes related to the Behavioral Health Redesign, the proposed action would not be in alignment with the ending of certain services and establishing of other services in the Redesign model. We should be moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.
Valerie Patton, Prince William County Community Services Board	Comment on Overhaul of DBHDS Regulations The DBHDS plan to separate the Licensing Regulations into a general chapter and separate service-specific chapters does not align with the DMAS Behavioral Health Redesign efforts. PWC CSB supports moving forward with one process that can both overhaul	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health

ACTION: Regulatory Restructuring – Case Management (Part 6 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
	regulations while speaking to the services of Behavioral Health Redesign.	Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into new restructured licensing chapters.

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ACTION: Regulatory Restructuring – Repeal and Replace (Part 7 of 7)

STAGE: NOIRA

Commenter	Comment	Agency Response
Jessica Bryant, CIBH	CIBH Comment on Regulation Overhaul In response to the Notice of Intended Regulatory Action (NOIRA) for the <i>Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services, 12 VAC 35- 105-10, et seq</i>, please reconsider the proposed action of separating regulations into a general chapter and service specific chapters. With pending regulation and service changes related to the Behavioral Health Redesign, the proposed action would not be in alignment with the ending of certain services and establishing of other services in the Redesign model. We should be moving forward with one process that can both overhaul regulations while speaking to the services of Behavioral Health Redesign	Thank you for your comment. The Behavioral Health Redesign effort is not at odds with this regulatory action to restructure the licensing chapters. The regulatory actions for Behavioral Health Redesign have not been completed, and regulatory actions are not permitted to incorporate changes that are outside of their scope. Therefore, the DBHDS regulatory actions to incorporate Behavioral Health Redesign must move forward as separate actions. Once the Behavioral Health Redesign regulatory actions are finalized, all new services as a part of that effort will be incorporated into the new restructured licensing chapters.

Project 7101 - NOIRA**Department of Behavioral Health And Developmental Services****Regulatory Restructuring - General Chapter (Part 1 of 7)**Chapter 270General Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental ServicesPart IGeneral**12VAC35-270-10. Authority and applicability.**

A. Section 37.2-404 of the Code of Virginia authorizes the commissioner to license providers subject to rules and regulations adopted by the State Board of Behavioral Health and Developmental Services.

B. No provider shall establish, maintain, conduct, or operate any service without first receiving a license from the commissioner.

C. The provisions of this chapter shall apply to every provider licensed by the Department of Behavioral Health and Developmental Services. Refer to the following service-specific chapters for additional regulatory requirements that may also apply:

12VAC35-272. Residential Chapter

12VAC35-274. Non-Center Based Chapter

12VAC35-276. Center-Based Chapter

12VAC35-278. Crisis Chapter

12VAC35-280. Case Management Chapter.

12VAC35-270-20. Definitions.

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

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

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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; and

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.

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

"Admission date" means the date at which an individual's services begin.

"Adverse action" means sanctions imposed on the provider pursuant to § 37.2-419 of the Code of Virginia; denial, suspension, or revocation of a license; or issuance of a provisional license due to noncompliance with regulatory requirements.

"Applicant" means the person, corporation, partnership, association or public agency that has applied for a license.

"Application closure" means an applicant can no longer pursue the current application to obtain a license issued in accordance with the requirements of § 37.2-404. A new application is necessary in order to pursue a license after an application closure. An application closure is not a denial of an application.

"Assertive community treatment (ACT) service" 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 services:

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

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

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

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

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

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

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

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

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

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

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

"Behavior intervention" means those practices utilized by a provider to help an individual receiving services to achieve a positive outcome and to address challenging behavior in an individualized and safe manner. Behavior intervention practices shall be utilized in accordance

with the individualized services plan; the provider's written policies and procedures governing safety (crisis prevention and intervention); and service expectations. The plan will utilize the least restrictive treatment possible, and will be based upon practices that are effective, therapeutic, and informed by evidence.

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

1. Improved behavioral functioning and effectiveness through the development of new or currently underutilized skills; and
2. Reduction of challenging behaviors.

"Board" or "State Board" as defined by § 37.2-100 of the Code of Virginia 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.

"Brain injury" as defined by § 37.2-403 of the Code of Virginia 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.

"Case management 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 and preferences. Case management services include: identifying potential users of the service; assessing needs and planning services using a person-centered approach; 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 and revising the service plan as indicated; discharge planning; and monitoring 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 future service needs. The terms "support coordination" and "care coordination" are used in certain communities to identify providers of targeted case management services.

"Center-based" means providing a service in a centralized provider-controlled building or facility, where individuals do not reside. Any overnight stays at a center-based location will be temporary and short term.

"Change of ownership" means any transaction that results in a change in control of a licensed provider except those which occur due to a provider following a succession plan. Change of ownership includes:

1. A transfer of a majority interest in the ownership of the program;
2. A change in the majority interest of the ownership of the parent company of any licensed provider;
3. A division of one licensed provider into two or more providers;
4. In the case of a for-profit corporation, transfer of a majority of any class of the stock thereof; the merger of the sponsor's corporation into another corporation; or the consolidation of the sponsor's organization with one or more other corporations, resulting in a new corporate body;

5. In the case of a partnership, adding or withdrawing any partners from the partnership, or transfer of a majority of the partnership interest;

6. In the case of a trust, change of the trustee or a majority of trustees;

7. In the case of a not-for-profit corporation, such changes in the corporate membership or trustees as the department determines to constitute a shift in control of the service; or

8. In the case of a limited liability company, filing of articles of amendment with the State Corporation Commission (SCC) due to a change in the majority of members, a majority of managers listed in the articles of organization, or a majority of the organizers of the limited liability company.

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

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

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

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

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

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

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

"Community Psychiatric Support and Treatment" or "CPST" means a multi-component, team-based service for adults and youth that consists of assessment, crisis and functional supports, counseling, therapeutic interventions, and care coordination. CPST services concentrate on restoring functional skills of daily living, building natural supports, and achieving identified person-centered goals and objectives identified in the individual's ISP. CPST services focus on the individual's ability to succeed in the community by showing improvement in school, work, and family function as well as improving the individual's family or caregiver capacity to help the individual successfully function in the home and community.

"Contracted employee" or "contractor" means a person with whom the licensed provider has an agreement to provide specialized services to an individual or individuals for a specified period of time.

"Corrective action plan" means the provider's pledged plan of action in response to cited areas of noncompliance documented by the regulatory authority. The corrective action plan includes dated descriptions of the corrective actions the provider will take to correct the deficient practice and addresses systemic changes including processes, policies, procedures, and protocols to ensure compliance with the regulation in the future and to help minimize the possibility of systemic deficiencies.

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

"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" 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 shall focus on enabling the individual to attain or maintain his highest potential level of functioning. Day support services shall offer 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.

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

"Developmental disability" as defined by § 37.2-100 of the Code of Virginia 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 age nine years, 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) of this definition if the individual, without services and supports, has a high probability of meeting those criteria later in life.

"Direct care position" as defined by § 37.2-416 of the Code of Virginia 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.

"Emergency services (crisis intervention)" means unscheduled and sometimes scheduled crisis intervention 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 (crisis intervention) shall provide immediate mental health care in the most appropriate and least restrictive environment available, to include the home or community, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention or experiencing crisis events originating from behavioral or mental health support needs. Emergency services (crisis intervention) shall include assessment, short-term counseling designed to stabilize the individual, and care coordination. Emergency services (crisis intervention) also may include walk-ins, home visits, office visits, jail interventions, and preadmission screening activities associated with the judicial process or telephone contacts.

"Full license" as defined by § 37.2-403 of the Code of Virginia means a license issued in accordance with the requirements of § 37.2-404 to a provider who demonstrates full compliance with the regulations governing licensure of providers.

"Group home" 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.

"Historical records" means past records the provider must retain for (i) individuals the provider no longer serves, or (ii) individuals the provider continues to serve after a period of three consecutive years. For individuals served by the provider for at least three consecutive years, the provider must maintain the last updated version of the individual's record and ISP on-site; however, previous versions and the rest of the individual's record must be maintained and may be stored as a historical record.

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“Human Rights Regulations” means the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services (12VAC35-115).

“Individual” or “individual receiving services” as defined by § 37.2-100 of the Code of Virginia 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.

“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. An assessment is not a licensed service.

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

“Intensive in-home service” means family preservation interventions for children and adolescents who have or are at-risk of serious emotional disturbance. 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 shall include 24-hour per day emergency response, which shall be delivered, as needed; 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.

“Legal guardian” means a person appointed by the court, including a person appointed under Chapter 20 (§ 64.2-2000 et seq.), to make decisions regarding the personal affairs of an incapacitated person.

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"Licensing report" means the report of findings issued by the department that notes whether there is noncompliance with any applicable regulation during an initial or ongoing review, inspection, or investigation. The licensing report describes the noncompliance and requests the provider to submit a corrective action plan for each regulatory violation cited.

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

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

"Medically monitored intensive inpatient treatment" or "Level of care 3.7" means a substance use treatment program that provides 24-hour care in a facility under the supervision of medical personnel. The care provided 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 legally permitted 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, pursuant to § 54.1-3408 of the Code of Virginia.

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

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

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

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

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

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

"Mental health skill building" or "MHSS" means goal-directed training and supports used to enable restoration of an individual to the highest level of baseline functioning and to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. MHSS services shall provide face-to-face activities, instruction, interventions, and goal-directed trainings that are designed to restore functioning as defined in the ISP. MHSS shall include goal-directed training in the following areas: (i) functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities.

"Mental illness" as defined by § 37.2-100 of the Code of Virginia 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.

"Neglect" as defined by § 37.2-100 of the Code of Virginia 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 (substance use disorder).

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

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

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

"Organizational license" means the general license authorizing a provider to provide services within the Commonwealth. The organizational license is tied to the provider organization as a whole, not to a particular service.

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

"Provider" as defined by § 37.2-403 of the Code of Virginia 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 disorder) or (ii) residential services for persons with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123, 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 § 54.1-3501, 54.1-3601, or 54.1-3701.

"Psychosocial rehabilitation" 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 (substance use disorder), 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.

"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. It consists of systematic and continuous actions that lead to measurable improvement in the services, supports, and health status of the individuals receiving services.

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

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

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

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

"Respite care" means providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular caregiver. Persons providing respite care are recruited, trained, and supervised by a licensed provider. Respite service is provided in the individual's home or place of residence, in the community, or in a licensed respite facility, such as a group 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.

"Restraint for behavioral purposes" means using a physical hold, medication, or mechanical device to control behavior or involuntarily restrict the freedom of movement of an individual 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.

"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, contractors, visitors, and others through identification, mitigation, early detection, monitoring, evaluation, and control of risks.

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

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

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

"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" as defined by § 37.2-403 of the Code of Virginia means:

1. Planned individualized interventions intended to reduce or ameliorate mental illness, developmental disabilities, or substance abuse (substance use disorder) 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 disorder). Services include outpatient services, intensive in-home services, opioid treatment services, inpatient psychiatric hospitalization, 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

2. 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.

"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.

"Substance abuse (substance use disorder)" as defined by § 37.2-100 of the Code of Virginia 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" or "Level of care 2.1" means structured treatment provided to individuals who require more intensive services than is normally provided in an outpatient service but do not require inpatient services. Treatment consists primarily of counseling and education about addiction-related and mental health challenges delivered a minimum of nine to 19 hours of services per week for adults or six to 19 hours of services per week for children and adolescents. Within this level of care an individual's needs for psychiatric and medical services are generally addressed through consultation and referrals.

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

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

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

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

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

"Substantial compliance" means a level of compliance with the regulations such that any identified deficiencies pose no greater risk to health and safety than the potential for causing minimal harm.

"Succession plan" means a written contingency plan prepared and signed by the licensed provider that identifies a new license holder to continue services in the event of the current provider's death or incapacitation.

"Supervised living residential service" means the provision of 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. Staff is available on a 24-hour basis

and able to respond in a timely manner. 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" (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.

"Systemic deficiency" means violations documented by the department that demonstrate multiple pervasive or institutional defects in the overall operation of the facility or one or more of the provider's services. Systemic deficiency factors may include the severity of noncompliance, the provider's service size, the number of individuals the provider serves, the number of provider locations, the provider's service type, and completion of any prior corrective action plans.

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

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

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

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

Part II

Provider Licensing

12VAC35-270-30. Necessity for license.

A. Licenses are issued to providers offering mental health, developmental disability, or substance abuse (substance use disorder), or residential brain injury services to individuals.

B. Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. The commissioner may grant a provider license for any of the following services:

1. Residential/inpatient services:

a. Clinically managed high-intensity residential care services or Level of Care 3.5;

b. Clinically managed high-intensity residential care services or Level of Care 3.5 for children and adolescents;

c. Clinically managed low-intensity residential care services or Level of Care 3.1;

- d. Clinically managed low-intensity residential care services or Level of Care 3.1 for children and adolescents;
 - e. Clinically managed population-specific high-intensity residential services or Level of Care 3.3;
 - f. Group home;
 - g. Group home for children and adolescents;
 - h. ICF/IID;
 - i. ICF/IID for children and adolescents;
 - j. Inpatient psychiatric hospitalization;
 - k. Medically managed intensive inpatient service or Level of Care 4.0;
 - l. Medically monitored intensive inpatient treatment service or Level of Care 3.7;
 - m. Psychiatric residential treatment facility for children and adolescents;
 - n. Respite residential;
 - o. Respite residential for children and adolescents;
 - p. Sponsored residential home; and
 - q. Supervised living residential service.
- 2. Center-based services:
 - a. Center-based day support services;
 - b. Center-based therapeutic day treatment for children and adolescents;
 - c. Center-based respite service;
 - d. Medication for opioid use disorder treatment programs;
 - e. Mental health intensive outpatient service;
 - f. Mental health outpatient service;
 - g. Mental health partial hospitalization service;
 - h. Psychosocial rehabilitation service;
 - i. Substance abuse intensive outpatient service or Level of Care 2.1;
 - j. Substance abuse outpatient service or Level of Care 1.0; and
 - k. Substance abuse partial hospitalization service or Level of Care 2.5.
- 3. Noncenter-based services:
 - a. Assertive community treatment (ACT) service;
 - b. Community psychiatric Support and Treatment (CPST)
 - c. Noncenter-based respite care service;
 - d. Intensive in-home service;
 - e. Mental health skill building;
 - f. Noncenter-based day support service;
 - g. Supportive in-home service; and
 - h. School-based therapeutic day treatment for children and adolescents.
- 4. Crisis:
 - a. 23-hour crisis stabilization;
 - b. Community-based crisis stabilization;
 - c. Mobile crisis;

- 652 d. REACH; and
- 653 e. Residential crisis stabilization units.
- 654 5. Case management.
- 655 C. A license addendum shall:
- 656 1. List the legal, assumed, fictitious, trading as, or doing business as name under which
- 657 the provider is appropriately credentialed to conduct business in the Commonwealth by
- 658 the SCC;
- 659 2. Describe the services licensed, the disabilities of individuals to be served, the age range
- 660 of individuals to be served, the specific locations where services are to be provided or
- 661 administered, and the terms and conditions for each service offered by a licensed provider;
- 662 and
- 663 3. For residential and inpatient services, identify the maximum number of individuals each
- 664 residential location may serve at a given time.
- 665 **12VAC35-270-40. Initial applications.**
- 666 A. All providers not currently or properly licensed as required pursuant to 12VAC35-270-30
- 667 shall apply for a license using the application designated by the commissioner. Applicants shall
- 668 submit:
- 669 1. A working budget showing projected revenue and expenses for the first year of
- 670 operation, including a revenue plan.
- 671 2. Documentation of working capital to include:
- 672 a. Appropriated revenue if the provider is a state or local government agency, board,
- 673 or commission; or
- 674 b. Documentation of funds or a line of credit in the name of the applicant or owner
- 675 sufficient to cover at least 90 days of operating expenses if the provider is a
- 676 corporation, an unincorporated organization or association, a sole proprietor, or a
- 677 partnership. Such funds may include:
- 678 (1) Personal or business savings accounts;
- 679 (2) Personal or business checking accounts;
- 680 (3) A home equity line of credit, which demonstrates the total amount of credit and the
- 681 amount currently available;
- 682 (4) A bank line of credit which demonstrates the total amount of credit and the amount
- 683 currently available; or
- 684 (5) A credit card with an available balance.
- 685 3. Documentation of authority to conduct business in the Commonwealth of Virginia.
- 686 4. A statement of:
- 687 a. The legal name of the applicant and, if the applicant is an association, partnership,
- 688 limited liability company, or corporation, the names and addresses of its officers,
- 689 agents, sponsors, partners, shareholders, or members; and
- 690 b. The legal name under which the applicant, any entity that operates group homes
- 691 that is affiliated with or under common ownership or control with the applicant, and any
- 692 entity that operates group homes and that is affiliated with or under common ownership
- 693 or control with any officer, agent, sponsor, partner, shareholder, or member of the
- 694 applicant to which a license to operate a service has been issued in any other state,
- 695 together with a list of the states in which such licenses have been issued and the dates
- 696 for which such licenses were issued.

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5. A statement of any previous revocation, suspension, or sanction comparable to those set forth in § 37.2-419 against any license to operate a service issued to the applicant or any entity affiliated with the applicant in any other state, including the dates and descriptions of such disciplinary actions or sanctions.

B. Applicants submitting an initial application shall be licensed for only one service. For the service the applicant seeks to be licensed, the applicant shall submit the following items:

1. A succession plan, unless the applicant is a community service board.

2. A staffing plan, in accordance with 12VAC35-270-310.

3. Employee credentials and job descriptions containing all the elements outlined in 12VAC35-270-280 A.

4. A service description containing all the elements outlined in 12VAC35-270-500 C.

5. The policies required by 12VAC35-270-190, 12VAC35-270-240, 12VAC35-270-290, 12VAC35-270-300, 12VAC35-270-320, 12VAC35-270-330, 12VAC35-270-410, 12VAC35-270-420, 12VAC35-270-430, 12VAC35-270-440, 12VAC35-270-450, 12VAC35-270-490, 12VAC35-270-500, 12VAC35-270-530, 12VAC35-270-540, 12VAC35-270-550, 12VAC35-270-560, 12VAC35-270-570, 12VAC35-270-580, 12VAC35-270-590, 12VAC35-270-660, and 12VAC35-270-700, and any policies required by the applicable service-specific licensing chapters.

6. For residential or inpatient services, the number of individuals each location may serve at a given time.

7. Any additional documentation the department requests to determine compliance with this chapter and applicable regulatory requirements of the department's corresponding service-specific licensing chapters.

C. In no event may an applicant reapply for a license after the commissioner has refused or revoked a license until a period of six months has elapsed from the effective date of that action, unless the commissioner in his sole discretion believes that there has been such a change in the conditions causing refusal of the prior application or revocation of the license as to justify consideration of the new application.

D. The department shall screen an application and accompanying documentation for completeness according to the date and time the application is received. An application will be considered complete when all required documents are received by the department.

1. If the department determines an application is incomplete, it shall notify the applicant that the application is not complete in writing. The notification shall specify the additional documentation required to complete the application.

2. If the application is incomplete, the applicant shall have 45 business days from the receipt of the notification to submit the required documentation. Applications that are not acted on within 45 business days shall be closed. The department shall notify the applicant in writing of the application closure and that a new application may be submitted.

3. The department shall not consider any application until it determines the application to be complete with all required documentation.

E. Any applicant who does not respond to application deficiencies or who does not schedule an onsite visit with a licensing specialist within time frames prescribed by the department will have the application closed from further action. The department shall notify the applicant in writing of the application closure and that a new application may be submitted.

12VAC35-270-50. License types.

A. The commissioner may issue the following types of licenses:

743 1. A conditional organizational license or a conditional license to operate a new service
744 may be issued to a provider that demonstrates compliance with administrative and policy
745 regulations but has not demonstrated compliance with all the regulations.

746 a. A conditional license shall not exceed six months but may be renewed, not to
747 exceed 12 successive months for all conditional licenses and renewals combined.

748 b. A provider holding a conditional license for a service shall demonstrate progress
749 toward compliance.

750 c. A conditional license may be renewed if the provider is not able to demonstrate
751 compliance with all the regulations at the end of the license period.

752 d. A provider holding a conditional organizational license shall not add services or
753 locations during the conditional period.

754 e. A provider that holds a full organizational license, may have more than one service
755 or location on a conditional license.

756 f. A group home provider shall be limited to providing services in a single location,
757 serving no more than four individuals during the conditional period.

758 2. A provisional license may be issued to a provider for a service that has demonstrated
759 an inability to maintain compliance with all applicable regulations, including this chapter
760 and Human Rights Regulations (12VAC35-115), has violations of human rights or
761 licensing regulations that pose a threat to the health or safety of individuals receiving
762 services, has multiple violations of human rights or licensing regulations, or has failed to
763 comply with a previous corrective action plan.

764 a. The commissioner may issue a provisional license at any time in accordance with
765 the provisions of § 37.2-415 of the Code of Virginia, to any previously fully licensed
766 provider who shows an inability to comply with licensing regulations.

767 b. The term of a provisional license shall not exceed six months, but may be renewed,
768 not to exceed 12 successive months for all provisional licenses and renewals
769 combined.

770 c. A provider holding a provisional license for a service shall demonstrate progress
771 toward compliance.

772 d. A provider holding a provisional license for a service shall not increase its services
773 or locations or expand the capacity of the service.

774 e. A provisional license shall be displayed in a format determined by the commissioner
775 at the site of the affected service and shall indicate the violations of licensing standards
776 to be corrected and the expiration date of the license.

777 3. A full license shall be issued after a provider or service demonstrates substantial
778 compliance with all the applicable regulations.

779 a. A full license may be issued to a provider for service for a term of one year or a term
780 of three successive years.

781 b. If a full license is issued for a three-year term, it shall be referred to as a triennial
782 license. A triennial license may be granted to providers for services that have
783 demonstrated full or substantial compliance with all applicable regulations for more
784 than a year and has a process in place that provides sufficient oversight to maintain
785 compliance.

786 c. If a full license is issued for a one-year term, it shall be referred to as an annual
787 license.

788 d. The term of the first full renewal license after the expiration of a conditional or
789 provisional license shall not exceed one year.

e. The commissioner may issue an annual license to a provider that has previously had a triennial license at any time, if the provider demonstrates noncompliance with these regulations or other applicable statutes or regulations.

B. The commissioner may add stipulations on a license issued to a provider that places limitations on the provider or imposes additional requirements on the provider.

C. No service shall be added to a license with an expiration date that occurs after the expiration date of the organizational license.

D. No provider shall be issued multiple licenses for the same service.

12VAC35-270-60. Inspection requirements.

A. The department shall conduct an announced or unannounced onsite review of all new providers and services to determine compliance with this chapter.

B. The department shall conduct unannounced onsite reviews of licensed providers and each service at any time and at least annually to determine compliance with these regulations. The annual unannounced onsite reviews shall be focused on preventing specific risks to individuals, including an evaluation of the physical facilities in which the services are provided.

C. The department may conduct announced and unannounced onsite reviews at any time as part of the investigations of complaints or incidents to determine if there is a violation of this chapter.

D. The provider shall permit representatives from the department to conduct reviews to:

1. Verify application information;
2. Assure compliance with this chapter; and
3. Investigate complaints.

E. The provider shall cooperate fully with onsite reviews, inspections, and investigations and shall provide all information requested by the department.

F. The provider shall produce to department staff within two hours of the request, any records or information required to be onsite and requested by department staff to conduct the onsite review, inspection, or investigation. Considerations shall be made for historical records. At the time of the request for historical records, the provider shall notify department staff of: (i) the location of the records and (ii) an estimated period of time that will be required to obtain the records. Service records of individuals the provider continues to serve for over three years may be stored as a historical record; however, the provider shall ensure that the latest copy of the individual's record and ISP are located on-site.

12VAC35-270-70. Renewals.

A. Licenses issued under this chapter shall expire pursuant to 12VAC35-270-50, as indicated on the license. The provider shall confirm its intent to renew the license prior to the expiration date and notify the department in advance of any changes in service or location.

B. The provider's completed renewal application shall be submitted at least 30 calendar days prior to the expiration of the current license.

1. Failure to submit a renewal application at least 30 calendar days prior to the expiration of the current license shall be considered notification to the department of intent to discontinue services and cease operations at the expiration of the license.

2. The provider shall continue to provide all services that are identified in each individual's ISP after it has given official notice of its intent to cease operations and until each individual is appropriately discharged or transferred.

3. The provider shall continue to maintain compliance with all applicable regulations as it discontinues its services.

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C. A conditional license may be renewed, not to exceed 12 successive months for all conditional licenses and renewals combined.

D. A provisional license may be renewed; not to exceed 12 successive months for all provisional licenses and renewals combined.

E. The term of the first full renewal period after the expiration of a conditional or provisional license shall not exceed one year.

F. A license shall continue in effect after the expiration date only if the provider's completed renewal application has been received by the department at least 30 days before the date of expiration. The department shall notify the provider that its license shall continue to be effective if the renewed license is not issued before the date of expiration.

12VAC35-270-80. Changes to licenses and notifications to the department.

A. A provider shall submit a written modification application and all attachments required by this chapter at least 30 calendar days in advance of a proposed modification to its license. Changes to the following characteristics require a modification application:

1. The provider's legal, assumed, fictitious, trading as, or doing business as name;
2. Characteristics of individuals served (disability, age, or gender);
3. Services offered, including adding a new service;
4. Service descriptions that substantially change the nature or delivery of the service;
5. The organizational or administrative structure of leadership of the provider;
6. The locations where services are provided, including expanding into new regions, acquiring a location, or adding a temporary location not identified within an emergency preparedness and response plan;
7. Office locations;
8. Existing stipulations; or
9. The maximum number of individuals served under the provider license, including bed capacity for residential or inpatient services.

B. Upon receipt of the completed modification application, the commissioner may revise the provider license. Approval of such request shall be at the sole discretion of the commissioner or his designee.

C. A license shall not be transferred or assigned to another provider. A new application shall be made and a new conditional license issued when there is a change in ownership.

D. The acquiring provider shall provide a change of ownership application at least 45 calendar days in advance of any change of ownership.

1. Any change of ownership applicant shall provide:
 - a. A change of ownership application including a clear service description;
 - b. A cover letter explaining the change of ownership;
 - c. Evidence of the upcoming sale or transfer;
 - d. Documentation of authority to conduct business in the Commonwealth of Virginia from the SCC;
 - e. A current organizational chart;
 - f. Position descriptions;
 - g. Evidence of financial resources to cover at least 90 days of operating expenses;
 - h. A proposed staffing plan;
 - i. A proposed working budget;

- 880 j. Certificate of occupancy;
881 k. Building floor plan;
882 l. The program's current health inspection;
883 m. The program's current fire inspection;
884 n. All operating policies and procedures; and
885 o. The existing license number, if applicable.
- 886 2. The department shall screen a change of ownership application and accompanying
887 documentation for completeness according to the date and time the application is
888 received. A change of ownership application will be considered complete when all required
889 documents are received by the department.
- 890 3. The department shall evaluate the suitability of the applicant prior to approving a change
891 of ownership application. A negative determination with respect to any one of the
892 department's evaluation factors constitutes an adequate ground for denying an
893 application. The evaluation factors are:
- 894 a. Past performance as a provider of a service licensed by the department, including:
895 (1) History of compliance with this chapter;
896 (2) Ability to provide services;
897 (3) History of response to corrective action plans under this chapter;
898 (4) History of failure to provide services to any individual when licensed or approved
899 to provide such service; and
900 (5) History of abuse or neglect of individuals.
- 901 b. Whether the applicant's financial resources are sufficient to provide services for
902 which the applicant seeks a license.
- 903 c. Whether the applicant is in compliance with all applicable laws of the
904 Commonwealth and whether the applicant has appropriate insurance coverage.
- 905 d. The record of compliance for health care facilities in the Commonwealth or other
906 states including any limitations on, suspension or revocation of, or refusal to grant or
907 renew a health care license or certification for Medicaid or Medicare to the applicant.
- 908 e. The adequacy of the applicant's legal capacity to operate, as demonstrated by
909 documents such as articles of incorporation and corporate bylaws.
- 910 f. Any attempt to obtain a license or approval by fraud, misrepresentation, or the
911 submission of false information.
- 912 g. Capacity to meet the requirements for licensure or approval.
- 913 h. Such other information as the department may require.
- 914 4. The applicant begins with a conditional license under new ownership.
- 915 E. The provider shall notify the department in writing prior to implementing changes that affect:
- 916 1. Contact information, including changes to the provider's telephone number, email
917 address, or to add or subtract a primary contact to a licensed service;
918 2. The provider's normal business hours;
919 3. Significant changes to the staffing plan, position descriptions, or employee or contractor
920 qualifications; or
921 4. Any changes that cause a provider to be unable to provide a service.

F. A change requiring a modification of the license shall not be implemented prior to approval by the commissioner. The department may send the provider a letter approving implementation of the modification pending the issuance of the modified license.

12VAC35-270-90. Variances.

A. The commissioner or his designee may grant a variance to a specific regulation if he determines that such a variance will not jeopardize the health, safety, or welfare of individuals.

B. A provider shall submit a request for a variance in writing to the commissioner.

1. A variance request shall only be granted to licensed providers.

2. The request shall demonstrate how (i) complying with the regulation would be a hardship unique to the provider, (ii) the hardship is not purely financial in nature, and that the variance will not jeopardize the health, safety, or welfare of individuals.

3. The department may limit the length of time a variance will be effective.

C. The provider shall not implement a variance until it has been approved in writing by the commissioner.

Part III

Regulatory Noncompliance

Article 1

Disciplinary Process

12VAC35-270-100. Investigations.

The department shall investigate all complaints regarding potential violations of licensing regulations. Complaint investigations may be based on onsite reviews, a review of records, a review of provider reports, telephone interviews, or other information that comes to the attention of the department.

12VAC35-270-110. Compliance.

A. The provider including its employees, contractors, students, and volunteers shall comply with:

1. This chapter;

2. The terms and stipulations of the license;

3. All applicable federal, state, or local laws, and regulations including:

a. Laws regarding employment practices including the Equal Employment Opportunity Act;

b. The Americans with Disabilities Act and the Virginians with Disabilities Act;

c. The Health Insurance Portability and Accountability Act (HIPAA);

d. For home and community-based services waiver settings subject to this chapter, 42 CFR 441.301(c)(1) through (4);

e. Occupational Safety and Health Administration regulations;

f. The Virginia Health Records Privacy Act (§ 32.1-127.1:03);

g. The Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services (12VAC35-115);

h. The Regulations to Ensure the Protection of Subjects in Human Research (12VAC35-180);

i. Virginia Department of Health regulations;

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- j. Virginia Department of Health Professions regulations;
- k. Virginia Department of Medical Assistance Services regulations;
- l. Virginia Uniform Statewide Fire Prevention Code 13VAC5-52; and
- m. Virginia Uniform Statewide Building Code 13VAC5-63.
4. Section 37.2-400 of the Code of Virginia and Human Rights Regulations (12VAC35-115) adopted by the state board; and
5. The provider's own policies and procedures. All required policies shall be in writing.
- B. The department shall determine the level of compliance with each regulation and note such compliance within the licensing report as follows:
1. "Compliance" (C) means the provider clearly meets the requirements of a regulation.
2. "Noncompliance" (NC) means the provider violates or fails to meet part or all of a regulation.
3. "Not determined" (ND) means that the provider must provide additional information to determine compliance with a regulation.
4. "Not applicable" (NA) means the provider is specifically exempted from or not required to demonstrate compliance with the provisions of a regulation.
5. "Systemic noncompliance" (SN) means the provider has had violations of the regulations documented by the department that demonstrate multiple or repeat deficiencies in the operation of one or more services.
- C. The provider, including its employees, contractors, student interns, and volunteers, shall comply with all applicable regulations.
- D. Providers shall not deviate significantly from the program or services for which a license was issued without obtaining prior written approval from the department, as required by 12VAC35-270-80 A.
- 12VAC35-270-120. Corrective action plan.**
- A. If there is noncompliance with any applicable regulation during an initial or ongoing review, inspection, or investigation, the department shall issue a licensing report describing the noncompliance and requesting the provider to submit a corrective action plan for each violation cited.
- B. The provider shall submit to the department a written corrective action plan for each violation cited.
- C. The corrective action plan shall include a:
1. Detailed description of (a) the corrective actions to be taken to cure the cited violations, and (b) the systemic changes to be made that will minimize the possibility that the violation will occur again;
2. Date of completion for each corrective action; and
3. Responsible designated to oversee implementation of the pledged corrective action.
- D. The provider shall submit a corrective action plan to the department within 15 business days of the issuance of the licensing report. One extension may be granted by the department when requested prior to the due date, but an extension shall not exceed an additional 10 business days. An immediate corrective action plan shall be required if the department determines that the violations pose a danger to individuals receiving the service.
- E. Upon receipt of the corrective action plan, the department shall review the plan and determine whether the plan is approved or not approved. The provider has an additional 10 business days to submit a revised corrective action plan after receiving a notice that the department has not approved the revised plan. If the second submission of the corrective action

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plan is not approved, the department shall offer the provider regulatory technical assistance prior to the third submission of the corrective action plan. If the third submission of the corrective action plan is not approved, the department shall incorporate the corrective action plan into the process enumerated in 12VAC35-270-120 F.

F. If a provider disagrees with a citation of a violation or the disapproval of a revised corrective action plan, the provider shall initially discuss this disagreement with the licensing specialist. If the disagreement is not resolved, the provider may ask for a meeting with the licensing specialist's supervisor, in consultation with the DBHDS Office of Licensing Director or designee, to challenge a finding of noncompliance. The determination of the licensing director or designee is final.

G. The provider shall implement an approved corrective action plan for each violation cited by the date of completion identified in the plan.

H. The provider shall monitor implementation and effectiveness of approved corrective actions as part of its quality improvement program required by 12VAC35-270-570. If the provider determines that an approved corrective action was fully implemented, but did not prevent the recurrence of a regulatory violation or correct any systemic deficiencies, the provider shall:

1. Continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies; or

2. Submit a revised corrective action plan to the department for approval in accordance with 12VAC35-270-120 E.

12VAC35-270-130. Sanctions.

A. The commissioner may invoke the sanctions enumerated in § 37.2-419 of the Code of Virginia upon receipt of information that a licensed provider is:

1. In violation of the provisions of §§ 37.2-400 through 37.2-422 of the Code of Virginia, these regulations, or the provisions of the Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services (12VAC35-115); and

2. Such violation adversely affects the human rights of individuals, or poses an imminent and substantial threat to the health, safety or welfare of individuals.

B. The commissioner shall notify the provider in writing of the specific violations found and of his intention to convene an informal conference pursuant to § 2.2-4019 of the Code of Virginia and 12VAC35-270-170 at which the presiding officer will be asked to recommend issuance of a special order.

C. The sanctions contained in the special order shall remain in effect during the pendency of any appeal of the special order.

Article 2

Enforcement Actions

12VAC35-270-140. Denial, revocation, or suspension of a license.

A. An application for a license, license renewal, or modification may be denied and a full, conditional, or provisional license may be revoked or suspended for one or more of the following reasons:

1. The provider or applicant has violated any provisions of Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2 of the Code of Virginia or these licensing regulations;

2. The provider's or applicant's conduct or practices are detrimental to the welfare of any individual receiving services or in violation of human rights identified in § 37.2-400 of the Code of Virginia or the Human Rights Regulations (12VAC35-115);

3. The provider or applicant permits, aids, or abets the commission of an illegal act;

4. The provider or applicant fails or refuses to submit reports or to make records available as requested by the department;

5. The provider or applicant refuses to admit a representative of the department who displays state-issued photo identification to the premises;

6. The provider or applicant fails to submit or implement an adequate corrective action plan; or

7. The provider or applicant submits any misleading or false information to the department.

B. A provider shall be notified in writing of the department's intent to deny, revoke, or suspend a license; the reasons for the action; the right to appeal; and the appeal process. The provider has the right to appeal the department's decision under the provisions of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

12VAC35-270-150. Summary suspension.

A. In conjunction with any proceeding for revocation, denial or other action, when conditions or practices exist that pose an immediate and substantial threat to the health, safety, and welfare of the individuals living there, the commissioner may issue an order of summary suspension of the license to operate any group home or residential service for adults when he believes the operation of the home or residential service should be suspended during the pendency of such proceeding.

B. Prior to the issuance of an order of summary suspension, the department shall contact the Executive Secretary of the Supreme Court of Virginia to obtain the name of a hearing officer. The department shall schedule the time, date, and location of the administrative hearing with the hearing officer.

C. The order of summary suspension shall take effect upon its issuance. It shall be delivered by personal service and certified mail, return receipt requested, to the address of record of the licensee as soon as practicable. The order shall set forth:

1. The time, date, and location of the hearing;

2. The procedures for the hearing;

3. The hearing and appeal rights; and

4. Facts and evidence that formed the basis for the order of summary suspension.

D. The hearing shall take place within three business days of the issuance of the order of summary suspension.

E. The department shall have the burden of proving in any summary suspension hearing that it had reasonable grounds to require the licensee to cease operations during the pendency of the concurrent revocation, denial, or other proceeding.

F. The administrative hearing officer shall provide written findings and conclusions together with a recommendation as to whether the license should be summarily suspended to the commissioner within five business days of the hearing.

G. The commissioner shall issue a final order of summary suspension or make a determination that the summary suspension is not warranted based on the facts presented and the recommendation of the hearing officer within seven business days of receiving the recommendation of the hearing officer.

H. The commissioner shall issue and serve on the group home or residential facility for adults or its designee by personal service or by certified mail, return receipt requested either:

1. A final order of summary suspension including (i) the basis for accepting or rejecting the hearing officer's recommendation, and (ii) notice that the licensee of the group home

or residential service may appeal the commissioner's decision to the appropriate circuit court no later than 10 days following issuance of the order; or

2. Notification that the summary suspension is not warranted by the facts and circumstances presented and that the order of summary suspension is rescinded.

I. The licensee may appeal the commissioner's decision on the summary suspension to the appropriate circuit court no more than 10 days after issuance of the final order.

J. The outcome of concurrent revocation, denial, and other proceedings shall not be affected by the outcome of any hearing pertaining to the appropriateness of the order of summary suspension.

K. At the time of the issuance of the order of summary suspension, the department shall contact the appropriate agencies to inform them of the action and the need to develop relocation plans for the individuals receiving residential or center-based services, and ensure that any other legal guardians or responsible family members are informed of the pending action.

12VAC35-270-160. Consent agreements.

A. A consent agreement may be entered into when the provider and the department seek to facilitate the provider's operation in accordance with applicable regulations without the need to enter into further adverse action. In no case may a proposed consent agreement be submitted after an informal conference.

B. An acceptable consent agreement shall contain the following specific elements:

1. Dates of key actions, and the names of the parties;

2. The assertion that all violations have been corrected or will be corrected by a time specified in the proposed agreement;

3. A description in detail of the case-specific systemic solution proposed that addresses the causes of the history of violations, including the methods the provider has in place to prevent violations and to monitor results;

4. A stipulation by the provider to the validity of the violations enumerated in the specified licensing report and waiver of right to hearing under the Administrative Process Act (§2.2-4000 et seq. of the Code of Virginia) solely with respect to those violations;

5. The duration of the consent agreement, including the information that the period begins when the commissioner or his designee signs it;

6. A statement that when the commissioner or his designee signs the agreement, signifying final acceptance, the commissioner or his designee is also agreeing to rescind the outstanding adverse action and that the provider is agreeing to withdraw all appeals to that action;

7. A statement directing the provider to review all pertinent state and federal regulations and contractual agents to determine any restrictions on reimbursement that may be imposed by other state agencies or payor sources as required by § 37.2-415 of the Code of Virginia; and

8. A statement outlining conditions for termination of the final consent agreement for cause, and the nature of the provider's appeal rights should termination occur.

12VAC35-270-170. Informal conferences.

A. Any provider appeal of a decision by the department pursuant to 12VAC35-270-130, 12VAC35-270-140, or 12VAC35-270-150 shall result in an informal conference pursuant to the requirements of the Virginia Administrative Process Act (§2.2-4000 et seq. of the Code of Virginia), unless the named party and the department consent to waive such an informal conference and go directly to a formal hearing. Requests for an informal conference shall be in writing to the Office of Licensing Director.

B. The provider appealing the decision ("the appellant") shall have the following rights to:

1. Reasonable notice of the informal conference, which shall include contact information consisting of the name, telephone number, and government email address of the person designated by the department to answer questions or otherwise assist a named party;

2. Appear in person or by counsel or other qualified representative before the department or its subordinates, or before a hearing officer for the informal presentation of factual data, argument, or proof in connection with the appellant's case;

3. Have notice of any contrary fact basis or information in the possession of the department that can be relied upon in making an adverse decision against the appellant; and

4. Be informed briefly and generally in writing of the factual or procedural basis for an adverse decision against the appellant.

C. The commissioner or his designee shall appoint an individual who has training to serve as the presiding officer at the informal conference. The staff member shall not be a staff member of the Office of Licensing or the Office of Human Rights.

D. The presiding officer shall be authorized to make decisions regarding the conduct of the informal conference, to regulate the procedure at the informal conference, to review all information presented, and to recommend a case decision to the commissioner.

E. The commissioner is not bound by the recommended decision of the presiding officer. The commissioner may review all relevant information in issuing a case decision. Any such case decision shall include factual findings, conclusions as to the violation of statutes or regulations, and, when appropriate, the recommended action against the provider's license.

F. If a provider is dissatisfied with the commissioner's decision under this section, a formal administrative hearing may be requested pursuant to §2.2-4020 of the Virginia Administrative Process Act, to be conducted by a hearing officer appointed from a list maintained by the Supreme Court of Virginia.

Part IV

Standards of Practice and Conduct

Article 1

Provider Management and Administration

12VAC35-270-180. Governance.

A. The provider shall have a designated full-time employee, such as an executive director or administrator, to whom it delegates in writing the authority and responsibility for the administrative direction and day-to-day operation of the provider and its services. The owner or operator of the provider may serve as the designated full-time employee. The designated employee shall have the following duties and responsibilities either directly or through delegation:

1. Overseeing of programs, goals, budgets, operational reviews, and licensure status;

2. Documenting the committee or person who is responsible for audit and finance; and

3. Maintaining records documenting action taken in accordance with this subsection.

B. The provider shall submit the following information to the department:

1. The names and professional contact of all owners, officers, directors, and financial investors whether they are individuals, general or limited partnerships, corporate bodies, or subdivisions of other bodies, and anyone else that meets the definition of provider; the provider shall notify the department of any changes to this information at the same time the provider notifies the SCC;

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1194 2. A certificate from the SCC; and

1195 3. A disclosure of ownership or financial interest in the service, program, or agency held
1196 by current employees, including the nature of such interest and the financial benefits
1197 received by the employee. The disclosure shall also state if no benefits are received.

1198 **12VAC35-270-190. Organizational structure.**

1199 A. The provider shall maintain and make available to any employee or client an organizational
1200 chart or a written policy that describes the organizational structure including lines of authority,
1201 responsibility, communication, and staff assignment.

1202 B. Each provider shall establish a system of business management and staffing to ensure that
1203 the provider maintains complete and accurate audits, accounts, books, and records, including
1204 required financial, personnel, and client records.

1205 **12VAC35-270-200. Executive director or administrator.**

1206 A. The executive director or administrator shall have the following responsibilities, either
1207 directly or through delegation:

1208 1. Responsibility for compliance with these regulations and other applicable law and
1209 regulations;

1210 2. Responsibility for all personnel;

1211 3. Responsibility for overseeing the service operation in its entirety, including the
1212 structured program of care and its implementation; and

1213 4. Responsibility for the provider's financial integrity, with the exception of community
1214 service boards.

1215 B. An executive director or administrator shall have at least:

1216 1. A master's degree in social work, psychology, counseling, rehabilitation counseling,
1217 special education, nursing, or administration.

1218 2. A baccalaureate degree in administration or a human service field including social work,
1219 psychology, counseling, rehabilitation counseling, special education, or nursing; or

1220 3. Four years professional experience working with disability populations in administration
1221 and supervision.

1222 C. Any executive director or administrator shall submit to the provider the following to
1223 demonstrate compliance with the minimum qualifications required in subsection B of this section:

1224 1. Primary source verification of the education requirements; or

1225 2. Documentation of prior relevant experience.

1226 D. The provider shall maintain the information in subsection C of this section in a manner
1227 accessible by the department.

1228 **12VAC35-270-210. Finances.**

1229 A. The provider shall maintain a system of financial recordkeeping that shows a separation of
1230 the provider's accounts from all other accounts.

1231 B. The provider shall keep individual accounts separate. Providers shall not commingle funds
1232 of multiple individuals receiving services.

1233 C. The provider shall identify in writing the title and qualifications of the person with the
1234 authority and responsibility for the fiscal management of the provider's services.

1235 D. The provider shall notify the department in writing when the provider's line of credit or other
1236 funds required by 12VAC35-270-40 and 12VAC35-270-80 have been cancelled or significantly
1237 reduced at any time during the licensing period.

12VAC35-270-220. Liabilities and insurance.

To protect the interests of individuals, employees, and the provider from risks of liability, the provider shall obtain and maintain continuous indemnity coverage to include:

1. General liability;
2. Professional liability;
3. Commercial vehicular liability; and
4. Property damage insurance.

Article 2**Human Resources and Records Management****12VAC35-270-230. Confidentiality and security of personnel records.**

A. The provider shall maintain an organized system to manage and protect the confidentiality of personnel files and records.

B. Providers shall comply with requirements of the Americans with Disabilities Act (42 USC § 12101 et seq.) and the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia) regarding retention of employee health-related information in a file separate from personnel files.

C. Providers shall comply with the requirements of § 19.2-389 of the Code of Virginia regarding dissemination of employees' and contractors' criminal history record information. The provider shall hold evidence of criminal history record checks separate and in a manner to ensure the information is only disseminated to those persons permitted by law to receive it.

12VAC35-270-240. Criminal background checks and registry searches.

A. Providers shall comply with the requirements for obtaining criminal history background checks as outlined in §§ 37.2-416, 37.2-416.1, 37.2-506, 37.2-506.1, and 37.2-607 of the Code of Virginia.

1. The documentation necessary to conduct the criminal history background check shall be submitted no later than the first day of work.

2. Except as otherwise provided by §§ 37.2-416 C and D of the Code of Virginia, providers shall not employ persons that have been convicted of any of the barrier crimes listed in § 19.2-392.02.

B. Providers shall comply with the requirement for searching the central registry of founded complaints of child abuse and neglect as outlined in § 37.2-416 D of the Code of Virginia.

1. The documentation necessary to conduct a search for complaints of abuse or neglect within the registry that is maintained by the Department of Social Services (DSS) pursuant to § 63.2-1515 of the Code of Virginia shall be submitted no later than the first day of work.

2. Providers shall not hire persons with founded complaints of abuse or neglect within the registry maintained by DSS pursuant to § 63.2-1515 of the Code of Virginia.

C. Providers using temporary agencies for the provision of contracted staff shall obtain a letter from the temporary agency containing the following information:

1. The name of the contractor;

2. The dates of employment;

3. A statement verifying that the national criminal history records check as required by §§ 37.2-416, 37.2-416.1, 37.2-506, 37.2-506.1, and 37.2-607 of the Code of Virginia was obtained within 30 days of employment, is on file at the temporary agency, and does not contain convictions of any barrier crimes listed in § 19.2-392.02; and

4. A statement verifying that a search of the child abuse or neglect registry maintained pursuant to § 63.2-1515 of the Code of Virginia was obtained, is on file with the temporary agency, and does not include founded complaints.

D. No person shall be permitted to work in a position that involves direct contact with an individual until an original criminal history background check and registry check, or the letter required by subsection C of this section, is received by the provider, unless such person works under the direct supervision of another employee for whom a criminal history background check and registry check was completed in accordance with this section.

E. The provider shall take immediate action in the event a person has a barrier crime returned on the criminal history background check or founded complaints of child abuse or neglect returned on the registry search. For all other persons for whom a criminal history background check or a registry search is returned the provider shall take action within five business days, which shall be documented. The documentation shall note either continued employment or termination due to the results of the criminal history background check or registry search.

F. The provider shall develop a written policy for criminal history background checks and registry searches. At a minimum, the policy shall:

1. Require all applicants disclose whether the applicant has (i) ever been convicted of or is the subject of pending charges for an offense listed in §§ 37.2-416, 37.2-416.1, 37.2-506, 37.2-506.1, or 37.2-607 of the Code of Virginia; or (ii) has a founded case of abuse or neglect. Any plea of nolo contendere shall be considered a conviction for purposes of this section.

2. Address what actions the provider must take if an applicant has certain prior convictions or a founded case of child abuse or neglect.

3. Require all persons, during the course of employment, to report any conviction of a barrier crime listed in § 19.2-392.02 of the Code of Virginia or any founded complaints of abuse or neglect within the registry that is maintained by DSS pursuant to § 63.2-1515.

4. State the provider's obligation to hold criminal history record information in a manner consistent with § 19.2-389 of the Code of Virginia, including holding the information within the person's personnel record separate and in a manner to ensure the information is only disseminated to those individuals permitted by law to receive it.

5. Establish procedures for acting on criminal history background information that does not rise to the level of a barrier crime. The procedures shall be appropriate for the population served by the provider and the expected duties of the employees.

6. Address how the provider shall handle criminal background checks and registry checks in relation to students and volunteers.

G. The provider shall submit all personally descriptive applicant information necessary to complete the criminal history background checks and registry searches.

H. The provider shall maintain the following documentation:

1. The letter from the temporary agency required by subsection C of this section, if applicable, maintained under the same retention requirements as a criminal history record report;

2. The disclosure statement from the applicant required pursuant to subsection F of this section; and

3. Evidence that the provider submitted all information necessary to complete the criminal history background checks and registry searches, report from the Central Criminal Records Exchange, or memoranda from the department transmitting the results to the provider, as applicable, and the results from the registry search.

12VAC35-270-250. Personnel records.**A. Employee personnel records shall include:**

1. Individual identifying information;

2. Verified education history if specific education is a requirement within the employee's job description or a legal requirement;

3. Employment or training history; and

4. A record of disciplinary action taken by the provider, if any.

B. Each employee personnel record shall be retained in its entirety for a minimum of three years after the employee's termination of employment.

12VAC35-270-260. Tuberculosis screening.

A. Each new employee, contractor, student, or volunteer who will have direct contact with individuals receiving services shall obtain a statement of certification by a qualified licensed practitioner indicating the absence of tuberculosis in a communicable form prior to initial contact with individuals receiving services. The employee shall submit a copy of the original screening to the provider. A statement of certification shall not be required for a new employee who has separated from service with another licensed provider with a break in service of six months or less or who is currently working for another department-licensed provider.

B. Any employee, contractor, student, or volunteer who comes in contact with a known case of active tuberculosis disease, or who develops symptoms of active tuberculosis disease, including fever, chills, hemoptysis, cough, fatigue, night sweats, weight loss, or anorexia, of three weeks duration, shall be screened as determined appropriate for continued contact with employees, contractors, students, volunteers, or individuals receiving services based on consultation with the local health department.

C. No employee, contractor, student, or volunteer suspected of having active tuberculosis shall be permitted to return to work or have contact with employees, contractors, students, volunteers, or individuals receiving services until a physician has determined that the person is free of active tuberculosis.

12VAC35-270-270. Job description.

Each employee or contractor shall have access to the employee's or contractor's current written job description that includes:

1. Job title;

2. Duties and responsibilities; and

3. Minimum knowledge, skills, and abilities; education or training; or experience or professional qualifications required for entry.

12VAC35-270-280. Qualifications of employees or contractors.

A. Each person who assumes the responsibilities of a position as an employee or a contractor shall meet the minimum qualifications of that position in accordance with the current job description.

B. Employees and contractors shall comply, as required, with the regulations of the Department of Health Professions (DHP). The provider shall design, implement, and document the process used to verify professional credentials and to identify any adverse action taken by DHP.

C. Supervisors shall have education, training, and experience working with individuals being served, including diagnosis and age, and in providing the services outlined in the service description.

D. Job descriptions shall include minimum knowledge, skills and abilities, professional qualifications, and experience appropriate to the duties and responsibilities required of the position and the population served.

E. Each employee or contractor shall demonstrate a working knowledge of the policies and procedures that are applicable to that employee's or contractor's specific job or position.

F. Additional service-specific licensing chapters may contain additional qualification requirements.

12VAC35-270-290. Employee training.

A. The provider shall provide training and development opportunities for employees and contractors to enable them to support the individuals receiving services and to carry out their job responsibilities. The provider shall develop a training policy that addresses the frequency of retraining. The training policy shall address initial and annual knowledge or skills testing, and any knowledge or skills testing that may be necessary due to appropriate implementation of the provider's risk management program required by 12VAC35-270-560 or the provider's quality improvement program required by 12VAC35-270-570. Participation in training and development opportunities and the results of knowledge and skills testing shall be documented and shall be accessible to the department.

B. New employees and contractors shall be oriented and trained as appropriate according to each employee's or contractor's function or job-specific responsibilities.

1. Required initial training. Within 15 business days following an employee's or contractor's start date, each employee or contractor responsible for supervision of individuals receiving services shall receive basic orientation and training regarding:

a. The provider's behavior intervention policies and procedures on least restrictive interventions, timeout, and physical restraint;

b. Emergency preparedness and response;

c. Practices of confidentiality including access, duplication, and dissemination of any portion of an individual's record;

d. Practices that ensure an individual's rights, including training regarding the Human Rights Regulations (12VAC35-115);

e. Person-centeredness;

f. Infection control practices and measures;

g. Other policies and procedures that apply to specific positions and specific duties and responsibilities;

h. Serious incident reporting, including when, how, and under what circumstances a serious incident report must be submitted and the consequences of failing to report a serious incident to the department in accordance with this chapter; and

i. Any additional initial training required by applicable service-specific licensing chapters.

2. First aid and medication administration. Within 30 business days following an employee's or contractor's start date, each employee or contractor shall receive training regarding:

a. Cardiopulmonary resuscitation (CPR) and first aid instruction issued by the American Red Cross, the American Heart Association, or a comparable authority in standard first aid and CPR. The training shall have a certification process that includes a hands-on, in-person demonstration of CPR competency. A valid certification from a previous employer or other source may meet this requirement. Employees certified as an emergency medical technician shall be deemed as having fulfilled this requirement.

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1420 There shall be at least one employee or contractor on duty at each location at all times
1421 during service hours who holds a current certificate issued by the American Red Cross,
1422 the American Heart Association, or comparable authority in standard first aid and
1423 cardiopulmonary resuscitation (CPR); and

1424 b. Medication administration including basic pharmacology and medication side
1425 effects. A valid training completed from a previous employer or other source within the
1426 past two years may meet this requirement.

1427 3. New employees, contractors, volunteers, and students shall not work alone until
1428 completing all orientation and training required under 12VAC35-270-290 B 1-2 and
1429 demonstrating knowledge or skills, as appropriate. All new employees, contractors,
1430 volunteers, and students shall complete all orientation and training required under
1431 12VAC35-270-290 B 1-2 and demonstrate knowledge or skills, as appropriate, prior to
1432 carrying out job responsibilities without supervision. Documentation of knowledge or skills,
1433 as appropriate, shall be documented and shall be accessible to the department.

1434 4. Exemptions to the new employee training deadlines may be permitted for part-time staff.
1435 Any exemptions shall be approved in advance by the department.

1436 C. All employees and contractors shall complete annual training that shall include:

1437 1. Retraining of all the elements required within 12VAC35-270-290 B 1-2, except for CPR
1438 training that will occur on a biennial basis;

1439 2. Any additional training that may be required due to appropriate implementation of a
1440 corrective action plan required by 12VAC35-270-120, the provider's risk management
1441 program required by 12VAC35-270-560, or the provider's quality improvement program
1442 required by 12VAC35-270-570; and

1443 3. Emergency medical drills.

1444 **12VAC35-270-300. Provider staffing plan.**

1445 A. The provider shall implement a written staffing plan that includes the types, roles, and
1446 numbers of employees and contractors that are required to provide the service. This staffing plan
1447 shall reflect the:

1448 1. Needs of the individuals receiving services;

1449 2. Types of services offered;

1450 3. Service description;

1451 4. Number of individuals to receive services at a given time; and

1452 5. Adequate number of staff required to safely evacuate all individuals during an
1453 emergency.

1454 B. The provider staffing plan shall not include volunteers or students and shall not rely on
1455 students or volunteers to supplant direct care positions.

1456 C. The provider shall develop a written transition staffing plan for new services, added
1457 locations, and changes in capacity.

1458 D. The provider shall meet the following minimum provisions related to supervision.

1459 1. The provider shall describe how employees and contractors will be supervised and how
1460 that supervision will be documented.

1461 2. Supervision of employees and contractors shall be provided by persons with experience
1462 (i) working with the population receiving services and (ii) providing the services outlined in
1463 the provider's service description.

1464 3. Supervision shall be appropriate to the services provided and the needs of the
1465 individual. Supervision shall be documented.

4. Supervision shall include responsibility for approving assessments and individualized services plans or treatment, as appropriate.

5. Supervision of developmental services shall be provided by a person who:

a. Has a minimum of one year of documented experience working directly with individuals who have developmental disabilities; and

b. Holds a bachelor's degree or higher in human services or a related field such as sociology, social work, special education, language development, therapeutic recreation, rehabilitation counseling, nursing, or psychology. Experience may be substituted for the education requirement at a rate of one month of verified experience for every two semester hours of college credit. A person with a minimum of five years of documented, paid experience directing, developing, implementing, or monitoring developmental services is exempt from the education requirement.

6. Supervision of brain injury services shall be provided at a minimum by a clinician in the health professions field who is trained and experienced in providing brain injury services to individuals who have a brain injury diagnosis including (i) a doctor of medicine or osteopathy; (ii) a psychiatrist who is a doctor of medicine or osteopathy specializing in psychiatry; (iii) a psychologist with at least one year of clinical experience who has a master's degree in psychology from a college or university; (iv) a social worker with at least two years of clinical experience providing direct services to individuals with a diagnosis of brain injury who has a bachelor's degree in human services or a related field from an accredited college or university; (v) a certified brain injury specialist; (vi) a registered nurse with at least one year of clinical experience; or (vii) any other licensed rehabilitation professional with one year of clinical experience.

E. Providers of brain injury services shall employ or contract with a neuropsychologist or licensed clinical psychologist specializing in brain injury to assist, as appropriate, with initial assessments, development of individualized services plans, crises, staff training, and service design.

F. Staff in direct care positions providing brain injury services shall (i) have at least a high school diploma or General Education Development (G.E.D.) certificate and two years of experience working with individuals with disabilities or (ii) have successfully completed a department-approved training curriculum on brain injuries within six months of employment.

G. Service-specific licensing chapters may contain additional staffing plan provisions.

12VAC35-270-310. Notification of policy changes.

A. The provider shall keep all employees and contractors informed of policy changes that affect the employee's or contractor's performance of duties.

B. The provider shall notify the department of any substantive changes to policies required by this regulatory chapter prior to implementation of the change.

12VAC35-270-320. Performance evaluation.

A. The provider shall implement a written policy for evaluating employee and contractor performance.

B. Employee development needs and plans shall be a part of the performance evaluation.

C. The provider shall evaluate employee and contractor performance at least annually and document the employee's or contractor's performance.

12VAC35-270-330. Disciplinary actions.

A. The provider shall maintain policies and procedures governing employee discipline. Such policies shall include:

1. The circumstances under which discipline will be administered;

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- 1513 2. The range of penalties permitted;
1514 3. Procedures for employee and contractor appeals of discipline;
1515 4. Documentation of disciplinary actions and results of appeals; and
1516 5. A list of types of individuals who may access documentation of disciplinary actions.
1517 B. Policies for employee and contractor behavior that are subject to discipline shall include
1518 penalties for:
1519 1. Abuse, mistreatment, neglect, or exploitation of individuals;
1520 2. Violation of rights of individuals;
1521 3. Violation of confidentiality rules; and
1522 4. Violation of the provider's policies.
1523 C. In lieu of the minimum requirements contained in this section, providers may develop a
1524 policy regarding employee discipline in accordance with the rules and regulations of the
1525 supervising personnel authority when a provider is subject to (i) rules and regulations of the
1526 Virginia Department of Human Resource Management or (ii) the rules and regulations of a local
1527 government personnel office.

Article 3

1529 Operational Policies, Procedures, and Practices

1530 **12VAC35-270-340. License availability.**

1531 The current license or a copy shall be prominently displayed for public inspection in all service
1532 locations.

1533 **12VAC35-270-350. Appropriate name.**

1534 A. Providers shall submit to the department the legal, assumed, or fictitious name under which
1535 the provider is doing business in the Commonwealth. Providers shall also submit any other
1536 Virginia corporate names of the provider, if different from the legal, assumed, or fictitious name
1537 under which the provider is doing business. The submission with the department of the provider's
1538 legal, assumed, or fictitious name shall occur:

- 1539 1. During the application process required by 12VAC35-270-40; or
1540 2. During any modification application or change of ownership process that occurs as
1541 required by 12VAC35-270-80.

1542 B. Any change to the provider's legal, assumed, or fictitious name under which the provider is
1543 doing business in the Commonwealth that does not coincide with an initial application or a change
1544 of ownership shall require a modification application as required by 12VAC35-270-80.

1545 C. The department shall list licensed providers on the department's website.

1546 **12VAC35-270-360. Regular business hours.**

1547 A. The provider shall establish regular business hours for each of the provider's offices where
1548 individual or personnel records are kept. The provider shall publish, post, and make available the
1549 provider's business hours in a manner accessible to individuals receiving services.

1550 B. Some portion of the provider's regular business hours shall include state business hours
1551 to ensure that the department has the ability to conduct unannounced inspections and
1552 investigations as required by 12VAC35-270-60. The business hours shall also include enough
1553 time for the department to conduct unannounced inspections and investigations.

1554 C. The provider shall submit the regular business hours to the department.

12VAC35-270-370. Office and service locations.

A. Offices shall have sufficient and appropriate space for storage of records of individuals receiving services, and employee and contractor personnel records. The office shall have sufficient and appropriate space for authorized personnel, such as individuals receiving services and department personnel conducting onsite reviews, to have access to the records within the office.

B. The provider shall submit all office locations to the department:

1. During the application process required by 12VAC35-270-40; or

2. During any modification application or change of ownership process that occurs as required by 12VAC35-270-80.

C. The addition or closure of either an office or service location that does not coincide with an initial application or a change of ownership shall require a modification application as required by 12VAC35-270-80.

12VAC35-270-380. Fee schedule.

A. If the provider charges for services, the written schedule of rates and charges shall be provided to the individual or his authorized representative upon admission.

B. The provider's fee schedule shall be available to the individual and his authorized representative, if applicable, upon request. The provider shall publish, post in a manner accessible to individuals receiving services, and make available the fee schedule.

C. The provider shall ensure the published fee schedule is up to date.

12VAC35-270-390. Deceptive or false advertising.

A. The provider shall not use any advertising that contains false, misleading, or deceptive statements or claims. The provider shall not use any advertising that contains false or misleading disclosure of fees and payment for services or false or misleading disclosure of outcomes of services.

B. The provider's name and service names shall not imply the provider is offering services for which it is not licensed. The provider's name and service names shall comply with 12VAC35-270-350.

C. A provider cannot utilize a name registered with the department by another provider.

12VAC35-270-400. Cessation of services.

A. A provider shall notify the department in writing of its intent to cease operation of any or all licensed services at least 30 business days prior to the cessation of any service. The provider shall continue to maintain substantial compliance with all applicable regulations as it ceases any or all of its services.

B. All individuals receiving services and their authorized representatives shall be notified of the provider's intent to cease services in writing at least 30 business days prior to the cessation of any service. The provider shall continue to provide all services that are identified in each individual's ISP after it has given official notice of its intent to cease operations and until each individual is appropriately discharged or transferred. The written notification shall include information regarding the individual's transition to a new provider, discharge planning, and notes regarding the individual's continuity of care.

C. No part of this section shall apply to a provider discontinuing services for a specific individual. Involuntary termination from treatment shall be governed by 12VAC35-270-440 of this chapter. Regular discharge of a specific individual is governed by 12VAC35-270-430.

12VAC35-270-410. Transition of individuals among services by the same provider.

A. Except when transfer is ordered by a court of competent jurisdiction, the receiving service shall obtain from the sending service at the time of transfer:

1. Documentation of:

a. Informed choice by the individual or authorized representative, as applicable, in the decision to and planning for the transfer;

b. Notification to the family, if appropriate; and

c. Signature of the employee or contractor responsible for preparing the transfer summary and transfer date;

2. A written summary of the individual's progress while at the facility, justification for the transfer, and the individual's current strengths and needs; and

3. The individual's record, including emergency medical information.

B. The sending service shall retain a copy of the face sheet and a written summary of the individual's progress while within the service and shall document the date of transfer and the name of the service to which the individual was transferred.

12VAC35-270-420. Emergency transfers.

A. The provider shall implement a written policy that defines the process for transitioning or discharging an individual who experiences an emergency or crisis that the provider is not equipped to serve. At a minimum, the policy shall address:

1. The process the provider will follow during the emergency or crisis while the individual is still within the provider's care;

2. The process the provider will follow to transfer or discharge the individual to the new provider; and

3. The process and timeframe for transferring the access to the individual's record and ISP, including the individual's discharge summary as required by 12VAC35-270-430 E.

B. All providers shall develop a method for documenting the provision of interventions that occur during a crisis or emergency. Documentation shall comply with 12VAC35-270-470. This documentation shall occur prior to transition of documentation required under this section.

12VAC35-270-430. Discharge planning.

A. Unless otherwise exempt, providers shall implement written policies and procedures regarding the discharge or termination of individuals from the service. These policies and procedures shall include medical and clinical criteria for discharge.

B. Discharge instructions shall be provided in writing to the individual, his authorized representative, and the successor provider, as applicable. At a minimum, discharge instructions shall include medications and dosages, if applicable; names, phone numbers, and addresses of any successor providers to whom the individual is referred; current medical issues or conditions; and the identity of the individual's treating health care practitioners.

C. The provider shall make appropriate arrangements or referrals to all services or successor providers identified in the discharge plan prior to the individual's scheduled discharge date.

D. The content of the discharge plan and the determination to discharge the individual shall be consistent with the ISP and the criteria for discharge.

E. The provider shall complete a written discharge summary within 30 days of discharge that includes, at a minimum, the following:

1. Reason for the individual's admission to and discharge from the service;

2. Description of participation by the individual or the individual's authorized representative in discharge planning, and documentation of informed choice in the decision to discharge and in planning for the discharge;

3. The individual's current level of functioning or functioning limitations, if applicable;

4. Recommended procedures, activities, or referrals to assist the individual in maintaining or improving functioning and increased independence;

5. The status, location, and arrangements that were made for future services;

6. Progress made by the individual in achieving goals and objectives identified in the ISP and a summary of critical events during service provision;

7. Date of discharge and when the discharge summary was actually written or documented; and

8. Signature of the provider's employee or contractor responsible for preparing the discharge summary.

F. Community-based crisis stabilization providers supplying mobile crisis response and crisis receiving center providers licensed under the crisis chapter (12VAC35-278) are exempt from the provisions of this section but shall follow the requirements of 12VAC35-278-120 (Warm Hand-Off).

12VAC35-270-440. Involuntary termination from treatment.

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

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

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

D. The provider shall provide appropriate discharge planning for all individuals who are involuntarily terminated under this section. The standards for appropriate discharge planning shall be governed by 12VAC35-270-430 and shall include notification of the individual's case manager.

12VAC35-270-450. Policies.

A. Each provider shall have written policies and procedures consistent with and implemented in accordance with the requirements of this chapter, any service-specific licensing chapter under which the provider is operating, department administrative guidelines, and applicable laws.

B. All policies required under this chapter shall be in writing, and available to staff, individuals, and department inspectors, and shall at a minimum address:

1. Succession planning except that community service boards and government agencies are not required to have a succession plan.

2. Handling funds of individuals receiving services, including providing for separate accounting of individual funds. The policy shall include:

a. Handling of any individual's own cash and petty cash.

b. Documented financial controls to minimize the risk of theft or embezzlement of funds of individuals receiving services.

c. Purchase of a surety bond to provide assurance for the security of all funds of individuals receiving services deposited with the provider.

3. Minimizing the risk of theft or embezzlement of provider funds. The development and implementation of written policies and procedures that address the day-to-day handling of facility funds shall include:

- 1689 a. Handling of deposits and petty cash; and
1690 b. Writing of checks.
- 1691 4. Prompt intervention in the event of a crisis or a behavioral, medical, or psychiatric
1692 emergency that may occur during screening and referral, at admission, or during the
1693 period of service provision. The policies and procedures shall include:
- 1694 a. A service-specific working definition of what constitutes a behavioral, medical, or
1695 psychiatric emergency;
- 1696 b. Employee or contractor responsibilities; and
- 1697 c. Location of emergency medical information for each individual receiving services,
1698 including any advance psychiatric or medical directive or crisis response plan
1699 developed by the individual, which shall be readily accessible to employees or
1700 contractors on duty in an emergency or crisis.
- 1701 5. Maintenance and use of medical equipment, including personal medical equipment and
1702 devices.
- 1703 6. A medication management policy addressing the provisions required by 12VAC35-270-
1704 490.
- 1705 7. The use of behavior interventions, including seclusion, restraint, and time out. The
1706 policies and procedures shall: include the provisions required by 12VAC35-270-500;
- 1707 8. Organizational structure;
- 1708 9. Emergency transfers;
- 1709 10. Discharge;
- 1710 11. Criminal history background checks and registry searches;
- 1711 12. Staffing policy;
- 1712 13. Employee and contractor training;
- 1713 14. Evaluation of employee and contractor performance;
- 1714 15. The use and responsibilities of students and volunteers;
- 1715 16. Disciplinary actions;
- 1716 17. A records management policy that describes confidentiality, accessibility, security, and
1717 retention of records pertaining to individuals receiving services and personnel records;
- 1718 18. Records review process;
- 1719 19. Onboarding of individuals receiving services;
- 1720 20. Quality improvement program sufficient to identify, monitor, and evaluate clinical and
1721 service quality and effectiveness on a systemic and ongoing basis;
- 1722 21. Root cause analysis;
- 1723 22. Serious incident reporting;
- 1724 23. Risk management;
- 1725 24. Transitioning individuals between or among services operated by the provider;
- 1726 25. Involuntary termination from treatment;
- 1727 26. Privacy, social media, photography, and audio or audio-video recordings of individuals;
- 1728 27. The use and possession of weapons on the premises; and
- 1729 28. Transportation.

12VAC35-270-460. Emergency medical information; face sheets.

A. The provider shall maintain and keep updated the following emergency medical information for each individual on a completed face sheet:

1. If available, the name, address, and telephone number of:

a. The individual's physician, and

b. The authorized representative or other person to be notified in the case of an emergency;

2. Medical insurance company name and policy or Medicaid, Medicare, or Tricare number, if any;

3. Currently prescribed medications and over-the-counter medications used by the individual;

4. Medication and food allergies;

5. History of substance abuse (substance use disorder);

6. Significant medical problems or conditions and a list of medical protocols for those problems or conditions. Detailed medical protocols shall be maintained separately in a manner easily accessible to emergency personnel;

7. Significant ambulatory or sensory problems;

8. Significant communication problems;

9. For individuals who are pregnant, the expected date of delivery and the name of the hospital to provide delivery services to the individual; and

10. Advance directive, if one exists.

B. Current emergency medical information shall be readily available to employees or contractors wherever program services are provided.

12VAC35-270-470. Documenting interventions that occur during a crisis or emergency.

A. All providers shall develop a method for documenting the provision of interventions that occur during a crisis or emergency. Documentation shall include the following:

1. Date and time;

2. Description of the nature of or circumstances surrounding the crisis or emergency;

3. Name of individual;

4. Description of precipitating factors;

5. Interventions or treatment provided;

6. Names of employees or contractors responding to or consulted during the crisis or emergency; and

7. Outcome.

B. Documentation of the interventions that occurred during a crisis or emergency shall become part of the individual's record within one business day.

12VAC35-270-480. Service description requirements.

A. The provider shall develop and implement its descriptions of services offered and shall make the service descriptions available for public review.

B. The provider shall outline how each service offers a structured program of individualized interventions and care designed to meet the individual's physical and emotional needs; provide protection, guidance, and supervision; and meet the objectives of any required ISP.

C. Elements of each service description shall include:

1. Service goals;

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- 1774 2. A description of care, treatment, skills acquisition, or other supports provided;
1775 3. Characteristics and needs of individuals to receive services;
1776 4. Contract services, if any;
1777 5. Eligibility requirements and admission, continued stay, and exclusion criteria;
1778 6. Service termination and discharge or transition criteria; and
1779 7. Type and role of employees or contractors.

1780 D. The provider shall not implement services that are inconsistent with its most current service
1781 description.

1782 E. The provider shall only admit and continue to treat those individuals whose service needs
1783 are consistent with the service description, for whom services are available, and for whom staffing
1784 levels and types meet the needs of the individual receiving services. The provider shall monitor
1785 and assess individuals consistent with reassessment and ISP reviews as required by the
1786 department's service-specific licensing chapters. The provider shall transfer or discharge
1787 individuals who develop service needs outside of the provider's service description.

1788 F. The provider shall provide for the physical separation of children and adults in residential
1789 and inpatient services and shall provide separate group programming for adults and children,
1790 except in the case of family services. The provider shall provide for the safety of children
1791 accompanying parents receiving services.

1792 G. The service description for substance abuse treatment services shall address the timely
1793 and appropriate treatment of pregnant women with substance abuse (substance use disorder).

1794 H. Refer to service-specific chapters regarding additional requirements related to service-
1795 specific descriptions that may also apply.

1796 **12VAC35-270-490. Medication management.**

1797 A. The provider shall implement written policies addressing:

- 1798 1. The safe administration, handling, storage, and disposal of medications;
1799 2. The use of medication orders. If the provider administers medications or supervises
1800 self-administration of medication in a service, a current medication order for all
1801 medications the individual receives shall be maintained on site;
1802 3. The self-administration, storage, and safekeeping of medication by individuals receiving
1803 services, including recognition of side effects;
1804 4. Employees or contractors who are authorized to administer medication and training
1805 required for administration of medication;
1806 5. Identification of the staff member responsible for routinely communicating to the
1807 prescriber the effectiveness of prescribed medications, any adverse reactions, or any
1808 suspected side effects; and
1809 6. The window within which medications can be given in relation to the ordered or
1810 established time of administration.

1811 B. Any staff responsible for medication administration shall have successfully completed a
1812 medication training program approved by the Virginia Board of Nursing or be authorized to
1813 administer medication by the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia).

1814 C. Medications shall be administered as prescribed and only to the individuals for whom the
1815 medications are prescribed.

1816 D. The provider shall maintain a daily log of all medicines received and refused by each
1817 individual. This log shall identify the employee or contractor who administered the medication, the
1818 name of the medication and dosage administered or refused, and the time the medication was
1819 administered or refused.

E. Any individuals whose ISP indicates self-administration is an appropriate objective shall receive training on how to administer their own medications.

1. No individual shall be permitted to self-administer medications until the individual demonstrates the competency to do so. Competency shall be defined by the provider's policies and procedures and be determined during the individual's assessment.

2. The provider shall have a procedure to follow regarding the daily medication log for each individual who self-administers. The procedure shall be reflected within the individual's ISP.

3. The provider shall maintain a current medication order for all medications the individual receives on site.

F. The provider shall ensure that all prescribed pro re nata (PRN) medications are present within the individual's medication supply.

1. Providers shall ensure that all medications administered PRN by staff have specific indications for use. This may require that the provider discuss the parameters of administering the PRN medications with the prescriber.

2. The provider shall follow up with the individual's prescriber if a PRN medication is not effective, or if the prescription is no longer necessary.

G. The provider shall promptly dispose of discontinued drugs, outdated drugs, and drug containers with worn, illegible, or missing labels according to the applicable regulations of the Virginia Board of Pharmacy. Drugs designated for a particular individual shall be immediately removed from the individual's current medication supply if discontinued by the individual's physician or other prescriber.

H. Syringes and other medical implements used for injecting or cutting skin shall be kept in a securely locked manner. Containers for used sharps shall be locked. Disposal of used sharps shall comply with the Virginia Regulated Medical Waste Management Regulations, 9VAC20-120.

I. Providers shall ensure all medication is properly labeled and securely locked.

12VAC35-270-500. Policies and procedures on behavior interventions and supports.

A. The provider shall implement written policies and procedures that describe conditions for the use of behavior interventions that comply with the requirements of 12VAC35-115, including seclusion, restraint, and time out. The policies and procedures shall:

1. Ensure seclusion is only utilized within an inpatient hospital, residential facilities for children, crisis receiving centers, or crisis stabilization units and only in an emergency.

2. List and define behavioral interventions in the order of relative degree of intrusiveness or restrictiveness and the conditions under which each intervention may be used in accordance with each individual's ISP;

3. Protect the safety and well-being of the individual at all times, including during fire and other emergencies; and

4. Specify the mechanism for monitoring and documenting the use of behavioral interventions.

B. Only employees and contractors trained in behavioral support interventions shall implement restrictive procedures as per the provider's written policies and procedures. Monitoring of the implementation of the restrictive interventions shall be in accordance with provider policy in addition to state and federal regulations.

C. Policies and procedures related to restrictive behavior interventions shall be available to individuals, their families, authorized representatives, and advocates. Notification of policies does not need to occur in correctional facilities.

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D. No individuals receiving services shall discipline, restrain, seclude, or implement behavior interventions on other individuals receiving services.

E. Injuries resulting from or occurring during the implementation of seclusion or restraint shall be reported to the department as provided in 12VAC35-115-230 C.

F. The department's service-specific licensing regulations may have additional requirements regarding behavioral interventions and supports.

12VAC35-270-510. Behavioral treatment plan.

A written behavioral treatment plan may be developed as part of the individualized services plan in response to behavioral needs identified through the assessment process. A behavioral treatment plan may include restrictions only if the plan has been developed according to procedures outlined in the Human Rights Regulations (12VAC35-115). A behavioral treatment plan shall be developed, implemented, and monitored by employees or contractors trained in behavioral treatment.

12VAC35-270-520. Fundraising.

The provider shall not use individuals in its fundraising activities without written permission of the individual and, if applicable, the individual's authorized representative.

12VAC35-270-530. Privacy.

Each provider shall have written policies and procedures regarding privacy, social media, photography, and audio or audio-video recordings of individuals that shall ensure and provide:

1. The written consent of the individual and, if applicable, the individual's authorized representative shall be obtained before the individual is photographed or recorded for publicity purposes, including publicity that occurs on social media.

2. No photographing or recording by the provider shall take place without the individual and, if applicable, the individual's authorized representative being informed.

3. All photographs or recordings shall be used in a manner that respects the dignity and confidentiality of the individual.

4. The dignity and privacy of individuals shall be protected during open houses. Open houses are events that open the service location to visitors that are not residents, family members, authorized representatives, staff, or representatives from the state.

12VAC35-270-540. Transportation.

A. This section only applies to transportation offered by a provider.

B. Transportation provided for or used by individuals shall comply with local, state, and federal laws relating to:

1. Vehicle safety and maintenance;

2. Licensure of vehicles;

3. Licensure of drivers; and

4. Passenger safety, including requiring individuals receiving services to wear appropriate seat belts or restraints for the vehicle in which they are being transported.

C. Only authorized employees or contractors shall transport individuals served. The provider shall document within the provider's transportation policy as required by 12VAC35-270-540 E standards to authorize an employee or contractor to transport individuals served.

D. The provider shall conduct a check of employees' or contractors' driving records who are authorized to transport individuals served. The provider shall not permit an employee or contractor to transport individuals if the employee or contractor's license is suspended, cancelled, revoked, or if the employee's or contractor's license disqualifies them from transporting individuals.

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1911 1. The provider shall verify each employee or contractor driving record at the time of
1912 employment.

1913 2. During the course of employment, employees and contractors authorized to transport
1914 individuals served shall report to the provider any new restrictions, suspensions,
1915 cancellations, disqualifications, or revocations on their driver's license.

1916 E. There shall be written policy for transportation of individuals appropriate to the population
1917 served. The written policy for transportation shall:

1918 1. Require insurance for transportation provided;

1919 2. Include standards for an acceptable driving record for any employees or contractors
1920 transporting individuals and enforcement methods for those standards;

1921 3. Address appropriate supervision standards for the population served during
1922 transportation. These standards will account for behavioral issues of the individuals being
1923 transported;

1924 4. Require all vehicles are heated and cooled appropriately; and

1925 5. Include provisions to ensure that in case of an emergency, any employees or
1926 contractors with restrictions, suspensions, cancellations, disqualifications, or revocations
1927 on their license are not utilized to transport individuals if doing so would be a violation of
1928 those restrictions. Documentation of the most recent check of the employee or contractor
1929 driving record shall be documented in a manner accessible to the department.

1930 F. The provider shall develop and implement written protocols for use and maintenance of
1931 vehicles and power equipment.

1932 Article 4

1933 Risk Management and Quality Improvement

1934 **12VAC35-270-550. Reporting to the department.**

1935 A. For purposes of this section the following terms shall have the following definitions:

1936 1. "Level I serious incident" means a serious incident that occurs or originates during the
1937 provision of a service or on the premises of the provider and does not meet the definition
1938 of a Level II or Level III serious incident. Level I serious incidents do not result in significant
1939 harm to individuals but may include events that result in minor injuries that do not require
1940 medical attention or events that have the potential to cause serious injury, even when no
1941 injury occurs.

1942 2. "Level II serious incident" means a serious incident that occurs or originates during the
1943 provision of a service or on the premises of the provider that results in a significant harm
1944 or threat to the health and safety of an individual that does not meet the definition of a
1945 Level III serious incident. Level II serious incident includes a significant harm or threat to
1946 the health or safety of others caused by an individual. Level II serious incidents include:

1947 a. A serious injury;

1948 b. An individual who is or was missing;

1949 c. An emergency room visit;

1950 d. An unplanned psychiatric or unplanned medical hospital admission of an individual
1951 receiving services other than licensed emergency services (crisis intervention) except
1952 that a psychiatric admission in accordance with the individual's wellness plan shall not
1953 constitute an unplanned admission for the purposes of this chapter;

1954 e. Choking incidents that require direct physical intervention by another person;

1955 f. Ingestion of any hazardous material; or

- 1956 g. A diagnosis of:
- 1957 (1) A decubitus ulcer or an increase in severity of level of previously diagnosed
- 1958 decubitus ulcer;
- 1959 (2) A bowel obstruction; or
- 1960 (3) Aspiration pneumonia.
- 1961 3. "Level III serious incident" means a serious incident whether or not the incident occurs
- 1962 while in the provision of a service or on the provider's premises and results in:
- 1963 a. Any death of an individual;
- 1964 b. A sexual assault of an individual; or
- 1965 c. A suicide attempt by an individual admitted for services, other than licensed
- 1966 emergency services (crisis intervention), that results in a hospital admission.
- 1967 4. "Missing" means a circumstance in which an individual is not physically present when
- 1968 and where he should be and his absence cannot be accounted for or explained by his
- 1969 supervision needs or pattern of behavior.
- 1970 5. "Sexual assault" means any type of sexual contact or behavior that occurs without the
- 1971 explicit consent of the recipient. It can involve physical force, threats, coercion, or drugs
- 1972 and alcohol.
- 1973 6. "Suicide attempt" means a non-fatal, self-directed, potentially injurious behavior with an
- 1974 intent to die as a result of the behavior regardless of whether it results in injury.
- 1975 B. The provider shall collect, maintain, and review at least quarterly all serious incidents,
- 1976 including Level I serious incidents, as part of the quality improvement program in accordance with
- 1977 12VAC35-270-570 to include an analysis of trends, potential systemic issues or causes, indicated
- 1978 remediation, and documentation of steps taken to mitigate the potential for future incidents.
- 1979 C. The provider shall collect, maintain, and report or make available to the Office of Licensing
- 1980 the following information:
- 1981 1. Each allegation of abuse or neglect shall be reported to the department as provided in
- 1982 12VAC35-115-230 A. Each allegation of abuse or neglect that meets the definition of Level
- 1983 II or Level III serious incident shall also be reported to the Office of Licensing as a part of
- 1984 the provider's serious incident reporting.
- 1985 2. Level II and Level III serious incidents shall be reported using the department's web-
- 1986 based reporting application and by telephone or email to anyone designated by the
- 1987 individual to receive such notice and to the individual's authorized representative within
- 1988 24 hours of discovery. Reported information shall include the information specified by the
- 1989 department as required in its web-based reporting application, but at least the following:
- 1990 the date, place, and circumstances of the serious incident. For serious injuries and deaths,
- 1991 the reported information shall also include the nature of the individual's injuries or
- 1992 circumstances of the death and any treatment received. For all other Level II and Level III
- 1993 serious incidents, the reported information shall also include the consequences that
- 1994 resulted from the serious incident. Deaths that occur in a hospital as a result of illness or
- 1995 injury occurring when the individual was in a licensed service shall be reported.
- 1996 3. Instances of seclusion or restraint shall be reported to the department as provided in
- 1997 12VAC35-115-230 C 4. Serious injury sustained during instances of seclusion or restraint
- 1998 shall also be reported to the Office of Licensing as a part of the provider's serious incident
- 1999 reporting.
- 2000 D. A root cause analysis shall be conducted by the provider within 30 calendar days of
- 2001 discovery of Level II serious incidents and any Level III serious incidents that occur during the
- 2002 provision of a service or on the provider's premises.

- 2003 1. The root cause analysis shall include at least the following information:
- 2004 a. A detailed description of what happened;
- 2005 b. An analysis of why it happened, including identification of all identifiable underlying
- 2006 causes of the incident that were under the control of the provider; and
- 2007 c. Identified solutions to mitigate its reoccurrence and future risk of harm when
- 2008 applicable.
- 2009 2. The provider shall develop and implement a root cause analysis policy for determining
- 2010 when a more detailed root cause analysis, including convening a team, collecting and
- 2011 analyzing data, mapping processes, and charting causal factors, should be conducted. At
- 2012 a minimum, the policy shall require for the provider to conduct a more detailed root cause
- 2013 analysis when:
- 2014 a. A threshold number, as specified in the provider's policy based on the provider's
- 2015 size, number of locations, service type, number of individuals served, and the unique
- 2016 needs of the individuals served by the provider, of similar Level II serious incidents
- 2017 occur to the same individual or at the same location within a six-month period;
- 2018 b. Two or more of the same Level III serious incidents occur to the same individual or
- 2019 at the same location within a six-month period;
- 2020 c. A threshold number, as specified in the provider's policy based on the provider's
- 2021 size, number of locations, service type, number of individuals served, and the unique
- 2022 needs of the individuals served by the provider, of similar Level II or Level III serious
- 2023 incidents occur across all of the provider's locations within a six-month period; or
- 2024 d. A death that occurs during the provision of a service or on the provider's premises
- 2025 as a result of an acute medical event that was not expected in advance or based on a
- 2026 person's known medical condition.
- 2027 E. The provider shall make available and, when requested, submit reports and information
- 2028 that the department requires to establish compliance with these regulations and applicable
- 2029 statutes.
- 2030 F. Records that are confidential under federal or state law shall be maintained as confidential
- 2031 by the department and shall not be further disclosed except as required or permitted by law;
- 2032 however, there shall be no right of access to communications that are privileged pursuant to §
- 2033 8.01-581.17 of the Code of Virginia.
- 2034 G. Additional information requested by the department if compliance with a regulation cannot
- 2035 be determined shall be submitted within 10 business days of the issuance of the licensing report
- 2036 requesting additional information. Extensions may be granted by the department when requested
- 2037 prior to the due date, but extensions shall not exceed an additional 10 business days.
- 2038 H. Applicants and providers shall not submit any misleading or false information to the
- 2039 department. The commissioner may invoke the sanctions listed within 12VAC35-270-130 if any
- 2040 applicant or provider submits misleading or false information to the department in relation to this
- 2041 section.
- 2042 I. The provider shall develop and implement a serious incident management policy, which
- 2043 shall be consistent with this section and which shall describe the processes by which the provider
- 2044 will document, analyze, and report to the department information related to serious incidents.
- 2045 **12VAC35-270-560. Risk management.**
- 2046 A. The provider shall designate a person responsible for the risk management function who
- 2047 has completed department approved training, which shall include training related to risk
- 2048 management, understanding of individual risk screening, conducting investigations, root cause
- 2049 analysis, and the use of data to identify risk patterns and trends.

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B. The provider shall implement a written plan to identify, monitor, reduce, and minimize harms and risk of harm, including personal injury, infectious disease, property damage or loss, and other sources of potential liability.

C. The provider shall conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services. The risk assessment review shall address at least the following:

1. The environment of care;

2. Clinical assessment or reassessment processes;

3. Staff competence through testing and adequacy of staffing;

4. Use of high-risk procedures, including seclusion and restraint; and

5. A review of serious incidents.

D. The systemic risk assessment process shall incorporate uniform risk triggers and thresholds as defined by the department.

E. The provider shall conduct and document that a safety inspection has been performed at least annually of each service location owned, rented, or leased by the provider. Recommendations for safety improvement shall be documented and implemented by the provider.

F. The provider shall document serious injuries to employees, contractors, students, volunteers, and visitors that occur during the provision of a service or on the provider's property. Documentation shall be kept on file for three years. The provider shall evaluate serious injuries at least annually. Recommendations for improvement shall be documented and implemented by the provider.

12VAC35-270-570. Monitoring and evaluating service quality.

A. The provider shall develop and implement written policies and procedures for a quality improvement program sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis.

B. The quality improvement program shall utilize standard quality improvement tools including root cause analysis and shall include a quality improvement plan.

C. The quality improvement plan shall:

1. Be reviewed and updated at least annually;

2. Define measurable goals and objectives;

3. Includes and report on statewide performance measures, if applicable, as required by the department;

4. Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-270-120; and

5. Include ongoing monitoring and evaluation of progress toward meeting established goals and objectives. The provider's policies and procedures shall include the criteria the provider will use to establish measurable goals and objectives.

D. The provider's policies and procedures shall include the criteria the provider will use to:

1. Establish measurable goals and objectives;

2. Update the provider's quality improvement plan; and

3. Submit revised corrective action plans to the department for approval or continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies when reviews determine that a corrective action was fully implemented but did not prevent the

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2095 recurrence of the cited regulatory violation or correct a systemic deficiency pursuant to
2096 12VAC35-270-120.

2097 E. Input from individuals receiving services and their authorized representatives, if applicable,
2098 about services used and satisfaction level of participation in the direction of service planning shall
2099 be part of the provider's quality improvement plan. The provider shall implement improvements,
2100 when indicated.

2101 Article 5

2102 Responsibilities to Individuals

2103 **12VAC35-270-580. Individual records.**

2104 A. The provider shall develop and implement a written records management policy that
2105 describes confidentiality, accessibility, security, and retention of records pertaining to individuals,
2106 including:

2107 1. Access, duplication, dissemination, and acquisition of individual information only to
2108 persons legally authorized according to federal and state laws;

2109 2. Storage, processing, and handling of active and closed records;

2110 3. Security measures to protect records from loss, unauthorized alteration, inadvertent or
2111 unauthorized access, disclosure of information, and transportation of records between
2112 service sites;

2113 4. Strategies for service continuity and record recovery from interruptions that result from
2114 disasters or emergencies, including contingency plans, electronic or manual back-up
2115 systems, and data retrieval systems; and

2116 5. Disposition of records in the event that the service ceases operation. If the disposition
2117 of records involves a transfer to another provider, the provider shall have a written
2118 agreement with that provider.

2119 B. The records management policy shall be consistent with applicable state and federal laws
2120 and regulations related to privacy of health records, including:

2121 1. Section 32.1-127.1:03 of the Code of Virginia;

2122 2. 42 USC § 290dd;

2123 3. 42 CFR Part 2; and

2124 4. The Health Insurance Portability and Accountability Act (Public Law 104-191) and
2125 implementing regulations (45 CFR Parts 160, 162, and 164).

2126 C. The policy shall specify what information is available to the individual.

2127 D. Active and closed records shall be kept in areas that are accessible to authorized staff and
2128 protected from unauthorized access, fire, and flood.

2129 E. Entries in the individual's record shall be current, dated, and authenticated by the person
2130 making the entry. Errors shall be corrected by striking through and initialing.

2131 **12VAC35-270-590. Onboarding of individuals.**

2132 A. The provider shall implement a written policy regarding the onboarding of individuals and,
2133 if applicable, their authorized representatives, to services.

2134 B. As appropriate to the scope and level of services, the policy shall require the provision of
2135 the following information to individuals and authorized representatives prior to or on the admission
2136 date of each service:

2137 1. The mission of the provider or service;

2138 2. Service confidentiality practices and protections for individuals receiving services;

- 2139 3. Human rights policies and protections and instructions on how to report violations;
2140 4. Opportunities for participation in services and discharge planning;
2141 5. Fire safety and emergency preparedness procedures, if applicable;
2142 6. Service guidelines including criteria for admission to and discharge or transfer from
2143 services;
2144 7. Hours and days of operation;
2145 8. Availability of after-hours service; and
2146 9. Any charges or fees due from the individual.
- 2147 C. In addition to the provisions within 12VAC35-270-590 B, individuals receiving treatment
2148 services in a correctional facility shall receive an onboarding to the facility's security restrictions.
- 2149 D. The provider shall document that the individual and, if applicable, authorized
2150 representative, received an onboarding to services.
- 2151 **12VAC35-270-600. Human rights.**
- 2152 The provider including all employees, contractors, students, and volunteers shall comply with
2153 the Regulations to Assure Rights of Individuals Receiving Services from Providers Licensed,
2154 Funded, or Operated by the Department of Behavioral Health and Developmental Services
2155 (12VAC35-115).
- 2156 **12VAC35-270-610. Prohibited actions.**
- 2157 The following actions shall be prohibited:
- 2158 1. Prohibition of contacts and visits with the individual's attorney, probation officer, placing
2159 agency representative, minister or chaplain;
2160 2. Any action that is humiliating, degrading, or abusive;
2161 3. Subjection to unsanitary living conditions;
2162 4. Deprivation of opportunities for bathing or access to toilet facilities except as ordered
2163 by a licensed physician for a legitimate medical purpose and documented in the
2164 individual's record;
2165 5. Deprivation of appropriate services and treatment;
2166 6. Deprivation of health care;
2167 7. Administration of laxatives, enemas, or emetics except as ordered by a physician or
2168 other professional acting within the scope of his license for a legitimate medical purpose
2169 and documented in the individual's record;
2170 8. Applications of aversive stimuli except as permitted pursuant to other applicable state
2171 regulations;
2172 9. Limitation on contacts with regulators, advocates, or staff attorneys employed by the
2173 department or the state-approved protection and advocacy organization;
2174 10. Deprivation of drinking water or food necessary to meet an individual's daily nutritional
2175 needs except as ordered by a licensed physician for a legitimate medical purpose and
2176 documented in the individual's record;
2177 11. Prohibition on contacts or visits with family or an authorized representative except as
2178 permitted by other applicable state regulations or by order of a court of competent
2179 jurisdiction;
2180 12. Delay or withholding of incoming or outgoing mail except as permitted by other
2181 applicable state and federal regulations or by order of a court of competent jurisdiction;
2182 13. Use of restraints that places the individual's body in a prone (face down) position;
2183 14. Standing order for the use of seclusion or restraint for behavioral purposes; and

15. Deprivation of opportunities for sleep or rest except as ordered by a licensed physician for a legitimate medical purpose and documented in the individual's record.

12VAC35-270-620. Choice of provider.

Each individual has a right to participate meaningfully in decisions regarding all aspects of services affecting the individual including the choice of health care providers. Individuals have the right to change providers without fear of coercion, retaliation, or the imposition of requirements that have no reasonable role in the orderly and timely transfer of care.

12VAC35-270-630. Least restrictive treatment.

Each individual shall receive treatment and services in accordance with 12VAC35-115-100 A 2.

Article 6

Physical Environment

12VAC35-270-640. Personal necessities.

A. In service locations where appropriate, an adequate supply of personal necessities shall be available to individuals receiving services at all times for purposes of personal hygiene and grooming.

B. In service locations where appropriate, clean, individual washcloths and towels shall be in good repair and available once each week and more often if needed.

C. In service locations where appropriate, when individuals are incontinent or not able to use the toilet independently:

1. Provision shall be made for sponging, diapering, or other similar care on a nonabsorbent changing surface that shall be cleaned and disinfected after each use.

2. A covered diaper pail, or its equivalent, with leakproof disposable liners shall be used to dispose of diapers. If both cloth and disposable diapers are used, there shall be a diaper pail for each.

3. Adapter seats and toilet chairs shall be cleaned immediately after each use with appropriate cleaning materials.

4. Staff shall thoroughly wash their hands with warm soapy water immediately after assisting an individual or themselves with toileting.

5. Appropriate privacy, confidentiality, and dignity shall be maintained for residents during toileting and diapering.

12VAC35-270-650. Animals.

A. Animals maintained on the premises shall be tested, inoculated, and licensed as required by law.

B. The service location shall not keep, feed or provide water to stray domestic animals.

C. Pets shall be provided with clean quarters and adequate food and water and, if appropriate, access to the outdoors.

D. The provider shall ensure that any individual's rights, and medical needs are not compromised by the presence of an animal.

E. Providers shall ensure the rights of individuals receiving services who have service animals are protected.

1. Individuals have a right to utilize their service animal within any facility to assist with performing tasks, unless the service animal is not under control, not housebroken, or its presence is fundamentally altering programs or services provided by the provider or poses a direct threat to the health or safety of others.

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2229 2. Individuals with service animals cannot be required to comply requirements not
2230 applicable to other persons.

2231 3. Allergies and fear of dogs are not valid reasons for denying access or refusing service
2232 to an individual with a service animal.

2233 **12VAC35-270-660. Weapons.**

2234 The provider or facility shall have and implement a written policy governing the use and
2235 possession of firearms, pellet guns, air rifles, and other weapons on the premises, including
2236 parking areas, of the provider's services. The policy shall provide that no firearms, pellet guns, air
2237 rifles, and other weapons shall be permitted unless the weapons are:

2238 1. In the possession of licensed security or sworn law-enforcement personnel;

2239 2. Kept securely under lock and key; or

2240 3. Used under the supervision of a responsible adult in accordance with policies and
2241 procedures developed by the provider for the weapons' lawful and safe use.

2242 **12VAC35-270-670. Computers and internet access.**

2243 All licensed service locations shall have access to appropriate technology, including computer
2244 and internet access, to comply with the regulatory requirements contained within this chapter and
2245 the service-specific chapters, including serious incident reporting into the department's web-
2246 based reporting application as required by 12VAC35-270-550.

2247 **12VAC35-270-680. Access to communication systems in emergencies; emergency** 2248 **telephone numbers.**

2249 A. The provider shall have redundant communication systems with the ability to provide a
2250 means of communication during commercial power failure.

2251 B. Instructions for contacting emergency services (crisis intervention) and telephone numbers
2252 shall be prominently posted including how to contact provider medical personnel if appropriate.

2253 C. This section does not apply to noncenter-based services and correctional facilities.

2254 **12VAC35-270-690. First aid kit accessible.**

2255 A. A well-stocked first aid kit shall be maintained and readily accessible for minor injuries and
2256 medical emergencies at each service location and to employees or contractors providing in-home
2257 services or traveling with individuals. The minimum requirements of a well-stocked first aid kit that
2258 shall be maintained include a thermometer, bandages, saline solution, band-aids, sterile gauze,
2259 tweezers, instant ice-pack, adhesive tape, first-aid cream, and antiseptic soap.

2260 B. A cardiopulmonary resuscitation (CPR) face guard or mask shall be readily accessible.

2261 **12VAC35-270-700. Operable flashlights or battery lanterns.**

2262 Operable flashlights or battery lanterns shall be readily accessible to employees and
2263 contractors in services that operate between dusk and dawn to use in emergencies. This section
2264 does not apply to noncenter-based services.

Project 8086 - NOIRA**Department of Behavioral Health And Developmental Services****Regulatory Restructuring - Residential Services (Part 2 of 7)**Chapter 272Regulations for Residential and Inpatient ServicesPart IGeneral**12VAC35-272-10. Definitions.**

A. The following words and terms when used in this chapter shall have the meanings ascribed in 12VAC35-270-20:

"Admission"

"Authorized representative"

"Behavior intervention"

"Brain injury"

"Case management service" or "support coordination"

"Clinically managed high-intensity residential care" or "Level of care 3.5"

"Clinically managed low-intensity residential care" or "Level of care 3.1"

"Clinically managed population-specific high-intensity residential services" or "Level of care 3.3"

"Commissioner"

"Correctional facility"

"Department"

"Developmental disability"

"Discharge"

"Discharge plan"

"Emergency services (crisis intervention)"

"Group home"

"Individual" or "individual receiving services"

"Individualized services plan" or "ISP"

"Informed choice"

"Initial assessment"

"Intermediate care facility/individuals with intellectual disability" or "ICF/IID"

"Medically managed intensive inpatient service" or "Level of care 4.0"

"Medically monitored intensive inpatient treatment" or "Level of care 3.7"

"Medication"

"Medication administration"

"Mental illness"

"Person-centered"

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"Provider"

"Referral"

"Residential service"

"Screening"

"Seclusion"

"Service"

"Sponsored residential home"

"Substance abuse (substance use disorders)"

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

"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.

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

"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.

"Comprehensive assessment" means a comprehensive and written assessment that updates and finalizes the initial assessment. The comprehensive assessment shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context and shall be completed in a time period appropriate to the nature and scope of the service provided. The comprehensive assessment includes all relevant social, psychological, medical, and level of care information as the basis for the development of the person-centered comprehensive ISP. The comprehensive assessment may be completed at the time of initial assessment if it includes all elements of the comprehensive assessment. In the event a comprehensive assessment is completed at the time of an initial assessment the provider is not required to update the assessment.

"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.

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

1. An addiction-credentialed physician or physician with experience or training in addiction medicine;

2. A licensed nurse practitioner or a licensed physician assistant with experience or training in addiction medicine;

3. A licensed psychiatrist;

4. A licensed clinical psychologist;

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85 5. A licensed clinical social worker;

86 6. A licensed professional counselor;

87 7. A licensed psychiatric clinical nurse specialist;

88 8. A licensed psychiatric nurse practitioner;

89 9. A licensed marriage and family therapist;

90 10. A licensed substance abuse treatment practitioner;

91 11. A resident who is under the supervision of a licensed professional counselor
92 (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or
93 licensed substance abuse treatment practitioner (18VAC115-60-10) and is registered
94 with the Virginia Board of Counseling;

95 12. A resident in psychology who is under supervision of a licensed clinical psychologist
96 and is registered with the Virginia Board of Psychology (18VAC125-20-10); or

97 13. A supervisee in social work who is under the supervision of a licensed clinical social
98 worker and is registered with the Virginia Board of Social Work (18VAC140-20-10).

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

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

107 "Initial individualized service plan" or "initial ISP" means a written plan developed and
108 implemented 24 hours after admission to address immediate service, health, and safety needs
109 as identified within the individual's initial assessment.

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

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

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

118 "Medical screening" means the collection of information about the nonpsychiatric medical or
119 surgical condition of an individual to determine whether there is a need for a physical
120 assessment before a decision is made regarding admission to the provider's service.

121 "Medication-assisted treatment" or "MAT" means the use of FDA-approved medications in
122 combination with counseling and behavioral therapies to provide treatment of substance use
123 disorders. Medication-assisted treatment includes medication-assisted opioid treatment.

124 "Medication error" means an error in administering a medication to an individual and
125 includes when any of the following occur:

126 1. The wrong medication is given to an individual;

127 2. The wrong individual is given the medication;

128 3. The wrong dosage is given to an individual;

129 4. Medication is given to an individual at the wrong time or not at all; or

130 5. The wrong method is used to give the medication to the individual.

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

"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 substance use.

"Planning team" means the team that is consulted to plan the individual's plan for supports. The planning team shall, at a minimum, consist of the individual receiving services and the case manager and any legally required authorized representative, including a legal guardian. The planning team may include the individual's family or family of choice or other identified persons, as desired by the individual.

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

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

12VAC35-272-20. License required.

Providers shall be licensed to provide specific services as defined in 12VAC35-270, this chapter, or as determined by the commissioner. The following services shall require a residential license:

1. Clinically managed high-intensity residential services or level of care 3.5 for adults;
2. Clinically managed high-intensity residential services or level of care 3.5 for children and adolescents;
3. Clinically managed low-intensity residential services or level of care 3.1 for adults;
4. Clinically managed low-intensity residential services or level of care 3.1 for children and adolescents;
5. Clinically managed population-specific high-intensity residential services or level of care 3.3;
6. Group home for adults;
7. Group home for children and adolescents;
8. ICF/IID for adults;
9. ICF/IID for children and adolescents;
10. Inpatient;
11. Medically managed intensive inpatient service or level of care 4.0;
12. Medically monitored intensive inpatient service or level of care 3.7;
13. QRTP - Psychiatric rehabilitation treatment facility;
14. QRTP - Group home;
15. Respite residential for adults;

16. Respite residential for children and adolescents;

17. Sponsored residential home; and

18. Supervised living.

12VAC35-272-30. Service descriptions.

A. Clinically managed high-intensity residential services include services that provide 24-hour supportive treatment in an environment to initiate or continue a recovery process that has failed to progress. Clinically managed high-intensity residential services are characterized by reliance on the treatment community as a therapeutic agent. These services include therapeutic community with appropriately clinically trained staff or a residential treatment center.

B. Clinically managed low-intensity residential services include low-intensity treatment of substance-related disorders. Treatment is characterized by services such as individual, group, and family therapy; medication management; and psychoeducation. These services include halfway houses, group homes, and other supportive living environments with 24-hour staff and close integration with clinical services.

C. Clinically managed population-specific high-intensity residential services include a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of patients to support recovery from substance-related disorders. These services include therapeutic rehabilitation facilities and traumatic brain injury programs.

D. Group home services include 24-hour direct awake supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living.

E. ICF/IID services include aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed toward the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible and the prevention or deceleration of regression or loss of current optimal functional status.

F. Inpatient services include intensive 24-hour medical, nursing, and treatment services provided to individuals with developmental disabilities, mental illness, or substance use disorders in a hospital or in a special unit of a hospital.

G. Medically managed intensive inpatient services include services delivered in an acute care inpatient setting. Such a program includes a regimen of medically directed evaluation and treatment services provided in a 24-hour treatment setting. These services include acute care general hospitals, acute psychiatric hospitals, psychiatric units within acute care general hospitals, and licensed addiction treatment specialty hospitals with acute care medical and nursing staff.

H. Medically monitored intensive inpatient services include a planned and structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. Medically monitored intensive inpatient services include an inpatient treatment center within the context of an acute care hospital or acute psychiatric unit, or a more intensive separate unit of a freestanding residential facility.

I. QRTP services include implementation of a trauma-informed treatment model designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances and, with respect to a child, that is able to implement the treatment identified for the child by assessment. QRTPs shall have registered or licensed nursing staff and other licensed clinical staff who provide care within the scope of their practice, are on site during business hours, and are available 24 hours a day and seven days a week. QRTPs shall, to the extent appropriate and in accordance with the child's best interests:

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1. Facilitate participation of family members in the child's treatment program;
2. Facilitate outreach to the child's family members, including siblings;
3. Document how the outreach is made;
4. Maintain contact information for any known biological family and fictive kin; and
5. Document how family members are integrated into the treatment process for the child, including post-discharge, and how sibling connections are maintained.

Q RTP services include discharge planning and family-based aftercare for at least six months post-discharge. Q RTPs shall be accredited by an independent, not-for-profit accrediting organization approved by the U.S. Secretary of Health and Human Services.

J. Respite residential services include providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular caregiver within a residential setting.

K. Sponsored residential home services include a service where providers arrange for, supervise, and provide programmatic, financial, and service support to a family or sponsor providing care or treatment in the family's or sponsor's own home for individuals receiving services.

L. Supervised living services include the provision of direct supervision and community support services to individuals living in apartments or other residential settings.

12VAC35-272-40. Screening.

A. Providers shall implement screening policies that include:

1. Identification, qualification, training, and duties of employees responsible for screening;
2. The following minimum required elements of screening for a residential setting:
 - a. Date of contact;
 - b. Legal name, preferred name, date of birth, sex, and gender of the individual;
 - c. Contact information for the individual, including address, telephone number, and email address, if applicable;
 - d. Reasons the individual is requesting services;
 - e. Current diagnoses and medical conditions;
 - f. Medical symptoms;
 - g. Psychoactive or other medications currently being used, including recent increases, decreases, discontinuation, misuse, or overdose of prescription medication;
 - h. Recent or current substance use or dependence, including risk for intoxication or substance withdrawal; and
 - i. Status of the individual, including the individual's referral to other services, further assessment, placement on a waiting list for service, or admission to the service; and
3. Methods to identify other appropriate services for referral to assist individuals who are not admitted to service after screening.

B. For an individual not admitted to the service, the provider shall retain documentation of the individual's screening for six months. For an individual who is admitted to service, documentation shall be included in the individual's record in accordance with 12VAC35-270-580.

C. The provider shall review all elements of the screening at the time of initial assessment and update as necessary.

12VAC35-272-50. Assessment.

A. The provider shall implement a written assessment policy. The policy shall define how assessments will be conducted and documented.

B. The provider shall actively involve the individual and the individual's authorized representative, if applicable, in the preparation of initial and comprehensive assessments. In these assessments, the provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

C. The assessment policy shall designate appropriately qualified employees or contractors who are responsible for conducting, obtaining, or updating assessments and medical screenings. These employees or contractors shall have experience in working with the needs of individuals who are being assessed, the assessment tools being utilized, and the provision of services that the individuals may require.

D. Assessment is an ongoing activity. The provider shall make reasonable attempts to obtain previous assessments or relevant history. The provider shall use previous assessments or relevant history in order to complete an individual's initial or comprehensive assessment. The provider shall use previous assessments or relevant history within the course of treatment, if applicable.

E. Providers shall utilize an assessment tool that meets the requirements in subsection F of this section for initial assessments and subsection G of this section for comprehensive assessments. Providers may utilize a standardized state-sanctioned or federally sanctioned assessment tool that does not meet the criteria in these regulations if the tool is approved by the department prior to use.

F. Providers shall conduct an individual's initial assessment prior to or at admission to the service. The provider shall complete or obtain information from other qualified providers in order to complete an initial assessment detailed enough to determine whether the individual qualifies for admission and to initiate an ISP for those individuals who are admitted to the service.

1. The initial assessment of the individual's immediate service, health, and safety needs shall be conducted using an assessment tool that evaluates, at a minimum, the following criteria concerning the individual:

a. Diagnosis;

b. Presenting needs, including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of needs;

c. Current medical issues;

d. Current medications;

e. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders;

f. At-risk behavior to self and others; and

g. Risk factors that may impact the individual's ability to seek treatment or continue to participate in services.

2. For individuals presenting with substance use disorder, at the time of the initial assessment the provider shall:

a. Identify any individual with a high risk for medical complications or who may pose a danger to himself or others;

b. Assess substances used and time of last use;

c. Document the time of the individual's last meal;

d. Analyze blood alcohol content or administer a breathalyzer; and

- 315 e. Record vital signs.
- 316 3. The comprehensive assessment may be completed at the time of initial assessment if
317 it includes all elements noted within subsection G of this section. In the event a
318 comprehensive assessment is completed at the time of an initial assessment, the
319 provider is not required to update the assessment unless a reassessment is medically or
320 clinically indicated.
- 321 G. Providers shall conduct a comprehensive assessment for each individual who is admitted
322 to the service. A comprehensive assessment shall update and finalize the initial assessment,
323 unless the comprehensive assessment is completed at the time of initial assessment as
324 provided in subdivision F 3 of this section.
- 325 1. Completion of the comprehensive assessment shall be based upon the nature and
326 scope of the service but shall occur no later than (i) 30 days after admission for
327 providers of mental health and substance abuse services or (ii) 60 days after admission
328 for providers of developmental services.
- 329 2. The comprehensive assessment may be completed at the time of initial assessment
330 only if it includes all elements enumerated in subdivision 3 of this subsection. In the
331 event a comprehensive assessment is completed at the time of an individual's initial
332 assessment, the provider is not required to update the assessment unless a
333 reassessment is medically or clinically indicated.
- 334 3. The comprehensive assessment shall be conducted using an assessment tool that
335 evaluates, at a minimum, the following criteria:
- 336 a. Onset and duration of needs;
- 337 b. Social, behavioral, developmental, and family history and supports;
- 338 c. Cognitive functioning, including strengths and weaknesses;
- 339 d. Employment, vocational, and educational background;
- 340 e. Previous interventions and outcomes, including interventions and outcomes that
341 were unsuccessful, with the provider ensuring that previous assessments are utilized
342 to note prior interventions as required by subsection D of this section;
- 343 f. Overall financial situation, including resources, support and benefits, and whether
344 the individual has the means to meet his financial needs;
- 345 g. Health history and current medical care needs, to include:
- 346 (1) Allergies, including allergies to food or medications;
- 347 (2) Recent physical complaints and medical conditions;
- 348 (3) Nutritional needs;
- 349 (4) Chronic conditions;
- 350 (5) Communicable diseases;
- 351 (6) Restrictions on physical activities, if any;
- 352 (7) Restrictive protocols or special supervision requirements;
- 353 (8) Past serious illnesses, serious injuries, and hospitalizations;
- 354 (9) Serious illnesses and chronic conditions of the individual's parents, siblings, and
355 significant others in the same household; and
- 356 (10) Current and past substance use, including alcohol, prescription and
357 nonprescription medications, and illicit drugs;
- 358 h. Psychiatric and substance use issues, including current mental health or
359 substance use needs, presence of co-occurring disorders, history of substance use

or abuse, and circumstances that increase the individual's risk for mental illness or substance use issues;

i. History of abuse, neglect, sexual or domestic violence, or other trauma, including psychological trauma;

j. Legal competency status, including authorized representative, commitment, and representative payee status;

k. Relevant criminal charges or convictions and probation or parole status;

l. Daily living skills;

m. Housing arrangements;

n. Ability to access services, including transportation; and

o. As applicable, fall risk, communication methods or needs, and mobility and adaptive equipment needs.

H. The provider shall retain documentation of the individual's assessments in the individual's record for a minimum of six years after the individual's discharge in accordance with § 54.1-2910.4 of the Code of Virginia and the provider's written records management policy pursuant to 12VAC35-270-580.

12VAC35-272-60. Individualized services plan (ISP); service planning.

A. The provider shall actively involve the individual and authorized representative, as appropriate, in the development, review, and revision of a person-centered ISP. The individualized services planning process shall be consistent with laws protecting confidentiality, privacy, human rights of individuals receiving services, and rights of minors.

1. Providers of developmental services shall collaborate with the individual's planning team to develop and implement the initial plan for supports, which is a component of the comprehensive ISP, no later than 24 hours after admission. The initial plan for supports shall address the individual's immediate health and safety needs for the first 60 days, may include assessment activities, and shall continue in effect until the ongoing comprehensive plan for supports is developed or the individual is discharged, whichever occurs first. An ongoing comprehensive plan for supports shall be completed within 60 days of admission.

2. Providers of mental health or substance abuse services shall develop and implement an initial ISP no later than 24 hours after admission. The initial ISP shall address the individual's immediate service, health, and safety needs for the first 30 days and shall continue in effect until the comprehensive ISP is developed or the individual is discharged, whichever occurs first. An ongoing comprehensive ISP based upon the nature and scope of services shall be completed as soon as possible, but no later than (i) 48 hours after admission by providers of short-term intensive services typically provided for less than 30 days, such as inpatient, or (ii) 30 days after admission.

B. If an individual has a case manager, informed choice shall be governed by the service-specific requirements governing case management providers (12VAC35-280). If the individual does not have a case manager, development of the initial ISP and the comprehensive ISP shall be developed based on the respective assessment with the participation and informed choice of the individual receiving services.

1. To ensure the individual's participation and informed choice, the following shall be explained to the individual or the individual's authorized representative, as applicable, in a reasonable and comprehensible manner:

a. The proposed services to be delivered;

b. Any alternative services that might be advantageous for the individual; and

- 407 c. Any accompanying risks or benefits of the proposed alternative services.
- 408 2. If no alternative services are available to the individual, it shall be clearly documented
- 409 within the ISP or within documentation attached to the ISP, that alternative services were
- 410 not available as well as the steps taken to identify alternative services.
- 411 3. Whenever there is a change to an individual's ISP, it shall be clearly documented
- 412 within the ISP or within documentation attached to the ISP that:
- 413 a. The individual participated in the development of or revision to the ISP;
- 414 b. The proposed and alternative services and their respective risks and benefits were
- 415 explained to the individual or the individual's authorized representative; and
- 416 c. The reasons the individual or the individual's authorized representative chose the
- 417 option included in the ISP.
- 418 **12VAC35-272-70. ISP minimum requirements.**
- 419 A. The initial ISP shall be based on the individual's immediate service, health, and safety
- 420 needs identified in the initial assessment. The initial ISP shall include:
- 421 1. Relevant and attainable goals, measurable objectives, and specific strategies for
- 422 addressing needs and preferences documented within the individual's initial assessment,
- 423 including documentation that the individual's needs and preferences are consistent with
- 424 a residential setting;
- 425 2. Services, supports, and frequency of services planned to accomplish the individual's
- 426 goals, including relevant psychological, mental health, substance abuse, behavioral,
- 427 developmental, medical, rehabilitation, training, and nursing needs and supports;
- 428 3. The role of the individual and others, including the individual's family, if appropriate, in
- 429 implementing the initial ISP; and
- 430 4. Target dates for the accomplishment of goals and objectives.
- 431 B. The comprehensive ISP shall be based on the individual's needs, strengths, abilities,
- 432 personal preferences, goals, and natural supports identified in the comprehensive assessment.
- 433 The comprehensive ISP shall include the following minimum provisions:
- 434 1. Relevant and attainable goals, measurable objectives, and specific strategies for
- 435 addressing each need documented within the individual's comprehensive assessment,
- 436 including documentation that the individual's needs require a provider-operated
- 437 residential setting;
- 438 2. Services and supports required to accomplish the individual's goals, including relevant
- 439 psychological, mental health, substance abuse, behavioral, developmental, medical,
- 440 rehabilitation, training, and nursing needs and supports;
- 441 3. The frequency at which services and supports must be provided to accomplish the
- 442 individual's goals;
- 443 4. The role of the individual and others, including the individual's family, if appropriate, in
- 444 implementing the comprehensive ISP;
- 445 5. A communication plan for individuals with communication barriers, including language
- 446 barriers;
- 447 6. A behavioral support or treatment plan, if applicable;
- 448 7. A physical safety plan that addresses identified risks to the individual or to others,
- 449 including a fall risk plan if indicated by the individual's assessment;
- 450 8. A crisis or recovery plan, if applicable;
- 451 9. Target dates for accomplishment of goals and objectives;

10. Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies, if applicable;

11. A transportation plan, if applicable;

12. Services the individual elects to self-direct, if applicable; and

13. Projected discharge plan and estimated length of stay within the service.

C. Both the initial ISP and the comprehensive ISP shall be signed and dated, at a minimum, by (i) the person responsible for implementing the plan and (ii) the individual receiving services or the authorized representative, if applicable, in order to document agreement.

1. If the signature of the individual receiving services or the authorized representative cannot be obtained, the provider shall document attempts to obtain the necessary signature and the reason the signature was unattainable. The provider shall attempt to obtain the necessary signature, on a periodic basis, while each ISP is in effect. An attempt to obtain the necessary signature shall occur at a minimum each time the provider reviews the ISP as required by 12VAC35-272-80 E.

2. Each ISP shall be distributed to the individual and others authorized to receive it prior to implementation. The provider shall document dates of the distribution within the individual's record.

D. The provider shall designate an employee or contractor who shall be responsible for developing, implementing, reviewing, and revising each individual's ISP in collaboration with the individual or authorized representative, as appropriate.

E. Employees or contractors who are responsible for implementing the ISP shall demonstrate a working knowledge of the objectives and strategies contained in the individual's current ISP, including an individual's detailed health and safety protocols.

1. Providers shall educate and train employees or contractors who are responsible for ISP implementation on the objectives and strategies contained within the individual's current ISP.

2. When changes occur to an individual's ISP, the provider shall notify and train the appropriate employees or contractors who are responsible for ISP implementation. The provider shall ensure that the employee or contractor is competent to implement the revised ISP.

3. After training on the individual's current ISP, providers shall maintain documentation of the employee's or contractor's education, training, and competency as demonstrated through supervision.

F. When a provider provides more than one service to an individual, the provider may maintain a single ISP document that contains individualized objectives and strategies for each service provided.

G. Whenever possible, the identified goals in the ISP shall be written in the words of the individual receiving services.

H. The provider shall use signed and dated progress notes to document the implementation of the goals and objectives contained within the ISP.

I. The individual's most current ISP shall be located at the individual's residential setting.

12VAC35-272-80. Reassessments and quarterly ISP reviews.

A. A reassessment shall be completed at least annually and any time there is a need based on changes in the medical, psychiatric, behavioral, or other status of the individual. The reassessment shall include documentation justifying that the individual's needs continue to require a provider-operated residential setting.

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B. The provider shall actively involve the individual and authorized representative, if applicable, in reassessments. The provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

C. Providers shall revise the ISP if the reassessment supports changes or if desired by the individual. If a reassessment does not support changes to the ISP, the provider shall document that no revisions are necessary and the reasoning.

D. If necessary as a result of reassessment, providers shall complete changes to medical protocols or collaborate with other providers to ensure changes to medical protocols are made, including medical equipment, behavioral, or other corresponding protocols, if appropriate.

E. The provider shall complete quarterly reviews in writing of the ISP at least every three months from (i) the date of the implementation of the most recent comprehensive ISP or (ii) the most recent reassessment, whichever occurs later. Documentation of the quarterly ISP review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed. This subsection only applies to respite residential services if the individual has utilized the service within the quarter.

F. A quarterly ISP review shall be conducted in a person-centered manner to determine if services are being delivered as described within the ISP. The individual receiving services and the authorized representative, if applicable, shall be included in the ISP review to determine if the individual's treatment needs and preferences are being met and whether the individual is satisfied with the services provided.

1. A quarterly ISP review shall evaluate the individual's progress toward meeting the ISP goals and objectives and the continued relevance of the ISP objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made.

2. A quarterly ISP review shall document evidence of progress toward or achievement of a specific targeted outcome for each goal and objective.

3. For goals and objectives that were not accomplished by the identified target date, or for which the individual did not demonstrate sufficient progress, the provider shall meet and collaborate with other service providers and appropriate treatment team members to review the reasons for lack of progress and provide the individual an opportunity to make an informed choice of how to proceed. The provider shall retain documentation of this meeting and the individual's informed choice within the individual's record.

4. A quarterly ISP review shall note:

a. the individual's family involvement, if any, in the individual's treatment;

b. whether the individual no longer needs the intensity of care provided within a residential setting;

c. the individual's progress towards discharge; and

d. the status of the individual's discharge planning.

G. The provider shall ensure after each reassessment that the individual's most current ISP is located at the individual's residential setting.

12VAC35-272-90. Progress notes.

A. The documentation system implemented by the provider pursuant to subdivision E of 12VAC35-270-580 shall ensure that progress notes are (i) maintained in a consistent format that satisfies the minimum provisions of subsection B of this section and (ii) entered into the individual's record in accordance with the provider's record management policy.

B. The provider shall use signed and dated progress notes or other documentation to document the services provided to the individual. Progress notes shall, at a minimum:

1. Be legible and readable;

2. Record the individual's interaction with the staff writing the progress note, including care provided and events relevant to diagnosis and treatment or care of the individual;

3. Provide a narrative or descriptive component;

4. Include next steps related to treatment or care of the individual; and

5. Be signed and dated by the staff member who rendered the service.

C. The provider shall document whether the individual no longer needs the intensity of care provided within a residential setting.

D. Progress notes shall be entered into the individual's record at a minimum of once per shift as defined in the provider's policies and procedures.

E. Communication logs, information notes, and supervision notes shall not be considered progress notes.

12VAC35-272-100. Discharge planning.

A. Providers shall implement a written policy that includes:

1. Identification, qualification, training, and duties of employees responsible for discharge planning; and

2. Completion of a discharge plan prior to an individual's discharge that incorporates the following minimum provisions:

a. The discharge plan involves the individual or the individual's authorized representative and reflects the individual's preferences to the greatest extent possible consistent with the individual's needs.

b. The discharge plan involves mental health, substance abuse, developmental disability, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services that the individual will need upon discharge into the community or transfer to another provider and identifies the public or private agencies or persons that have agreed to provide those services.

B. Providers of short-term intensive services typically provided for less than 30 days, such as inpatient, shall develop the required discharge plan no later than 48 hours prior to discharge. Providers of all other residential services shall develop a discharge plan within seven days prior to discharge.

C. Providers shall also comply with the criteria for discharge in 12VAC35-270-430.

12VAC35-272-110. Emergency preparedness and response plan.

A. The scope of emergency preparedness in relation to this section applies to disasters and emergencies as defined by § 44-146.16 of the Code of Virginia.

B. The provider shall develop a written emergency preparedness and response plan that includes specifics for all services and locations. The plan shall address:

1. An analysis and prioritization of vulnerability of all services and locations to various hazards that may impact the provider. Vulnerability is a combination of the likelihood and severity of hazard occurrence.

2. A base-level response plan that is applicable to all hazards and includes:

a. Documentation of preparedness activities, such as emergency planning team meetings, emergency medical drills, incident reviews, plan revisions, and other activities.

b. Maintenance of 24-hour communications capability to respond to emergencies.

- 589 c. Documented procedure for activation of the emergency plan, including a
590 description of various triggers for activation, who may activate, overall situation
591 assessment, response escalation, situation stabilization, and life and property
592 preservation as first priority during any response.
- 593 d. Documented procedure to notify the department of activation of the emergency
594 plan as soon as possible, but no later than 24 hours after incident occurrence.
- 595 e. Documented policies outlining specific responsibilities for incident command and
596 an incident management team, including operations, logistics, planning, and finance.
- 597 f. Documented policies and procedures to ensure, to the extent possible, the life
598 safety of individuals, employees, contractors, volunteers, and visitors.
- 599 g. Policy and procedures for building access and security, including the provision of a
600 secure building under adverse circumstances and appropriate access to the building
601 by emergency responders.
- 602 h. Documented policies and procedures for the resumption of normal activities
603 following service disruption from an emergency, including any necessary site
604 inspections required before repatriation can take place.
- 605 i. Documented identification, consideration, and mitigation activities related to high-
606 priority vulnerabilities as identified by a vulnerability analysis.
- 607 3. An evacuation plan that includes:
- 608 a. Documented, current consideration of local or regional sites that could function as
609 evacuation locations or stop-over points, including documentation of any
610 arrangements the provider has made with such local or regional sites.
- 611 b. Policy and procedures for executing an evacuation or relocation of individuals
612 receiving services to include ensuring individuals who use wheelchairs, or other
613 mechanical devices for assistance in walking are provided with means of effective
614 egress, individual and staff location tracking, and preservation of all critical services
615 (e.g., pharmacy, feeding).
- 616 c. Policy and procedures for ensuring handling protected health information (PHI)
617 during an evacuation or relocation to ensure the PHI is both properly secured and
618 accessible at the new location or by new service providers to allow for proper
619 continuity of care.
- 620 C. The provider shall develop a written communication plan detailing:
- 621 1. The process for notifying local and state authorities, including the department, of an
622 emergency.
- 623 2. The process for notifying and communicating with staff, employees, contractors,
624 volunteers, and community responders during emergencies.
- 625 3. The process for warning, notifying, and communicating with individuals receiving
626 services.
- 627 4. The process for notifying and communicating with family members or authorized
628 representatives during emergencies.
- 629 D. The provider shall develop a written Continuity of Operations Plan detailing:
- 630 1. Delegation of authority under emergency conditions.
- 631 2. Succession planning for emergency conditions, including the event of the license
632 holder's death or incapacitation as required by subsection B 1 of 12VAC35-270-40.
633 Community service boards are not required to have a succession plan.

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3. Indication of which services are critical to the health and well-being of the individuals being served and therefore must be continued; services less critical that may be delayed; ancillary services that may be discontinued during emergency circumstances; and triggers with regard to the continuity of these services.

4. Documented plans for continuity of activities related to the provision of care, treatment, and services, including scheduling, modifying, or discontinuing services; personally identifiable information (PII) and PHI access and security; providing medication; and transportation services.

5. Contingency planning for supply chain disruptions of critical supplies such as pharmaceuticals, food, water, toiletries, linens, and any other supplies required for subsistence.

E. Providers shall ensure a three-day supply of emergency food and water for all individuals and staff. Emergency food caches should include food that is easily prepared and does not need to be cooked. One gallon of potable water per person, per day is required.

1. The emergency food cache shall include no expired food.

2. The emergency food cache shall be appropriate for meeting the dietary needs of the population served.

3. The provider shall ensure that any tools needed to prepare the emergency food supply, such as can openers or portable blenders, are stored with the emergency food cache.

4. The emergency food cache shall be separate from the provider's day-to-day food supply.

5. The emergency food cache shall be packed and ready for transport in case of emergency.

F. The provider shall maintain documentation of outreach to local emergency officials to include local emergency managers at least annually.

G. The provider shall implement annual emergency preparedness and response training for all employees, contractors, students, and volunteers pursuant to 12VAC35-270-290. This training shall also be provided during the onboarding of new employees and shall include:

1. Activation and notification for the emergency plan.

2. Evacuation procedures that include consideration of individuals with medical, functional, and access needs.

3. Use, maintenance, and operation of any emergency equipment.

4. Medical record stewardship during emergencies.

5. Utilization of community support services in emergencies.

H. The provider shall document review of the emergency preparedness plan and continuity of operations annually and make necessary revisions. Such revisions shall be (i) communicated to employees, contractors, students, volunteers, and individuals receiving services and (ii) incorporated into training for employees, contractors, students, and volunteers and into the orientation of individuals to services.

I. The provider shall schedule for testing the implementation of the emergency preparedness plan and conducting emergency preparedness drills. A fire, evacuation, or emergency medical drill shall be conducted at least once a month on a schedule that ensures that a fire, evacuation, and emergency medical drill shall be conducted at least quarterly.

12VAC35-272-120. Health care policy.

A. Providers shall provide or arrange for the provision of appropriate medical and dental care.

B. The provider shall implement a policy that addresses provision of adequate and appropriate medical and dental care. This policy shall describe how and to what extent:

1. Medical and dental care needs will be assessed and the circumstances that will prompt the decision to obtain a medical assessment.

2. ISPs will address any medical and dental care needs appropriate to the scope and level of service.

3. The provider will provide or arrange for the provision of medical and dental care needs identified at admission.

4. The provider will provide or arrange for the provision of routine ongoing and follow-up medical and dental care services after admission.

5. The provider will communicate the results of physical examinations, medical assessments, and diagnostic tests, treatments, or examinations conducted by the provider to the individual and the individual's authorized representative, as appropriate.

6. The provider will keep accessible to employees and contractors on duty the names, addresses, and phone numbers of the individual's medical and dental providers.

7. The provider will ensure a means for facilitating and arranging, as appropriate, transportation to medical and dental appointments and medical tests when services cannot be provided on site.

8. The provider will ensure the provision of emergency medical services for each individual.

C. The provider shall identify any individuals who are at risk for falls and develop and implement a fall prevention and management plan and program for each at-risk individual.

D. The provider shall implement written infection control measures including the use of universal precautions.

E. The provider shall report outbreaks of infectious diseases to the Department of Health pursuant to § 32.1-37 of the Code of Virginia.

F. All employees, contractors, students, and volunteers in residential treatment services shall complete tuberculosis education as part of initial orientation and thereafter on an annual basis. The education shall focus on self-presentation in the event of exposure to active tuberculosis or the development of symptoms of active tuberculosis disease.

12VAC35-272-130. Crisis or emergency interventions; required elements.

A. The provider shall implement written policies, as approved by the department, for prompt intervention in the event of a crisis or behavioral, medical, or psychiatric emergency that may occur during screening and referral, at admission, or during the period of service provision. For the purposes of this section, a crisis or behavioral, medical, or psychiatric emergency is a situation that poses an imminent risk to the individual or others and cannot be addressed within the scope of the provider's services, but does not include events that require the use of restrictive behavior intervention and supports as referenced in 12VAC35-270-500.

B. The policies and procedures shall include:

1. Procedures for immediately accessing appropriate internal and external resources, including a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the crisis or emergency;

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2. Employee or contractor responsibilities; and

3. Location of the face sheets with emergency medical information as required by 12VAC35-270-460.

12VAC35-272-140. Staffing.

A. The provider shall have a designated staff member who is responsible for ensuring supervision of the site and ensuring compliance with this chapter and 12VAC35-270. The designated staff member shall be on the premises during regular business hours. In the event the designated staff member cannot be on the premises during regular business hours, the provider shall have a contact number posted in a method accessible to individuals, parents, and legal guardians and within the Office of Licensing's official licensing and communication system (CONNECT). The designated staff shall return to the premises within one hour of a call to the contact number.

B. Clinically managed high-intensity residential services shall meet the following staffing 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 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 the treatment of such disorders. 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.

C. Clinically managed low-intensity residential services shall meet the following staffing 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 on site 24 hours a day;

2. Have clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use disorder and the treatment of substance use disorder 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.

D. Clinically managed population-specific high-intensity residential services shall meet the following staffing 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;

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2. Have allied health professional staff on site 24 hours a day. At least one clinician with competence in the treatment of substance use disorder shall be available on site or by telephone 24 hours a day;

3. Have clinical staff knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment and able to identify the signs and symptoms of acute psychiatric conditions. Staff shall have specialized training in behavior management techniques; and

4. 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.

E. Group homes shall maintain staffing ratios sufficient to meet the needs of individuals admitted to the service as described within each individual's ISP.

F. ICF/IIDs shall meet the following staffing requirements. The program shall:

1. Have qualified direct care staff, sufficient to meet the 24 hour scheduled and unscheduled needs of each individual;

2. Have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every ISP;

3. Have professional staff who work with individuals on a periodic basis and who shall not be included in direct care staff ratios;

4. Have supervisors of direct care professionals who shall be counted in direct care staff ratios only if they share in the actual work of direct care of individuals;

5. Have direct care supervisors whose principal assigned function is to supervise direct care staff and who shall not be included in direct care staff ratios although they may occasionally provide direct care services to individuals;

6. Have non-direct care staff supervisors whose principal assigned function is to supervise non-direct care staff and who shall not be included in direct care staff ratios; and

7. Have professional program staff who shall participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

G. Inpatient services shall meet the following staffing requirements. The program shall:

1. Have a licensed psychiatrist who has experience working with the population;

2. Have a sufficient number of qualified attending psychiatrists to provide basic treatment functions including evaluations, admissions, diagnoses, prescribing of treatment, discharging patients, and clinical treatment team supervision;

3. Have at least one full-time social worker. A program shall maintain a social worker staff ratio equivalent to one full-time position to 10 individuals served. The amount of social worker staff may need to increase if extensive supplementary functions are included;

4. Have a registered psychiatric nurse. A program shall maintain a staff ratio of one psychiatric nurse per shift for every 12 individuals served. This number shall be adjusted according to the acuity, medical treatment, medication, and extensive functions;

5. Have a licensed practical nurse; and

6. Have a sufficient number of psychiatric technicians to maintain a staff ratio that meets the supervision needs of individuals receiving services.

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H. Medically managed intensive inpatient services shall meet the following staffing requirements. The program shall:

1. Have a team of appropriately trained and credentialed professionals who provide medical management by physicians 24 hours a day, primary nursing care and observation 24 hours a day, and professional counseling services 16 hours a day;
2. Have an interdisciplinary team of appropriately credentialed clinical staff, including addiction-credentialed physicians, nurse practitioners, physician assistants, nurses, counselors, psychologists, and social workers, who assess and treat individuals with severe substance use disorders or addicted individuals with concomitant acute biomedical, emotional, or behavioral disorders;
3. Have staff who are knowledgeable about the biopsychosocial dimensions of addiction as well as biomedical, emotional, behavioral, and cognitive disorders;
4. Have facility-approved addiction counselors or licensed, certified, or registered addiction clinicians who administer planned interventions according to the assessed needs of the individual; and
5. 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.

I. Medically monitored intensive inpatient services shall meet the following staffing 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 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.

J. Respite residential shall maintain staffing ratios sufficient to meet the needs of individuals admitted to the service as described within each individual's ISP.

K. Sponsored residential homes shall meet the following staffing requirements. The program shall:

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1. Have qualified direct care staff sufficient in number to meet the 24-hour scheduled and unscheduled needs of each individual;

2. Ensure that if an individual requires awake overnight staff that adequate staffing is provided; and

3. Have at least one on-call staff member or substitute care arrangement per location. Substitute care arrangements shall not serve as substitute care for more than two locations at a time.

L. Supervised living shall have qualified direct care staff readily available and sufficient in number to meet the 24-hour scheduled and unscheduled needs of each individual.

M. Providers of residential services to children shall meet the following staffing requirements. The program shall:

1. Have a program director, who shall submit the following to demonstrate compliance with the qualifications required by this regulation for the program director:

a. Official transcripts from the accredited college or university of attendance within 30 days of hire; and

b. Documentation of prior relevant experience.

2. Have a case manager responsible for coordination of all services offered to individuals receiving services. The case manager shall have:

a. A master's degree in social work, psychology, or counseling;

b. A baccalaureate degree in social work or psychology with documented field work experience. An applicant who qualifies under this subdivision shall be supervised by the program director or other equally qualified designee; or

c. A baccalaureate degree and three years of professional experience working with children.

3. Have child care supervisors who are responsible for the (i) development of the daily living program within each child care unit and (ii) orientation, training, and supervision of direct care workers. Child care supervisors shall have the following qualifications:

a. A baccalaureate degree in social work or psychology and two years of professional experience working with children, one year of which must have been in a residential facility providing services for children and adolescents;

b. A high school diploma or a General Education Development (GED) certificate and a minimum of five years of professional experience working with children with at least two years in a residential facility providing services to children and adolescents; or

c. A combination of education and experience working with children as approved by the department.

4. Have child care staff who are responsible for guidance and supervision of the children to whom they are assigned. A person serving in a child care worker's position shall be at least 19 years of age, except as provided in subdivision 7 of this subsection.

5. Child care staff and relief child care staff shall furnish evidence of having obtained one of the following experience or education standards:

a. A baccalaureate degree in human services;

b. An associate's degree and three months of experience working with children; or

c. A high school diploma or GED and six months of experience working with children.

6. A person with a high school diploma or GED and less than six months of experience working with children may be hired as child care staff, provided that the person does not work independently. Provisional child care staff shall at all times work directly with the

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program director, case manager, child care supervisor, or an experienced child care worker who has at least one year of professional experience working with children.

7. In lieu of the minimum position qualification contained in subdivision 4 of this subsection, providers subject to (i) the rules and regulations of the Virginia Department of Human Resource Management or (ii) the rules and regulations of a local government personnel office may develop written minimum entry-level qualifications in accordance with the rules and regulations of the supervising personnel authority.

12VAC35-272-150. Provider staffing plan.

A. In addition to the provisions of 12VAC35-270-300, providers of residential services shall incorporate the following service-specific requirements into the provider's written staffing plan.

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

1. Supervision of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature, such as inpatient, shall be provided by a licensed mental health professional or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions.

2. Supervision of mental health, substance abuse, or co-occurring services that are of a supportive or maintenance nature, such as supervised living, shall be provided by a QMHP, a licensed mental health professional, or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions. An individual who is a QMHP-T may not provide this type of supervision.

C. The provider shall employ or contract with persons with appropriate training, as necessary, to meet the specialized needs of and to ensure the safety of individuals receiving services with medical or nursing needs; speech, language, or hearing problems; or other needs where specialized training is necessary.

D. In addition to the provisions of 12VAC35-270-300, providers of residential services to children shall incorporate the following service-specific requirements into the provider staffing plan:

1. No member of the child care staff shall be on duty more than six consecutive days without a rest day, except in an emergency or as approved by the department for live-in staff.

2. Child care staff shall have an average of at least two rest days per week in any four-week period. Rest days shall be in addition to vacation time and holidays.

3. No child care staff, other than live-in staff, shall be on duty more than 16 consecutive hours, except in an emergency.

4. There shall be at least one trained child care worker on duty and actively supervising individuals at all times that one or more individuals are present.

E. Providers of residential services to children shall develop and implement staff supervision contingency plans to accommodate for illnesses among the population served or staff, emergencies, off-campus activities, and personal preferences of the individual receiving services. Contingency plans shall be based on the:

1. Needs of the population served;

2. Types of services offered;

3. Qualifications of staff on duty; and

4. Number of individuals served.

F. In addition to the provisions of 12VAC35-270-300, providers of residential services to children shall incorporate the following service-specific minimum staffing ratios into the provider

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staffing plan. At all times, during hours individuals are awake, the ratios of staff to children shall be:

1. For children from birth to 16 months of age: one staff member for every three children;
2. For children 16 months to two years of age: one staff member for every four children;
3. For children two to three years of age: one staff member for every six children; and
4. For children three years of age and older: one staff member for every eight children.

G. Providers of residential services to children shall obtain prior written approval by the department to allow a higher number of children to be supervised by one staff member.

H. Upon request, providers of residential services to children shall provide a copy of the staffing plan or a summary of its supervision policies to the placing agency or legal guardian prior to placement.

12VAC35-272-160. Nutrition.

A. Nothing in this section shall be construed to limit the individual's right to make personal dietary choices.

B. The provider shall implement a service protocol for the provision of food services, which ensures access to nourishing, well-balanced, varied, and healthy meals that shall, at a minimum:

1. Ensure that each individual's dietary needs reflected within the individual's ISP are fulfilled;
2. Provide methods for the provider to (i) learn the cultural background, personal preferences, religious requirements, and food habits of the individuals receiving services and (ii) ensure meals are prepared in a manner that considers these preferences; and
3. List steps staff shall take to assist individuals who require assistance feeding themselves in a manner that effectively addresses any deficits while maintaining the dignity of individuals.

C. The provider shall have menus or documentation of meal planning that:

1. Meet the nutritional needs of each individual as indicated within the individual's ISP;
2. Are prepared in advance;
3. Are followed;
4. Reflect the religious, cultural, and ethnic needs of individuals receiving services based on the provider's reasonable efforts; and
5. Are updated on a quarterly basis.

D. The provider shall implement protocols to monitor each individual's food consumption and nutrition for:

1. Warning signs of changes in physical or mental status related to nutrition; and
2. Compliance with any needs determined by the ISP or prescribed by a physician, nutritionist, or health care professional.

E. Each individual shall be provided a daily diet that consists of at least three nutritionally balanced meals that include an adequate variety and quantity of food for the age of the individual and meet minimum nutritional requirements and the U.S. Department of Health and Human Services and U.S. Department of Agriculture Dietary Guidelines for Americans. Providers of residential services to children shall also provide an evening snack to each individual.

12VAC35-272-170. Food service inspections.

A. Any location where the provider is responsible for preparing or serving food shall request inspection and obtain approval by state or local health authorities regarding food service and general sanitation at the time of the original application and annually thereafter in accordance with Food Regulations (12VAC5-421).

B. Documentation of the most recent inspection and approval shall be kept on file. This section does not apply to sponsored residential services or to group homes or community residential homes.

12VAC35-272-180. Community participation and relationships.

A. Individuals shall be afforded opportunities to participate in community activities and utilize community resources that are based on personal interests and preferences. The provider shall:

1. Document efforts to learn each individual's preferred community activities;

2. Document opportunities for participation in community activities made available to each individual;

3. Ensure that individuals are afforded opportunities for community participation on an individual basis, except those programs in which individuals do not leave the provider's premises as outlined within the provider's policies and procedures, such as short-term substance use treatment programs; and

4. Ensure that the frequency of opportunities afforded to each individual is consistent with the ISP.

B. The provider shall implement a written policy regarding opportunities for individuals to participate in each individual's preferred religious activities. The provider's policies on religious participation shall be available to individuals and authorized representatives, if applicable. The policy shall also be available to any individual considering admission to a residential service and that individual's authorized representative, if applicable, and any agency considering placement of a child into a children's residential service.

C. No individual shall be coerced to participate in religious activities.

D. Providers of residential services to children shall develop and implement written policies and procedures for evaluating persons or organizations in the community who wish to associate with individuals on the premises or take individuals off the premises. The procedures shall cover how the facility will determine if participation in such community activities or programs would be in the individual's best interest and document permission by the parent or legal guardian authorizing the community participation and absence from the premises.

E. Each facility providing residential services to children shall have a staff community liaison responsible for facilitating cooperative relationships with neighbors, the local school system, local law enforcement, local government officials, and the community at large.

F. This section does not apply to respite residential services.

F. Each provider of residential services to children shall develop and implement written policies and procedures, approved by the department, for promoting positive relationships with neighbors.

12VAC35-272-190. Medication errors and drug reactions.

In the event of a medication error or adverse drug reaction:

1. First aid shall be administered if indicated.

2. An employee or contractor shall promptly contact a poison control center, pharmacist, nurse, or physician and shall take actions as directed.

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3. The individual's physician shall be notified as soon as possible, unless the situation is addressed in standing orders.

4. All actions taken by employees or contractors shall be documented, such as in incident reports or progress notes.

5. The provider shall review medication errors at least quarterly as part of the quality assurance in 12VAC35-270-570.

6. Medication errors and adverse drug reactions shall be recorded in the individual's medication log.

12VAC35-272-200. Reserved.

12VAC35-272-210. Physical examination.

A. Within 30 days of an individual's admission, providers of residential services to adults shall either administer a physical exam or obtain results of a physical exam conducted within the preceding 12 months. Providers of inpatient services shall administer physical exams within 24 hours of an individual's admission. Providers of residential services to children shall have a physical examination conducted by or under the direction of a licensed physician no earlier than 90 days prior to admission to the facility or no later than seven days following admission, except that (i) the report of an examination within the preceding 12 months shall be acceptable if a child transfers from one residential facility licensed or certified by a state agency to another and (ii) a physical examination shall be conducted within 30 days following an emergency admission if a report of physical examination is not available.

B. Within seven days of admission, each individual shall undergo a screening assessment for tuberculosis as evidenced by the completion of a screening form containing, at a minimum, the elements found on the Report of Tuberculosis Screening form published by the Virginia Department of Health. The screening assessment may be no older than 30 days. No screening assessment shall be required for an individual who is (i) transferred from another department-licensed provider or (ii) separated from a service with another licensed provider with a break in service of six months or less.

C. A physical examination shall include the date of examination and signature of a qualified practitioner.

D. The provider shall review and follow up with the results of the physical examination and of any follow-up diagnostic tests, treatments, or examinations in the individual's record.

E. Each individual's health record shall include notations of health and dental complaints mentioned by the individual and injuries and shall summarize symptoms and treatment given.

F. Each individual's health record shall include or document the facility's efforts to obtain treatment summaries of ongoing psychiatric or other mental health treatment and reports.

G. The provider shall develop and implement written policies and procedures that include use of standard health precautions and address communicable and contagious medical conditions.

H. In addition to the provisions of subsection C of this section, a physical examination of an individual served by a provider of residential services to children shall include:

1. Immunizations administered at the time of the exam;

2. A vision screening; and

3. A hearing screening.

I. Providers of residential services to children shall ensure that each individual's health record includes written documentation of (i) the initial physical examination and (ii) an annual physical examination by or under the direction of a licensed physician, including any follow-up care recommended by the physician or as indicated by the needs of the individual.

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J. Providers of residential services to children shall include in each individual's record written documentation of (i) an annual examination by a licensed dentist and (ii) follow-up dental care recommended by the dentist or as indicated by the needs of the individual. This requirement does not apply to respite care facilities or short-term intensive services that are typically provided for less than 30 days.

12VAC35-272-220. Seclusion, restraint, and time out.

A. The use of seclusion, restraint, and time out shall comply with applicable federal and state laws and regulations and be consistent with the provider's written policies and procedures implemented pursuant to 12VAC35-270-500.

B. Restraints for behavioral purposes shall be designed specifically for emergency behavior management of human beings in clinical or therapeutic programs. An individual under mechanical restraint shall be continuously observed face-to-face by a staff member who shall conduct a status check every 15 minutes. During status checks, the staff member will assess and, if necessary, respond to the individual's needs for hygiene, elimination, and hydration. Providers of residential services to children are prohibited from utilizing mechanical restraints, except as permitted by other applicable state regulations or as ordered by a court of competent jurisdiction.

C. Application of time out, seclusion, or restraint shall be documented in the individual's record and include the following:

1. Physician's order for seclusion or mechanical restraint or pharmacological restraint;
2. Date and time;
3. Employees or contractors involved;
4. Circumstances and reasons for use, including other behavior management techniques attempted;
5. Duration;
6. Type of technique used; and
7. Outcomes, including documentation of debriefing of the individual and staff involved following the incident.

D. Providers of residential services to children are prohibited from use of pharmacological restraints.

12VAC35-272-230. Requirements for seclusion room.

A. Seclusion may only be used in facilities providing residential services to children, inpatient hospitals, crisis receiving centers, and crisis stabilization units and only in case of an emergency. Seclusion shall comply with the provisions of 12VAC35-115-110.

B. The room used for seclusion shall meet the design requirements for buildings used for detention or seclusion of individuals.

C. The seclusion room shall be at least six feet wide and six feet long with a minimum ceiling height of eight feet.

D. The seclusion room shall be free of all protrusions, sharp corners, hardware, fixtures, or other devices that may cause injury to the individual.

E. Windows in the seclusion room shall be so constructed as to minimize breakage and otherwise prevent the individual from self-harm.

F. Light fixtures and other electrical receptacles in the seclusion room shall be recessed or so constructed as to prevent the individual from self-harm. Light controls shall be located outside the seclusion room.

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G. Doors to the seclusion room shall be at least 32 inches wide, shall open outward, and shall contain observation view panels of transparent wire glass or its approved equivalent, not exceeding 120 square inches, but of sufficient size for someone outside the door to see into all corners of the room.

H. The seclusion room shall contain only a mattress with a washable mattress covering designed to avoid damage by tearing.

I. The seclusion room shall maintain temperatures appropriate for the season.

J. All space in the seclusion room shall be visible through the locked door, either directly or by mirrors so constructed or installed as to minimize breakage and otherwise reduce the risk of self-harm.

12VAC35-272-240. Medication-assisted treatment.

All providers of medication-assisted treatment shall comply with Part II (12VAC35-276-210 et seq.) of 12VAC35-276, Regulations for Center-Based Services.

12VAC35-272-250. Security of residential hazards.

A. The provider shall secure opioid agonist medication supplies by:

1. Restricting access to medication areas to medical or pharmacy personnel;
2. Reconciling the medication inventory monthly;
3. Keeping inventory records, including the monthly reconciliation, for three years; and
4. Maintaining a current plan to control the diversion of medication to unprescribed or illegal uses.

B. The provider shall secure all hazards and toxic substances by:

1. Ensuring all hazardous materials, including products for cleaning, vehicle maintenance, gardening, and landscaping, are kept in labeled containers and stored according to package instructions or material safety data sheets; and
2. Keeping hazardous materials stored in a manner consistent with package instructions and the needs of individuals served, which may require storage out of sight or in a secure area.

12VAC35-272-260. Beds.

A. For the purposes of this section, "clean" means freshly laundered, sanitized, and not soiled or stained.

B. The provider shall arrange for each individual to have a bed.

C. No provider shall operate more beds than the number for which the service location is licensed.

D. Pursuant to § 32.1-102.1:3 of the Code of Virginia, no ICF/IID may have more than 12 beds at any one location. This applies to new applications for services and not to existing services or locations licensed prior to December 7, 2011.

E. Beds and bed linens shall be clean, comfortable, and well-maintained.

F. Beds shall be equipped with a clean mattress, clean pillow, clean blankets, and clean bed linens. When a bed is soiled, providers shall assist individuals with bathing as needed and provide clean clothing and bed linens. Providers of residential services to children shall provide a clean, waterproof mattress cover, if needed.

G. Providers of residential services to children shall change used bed linens at least every seven days and more often if needed.

H. Providers of residential services to children shall provide mattresses that are fire retardant as evidenced by documentation from the manufacturer, except in buildings equipped

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1178 throughout with an automatic sprinkler system in accordance with the Virginia Uniform
1179 Statewide Building Code (13VAC5-63).

1180 I. Providers of residential services to children shall provide cribs for individuals under two
1181 years of age. Cribs shall be placed where no objects outside the crib, such as cords from blinds
1182 or curtains, are within reach of infants or toddlers. No pillows or filled comforters shall be used
1183 by children younger than two years of age.

1184 J. Providers of sponsored residential home services shall certify that each sponsored
1185 residential home complies with this section.

1186 **12VAC35-272-270. Bedrooms.**

1187 A. Bedrooms shall meet the following square footage requirements:

1188 1. Single occupancy bedrooms shall have no less than 80 square feet of floor space.

1189 2. Multiple occupancy bedrooms shall have no less than 60 square feet of floor space
1190 per individual.

1191 B. No more than four individuals shall share a bedroom, except in group homes, where no
1192 more than two individuals shall share a room. This subsection does not apply to group home
1193 locations licensed prior to December 7, 2011.

1194 C. Each individual shall have adequate private storage space accessible to the bedroom for
1195 clothing and personal belongings, except in secure custody facilities.

1196 D. Each sleeping area shall have a door that can be (i) closed for privacy or quiet and (ii)
1197 readily opened in case of fire or other emergency.

1198 E. Providers of residential services to children shall provide separate sleeping areas for
1199 boys and girls when such individuals are four years of age or older.

1200 F. Providers of residential services to children shall ensure beds are at least three feet apart
1201 at the head, foot, and sides and double-decker beds shall be at least five feet apart at the head,
1202 foot, and sides.

1203 G. This section does not apply to correctional facilities and jails. Providers of sponsored
1204 residential home services shall certify that each sponsored residential home complies with this
1205 section.

1206 **12VAC35-272-280. Laundry areas.**

1207 A. Appropriate space and equipment in good repair shall be provided if laundry is done at
1208 the location.

1209 B. For all services in which it is appropriate:

1210 1. An adequate quantity of clean linens shall be available at all times to provide for
1211 proper care and comfort of individuals receiving services.

1212 2. Linens and other laundry must be handled, stored, and processed to control the
1213 spread of infection.

1214 3. Clean linens shall be stored in a clean and dry area accessible to staff.

1215 4. Soiled linens shall be stored in covered containers in separate, well-ventilated areas
1216 and shall not accumulate.

1217 5. Soiled linens shall not be sorted, laundered, rinsed, or stored in bathrooms,
1218 bedrooms, kitchens, or food storage areas.

1219 6. Arrangements for laundering each individual's personal clothing shall be provided. If
1220 laundry facilities are not provided on premises, commercial laundry services shall be
1221 utilized.

1222 12VAC35-272-290. Computers and Internet access.

1223 All providers shall provide individuals access to appropriate technology, including computer
1224 and Internet access, at the individual's request.

1225 12VAC35-272-300. Physical environment.

1226 A. The physical environment, design, structure, furnishings, and lighting shall be appropriate
1227 and safe for the individuals receiving services and the services provided.

1228 B. The physical environment shall be accessible to individuals with physical or sensory
1229 disabilities, if applicable.

1230 C. The exterior and interior physical environment and furnishings shall be kept clean and in
1231 good repair to (i) protect against dust, dirt, mold, or transmission of disease, and (ii) prevent the
1232 entrance or harboring of insects, rodents, vermin, and other pests. Exterior and interior furnishings
1233 shall be dry, free of foul odors, safe, and well-maintained.

1234 D. Floor surfaces and floor coverings shall promote mobility in areas used by individuals and
1235 shall promote maintenance of sanitary conditions. There shall be clear pathways through the
1236 residential setting, free of tripping hazards, to ensure that all individuals can move about the
1237 setting safely. Any electrical cords, extension cords, or power strips utilized by the provider shall
1238 be properly secured and shall not be placed anywhere that the cord or strip can cause trips or
1239 falls.

1240 E. Unless otherwise mandated by state or federal authorities, heat shall be evenly distributed
1241 in all rooms occupied by individuals such that a temperature no less than 68°F is maintained.
1242 Natural or mechanical ventilation to the outside shall be provided in all rooms used by individuals
1243 receiving services. If a provider is supplying heat throughout the residential setting by means of
1244 a wood stove or fireplace the provider shall:

1245 1. Verify the wood burning stove or fireplace and associated chimneys, if used, are
1246 installed, maintained, and cleaned as needed by having them inspected annually by a
1247 qualified professional, and maintaining documentation of the inspection and cleaning;

1248 2. Ensure that the wood burning stove or fireplace is operated safely, including storing fuel
1249 and disposing of ashes, and providing safety for the individual; and

1250 3. Ensure the wood burning stove or fireplace is clean and well maintained.

1251 F. Plumbing shall be maintained in good operational condition. Adequate hot and cold running
1252 water of a safe and appropriate temperature shall be available. Hot water accessible to individuals
1253 receiving services shall be maintained within a range of 100° to 120°F. The provider shall take
1254 precautions to protect individuals from injury due to scalding.

1255 G. Adequate provision shall be made for the collection and legal disposal of garbage and
1256 waste materials.

1257 H. If smoking is permitted, the provider shall make provisions for alternate smoking areas that
1258 are separate from the service environment. Smoking shall be prohibited in living areas and in
1259 areas where individuals participate in programs. This subsection does not apply to home-based
1260 services.

1261 I. For all program areas added after September 19, 2002, minimum room height shall be 7-
1262 1/2 feet exclusive of protrusions, duct work, or dormers.

1263 J. Bedroom, bathroom and dressing area windows and doors shall provide privacy.

1264 K. Bathrooms intended for use by more than one individual at the same time shall provide
1265 privacy for showers and toilets.

1266 L. No required path of travel to the bathroom shall be through another bedroom. Each
1267 individual's bedroom shall have direct access to a corridor, living area, dining area, or other
1268 common area.

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M. The provider shall ensure that a house number for the residential location can be identified clearly from the road.

N. All provider locations shall have an appropriate number of properly installed smoke detectors based on the size of the location, which shall include at a minimum:

1. At least one smoke detector on each level of multi-level buildings, including the basement;

2. At least one smoke detector in each bedroom in locations with bedrooms;

3. At least one smoke detector in any area adjacent to any bedroom in locations with bedrooms; and

4. Any additional smoke detectors necessary to comply with all applicable federal and state laws and regulations and local ordinances.

O. Smoke detectors shall be tested monthly for proper operation.

P. Providers shall comply with state and local health department rules and regulations regarding swimming pools.

Q. Providers of residential services to adults shall make available at least one toilet, one hand basin, and shower or bath for every four individuals.

R. Providers of residential services to children shall:

1. Make available at least one toilet, one hand basin, and one shower or bathtub in each living unit;

2. Make available at least one bathroom equipped with a bathtub in each facility;

3. Make available at least one toilet, one hand basin, and one shower or bathtub for every eight individuals for facilities licensed before July 1, 1981; and

4. Make available one toilet, one hand basin and one shower or bathtub for every four individuals in any building constructed or structurally modified after July 1, 1981, except secure custody facilities. Facilities licensed after December 28, 2007, shall comply with the one-to-four ratio. The maximum number of staff members on duty in the living unit shall be counted in determining the required number of toilets and hand basins when a separate bathroom is not provided for staff.

S. Providers of residential services to children shall provide privacy from routine sight supervision by staff members of the opposite gender while bathing, dressing, or conducting toileting activities. This subsection does not apply to medical personnel performing medical procedures, staff assisting infants, or staff assisting any individuals whose physical, mental, or safety needs indicate the need for assistance with these activities as justified in the individual's record.

T. This section does not apply to correctional facilities and jails. Providers of sponsored residential home services shall certify that their sponsored residential homes comply with this section.

12VAC35-272-310. Building inspection and classification.

A. All locations shall be inspected and approved as required by the appropriate building regulatory entity. Documentation of approval shall be a Certificate of Use and Occupancy indicating the building is classified for its proposed licensed purpose. The provider shall submit a copy of the Certificate of Use and Occupancy to the department for new locations.

B. This section does not apply to correctional facilities. Sponsored residential service providers shall certify that sponsored residential homes comply with this chapter.

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1313 **12VAC35-272-320. Fire inspections.**

1314 The provider shall document at the time of the original application and annually thereafter that
1315 buildings and equipment in residential service locations serving more than eight individuals are
1316 maintained in accordance with the Virginia Statewide Fire Prevention Code (13VAC5-52).

1317 **12VAC35-272-330. Building and grounds.**

1318 A. The interior and exterior of all buildings shall be safe, properly maintained, clean, and in
1319 good working order. This includes required locks, mechanical devices, indoor and outdoor
1320 equipment, recreational spaces, and furnishings.

1321 B. The provider shall implement policies for infrastructure concerns, including building and
1322 site maps, to shut off utilities when necessary.

1323 **12VAC35-272-340. Building modifications.**

1324 The provider shall submit a plan to the department addressing safety and continued service
1325 delivery for any planned construction involving (i) changes in the use of existing locations or (ii)
1326 structural modifications to new or existing buildings.

1327 **12VAC35-272-350. Reserved.**

1328 **12VAC35-272-360. Sewer and water inspections.**

1329 A. Service locations shall be on a public water and sewage system or on a nonpublic water
1330 and sewage system. Prior to a location being licensed, the provider shall obtain the report from
1331 the building inspector pertaining to the sewage disposal system and its capacity. Nonpublic
1332 water and sewer systems shall be maintained in good working order and in compliance with
1333 local and state laws.

1334 B. Service locations that are not on a public water system shall have a water sample tested
1335 by an accredited, independent laboratory for the absence of coliform (i) prior to being licensed
1336 and (ii) on an annual basis thereafter. The water sample shall also be tested for lead or nitrates
1337 if recommended by the local health department. Documentation of the three most recent test
1338 samples shall be kept on file.

1339 Part II

1340 Residential Facilities Serving Children

1341 **12VAC35-272-370. Interstate compact on the placement of children.**

1342 A. Documentation of the prior approval of the administrator of the Virginia Interstate
1343 Compact on the Placement of Children (ICPC) at the Virginia Department of Social Services
1344 shall be retained in the record of each individual admitted from outside Virginia. The
1345 requirements of this section shall not apply to a facility providing documentation that the Virginia
1346 ICPC administrator determined that the facility is statutorily exempt from the compact's
1347 provisions.

1348 B. Documentation that the provider sent copies of all serious incident reports regarding any
1349 child placed through the ICPC to the administrator of the Virginia ICPC shall be kept in the
1350 individual's record.

1351 C. No later than five days after an individual is transferred to another facility operated by the
1352 same sponsor, the individual's record shall contain documentation that the administrator of the
1353 Virginia ICPC was notified in writing of the individual's transfer.

1354 D. No later than 10 days after discharge, the individual's record shall contain documentation
1355 that the administrator of the Virginia ICPC was notified in writing of the discharge.

1356 E. No provider shall discharge or send out-of-state youth in the custody of out-of-state social
1357 services agencies and courts to reside with a parent, relative, or other individual who lives in
1358 Virginia without the approval of the administrator of the Virginia ICPC.

F. This section does not apply to respite residential services for children and adolescents.

12VAC35-272-380. Admission procedures.

A. The facility shall have written criteria for admission that include:

1. A description of the population to be served, including the age and gender of individuals seeking services;

2. A description of the types of services offered;

3. Intake and admission procedures;

4. Exclusion criteria defining those behaviors or problems that the facility is unable to manage because it does not have the staff with appropriate experience or training; and

5. A description of how educational services will be provided to the population receiving services.

B. The facility shall accept and serve only those children whose needs are compatible with the services provided through the facility, unless a child's admission is ordered by a court of competent jurisdiction.

C. Acceptance of a child as eligible for respite care by a facility approved to provide residential respite care is considered admission to the facility. Each individual period of respite care is not considered a separate admission.

D. Each facility shall provide documentation showing proof of staff expertise or contractual agreements to provide educational services, counseling services, psychological services, medical services, or any other services needed to serve the individuals in accordance with the facility's program description as defined by the facility's criteria of admission.

12VAC35-272-390. Types of admission.

A. Children shall be accepted only by court order or by written placement agreement with legal guardians.

B. Providers accepting emergency or self-admissions shall:

1. Develop and implement written policies and procedures governing such admissions that shall include procedures to obtain (i) a written placement agreement signed by the legal guardian prior to admission or (ii) the order of a court of competent jurisdiction;

2. Place in each individual's record the order of a court of competent jurisdiction, a written request for care, or documentation of an oral request for care and justification for admission on an emergency basis; and

3. Clearly document written assessment information gathered for the emergency admission that the individual meets the facility's criteria for admission

C. This section does not apply to respite residential services for children and adolescents.

12VAC35-272-400. Application for admission.

A. Admission shall be based on evaluation of a screening application for admission. Nothing in this section applies to court-ordered placements or transfer of an individual between residential facilities located in Virginia and operated by the same sponsor.

B. Prior to acceptance for care, providers shall develop and fully complete an application for admission designed to compile screening information necessary to determine:

1. The educational needs of the individual;

2. The mental health, emotional, and psychological needs of the individual;

3. The physical health needs, including the immunization needs, of the individual;

4. The protection needs of the individual;

5. The behavioral support needs of the individual;

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- 1404 6. Current behavioral functioning and social competence;
1405 7. Family history and relationships;
1406 8. Social and development history;
1407 9. History of previous treatment for mental health, developmental disability, substance
1408 abuse, brain injury, and behavior problems;
1409 10. The suitability of the individual's admission; and
1410 11. Medication and drug use profile, which shall include:
1411 a. History of prescription, nonprescription, and illicit drugs taken over the six months
1412 prior to admission;
1413 b. Drug allergies, unusual and other adverse drug reactions, and ineffective
1414 medications; and
1415 c. Information necessary to develop an ISP and a behavioral support plan.
1416 C. The individual's record shall contain a completed assessment based on information
1417 compiled from the screening application at the time of a routine admission or within 30 days
1418 after an emergency admission. This subsection does not apply to respite residential services for
1419 children and adolescents.
1420 D. Each facility shall develop and implement written policies and procedures to assess each
1421 individual as part of the application process to ensure that:
1422 1. The needs of the individual can be addressed by the facility's services;
1423 2. The facility's staff is trained to meet the individual's needs; and
1424 3. The admission of the individual would pose no significant risk to (i) the individual or (ii)
1425 the other individuals receiving services from the facility or facility staff.
1426 **12VAC35-272-410. Written placement agreement.**
1427 A. The facility shall develop and execute a written agreement authorizing the individual's
1428 placement, signed by a facility representative and the parent, legal guardian, or placing agency.
1429 B. Notwithstanding the provisions of subsection A of this section, a facility that accepts an
1430 admission upon receipt of the order of a court of competent jurisdiction shall place a copy of the
1431 court order in the individual's record.
1432 C. This section does not apply to respite residential services for children and adolescents.
1433 **12VAC35-272-420. Transfer between residential facilities located in Virginia and operated**
1434 **by the same provider.**
1435 A. Except when transfer is ordered by a court of competent jurisdiction, the provider's
1436 receiving service or facility shall document receipt of the following at the time of the individual's
1437 transfer:
1438 1. Documentation of advance notification to the family, if appropriate, the individual, the
1439 placement agency, and the legal guardian;
1440 2. A written summary of the individual's progress while at the transferring facility,
1441 justification for the transfer, and the individual's current strengths and needs; and
1442 3. A copy of the individual's record.
1443 B. The transferring service or facility shall document the date of transfer and the name of the
1444 receiving service or facility to which the individual was transferred.
1445 **12VAC35-272-430. Facilities that serve individuals over 17 years of age.**
1446 Facilities approved to serve individuals over 17 years of age shall comply with these
1447 regulations for all children regardless of age, except when it is determined by the department that

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1448 housing, programs, services, and supervision for children over 17 years of age are provided
1449 separately from those for the other individuals.

1450 **12VAC35-272-440. Additional requirements for facilities that serve individuals with brain**
1451 **injury.**

1452 The provider of brain injury services shall employ or contract with a neuropsychologist or
1453 licensed clinical psychologist specializing in brain injury to assist, as appropriate, with initial
1454 assessments, development of individualized services plans, crises, staff training, and service
1455 design.

1456 **12VAC35-272-450. Reserved.**

1457 **12VAC35-272-460. Reserved.**

1458 **12VAC35-272-470. Reserved.**

1459 **12VAC35-272-480. Service requirements.**

1460 A. The provider shall develop and implement written policies and procedures for the on-site
1461 provision of a structured program of care or treatment of individuals with mental illness,
1462 developmental disability, substance abuse, or brain injury. The provision, intensity, and
1463 frequency of mental health, substance abuse, developmental disability, or brain injury
1464 interventions shall be based on the assessed needs of the individual. These interventions,
1465 applicable to the population served, shall include:

- 1466 1. Individual counseling;
- 1467 2. Group counseling;
- 1468 3. Training in decision making, family and interpersonal skills, problem solving, self-care,
1469 and social and independent living skills;
- 1470 4. Training in functional skills;
- 1471 5. Assistance with activities of daily living (ADLs);
- 1472 6. Social skills training in therapeutic recreational activities, such as anger management,
1473 leisure skills education and development, and community integration;
- 1474 7. Providing positive behavioral supports;
- 1475 8. Physical, occupational, or speech therapy;
- 1476 9. Substance abuse education and counseling; and
- 1477 10. Neurobehavioral services for individuals with brain injury.

1478 B. Each provider shall have formal arrangements for the evaluation, assessment, and
1479 treatment of the mental health, developmental disability, substance abuse, or brain injury needs
1480 of the individual.

1481 C. The provider shall develop and implement written policies and procedures that address
1482 the provision of:

- 1483 1. Psychiatric care;
- 1484 2. Family therapy; and
- 1485 3. Staffing appropriate to the needs and behaviors of the individuals served as
1486 determined by each individual's ISP. The policies and procedures shall document how
1487 the staffing provided is appropriate to the needs and behaviors of the individuals served.

1488 **12VAC35-272-490. Structured program of care.**

1489 A. There shall be evidence of a structured program of care designed to:

- 1490 1. Meet the individual's physical and emotional needs as outlined in the individual's ISP;
- 1491 2. Provide protection, guidance, and supervision; and

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3. Meet the objectives of any required ISP.

B. Documentation of evidence of a structured daily routine designed to ensure the delivery of program services shall be readily available for individuals receiving services or authorized representatives.

C. The provider shall maintain a daily communication log to share information with staff about significant happenings or problems experienced by individuals, with the identity of the person making each entry in the log recorded.

D. Health and dental complaints and injuries shall be recorded and shall include the (i) individual's name, complaint, and affected area; and (ii) time of the complaint.

E. Routines shall be planned to ensure that each individual receives the amount of sleep and rest appropriate for the individual's age and physical condition.

F. Staff shall promote good personal hygiene of individuals by monitoring and supervising hygiene practices each day and by providing instruction when needed.

12VAC35-272-500. Reserved.

12VAC35-272-510. Physical or mental health of personnel.

A. The provider or the department may require a report of examination by a licensed physician or mental health professional when there are indications that a staff member's physical, mental, or emotional health may jeopardize the care of the other staff or the population of individuals receiving services.

B. A staff member who is determined by a licensed physician or mental health professional to show an indication of a physical, mental, or emotional condition that may (i) jeopardize the safety of other staff or individuals receiving services or (ii) prevent the performance of duties shall be removed immediately from contact with individuals and food service. The provider shall not allow the staff member to return to the facility until the condition is cleared as evidenced by a signed statement from the physician or mental health professional.

12VAC35-272-520. Suspected child abuse or neglect.

A. In addition to the requirements of 12VAC35-270-290, written policies and procedures related to child abuse and neglect shall be distributed and reviewed as part of the training to all staff members. These shall include procedures for:

1. Handling accusations against staff; and

2. Promptly referring, consistent with requirements of the Code of Virginia, suspected cases of child abuse and neglect to the local child protective services unit and for cooperating with the unit during any investigation.

B. Any case of suspected child abuse or neglect shall be reported to the local child protective services unit as required by the Code of Virginia.

C. Any case of suspected child abuse or neglect occurring at the facility, on a facility-sponsored event or excursion, or involving facility staff shall be reported immediately to (i) the Office of Human Rights and the placing agency and (ii) the individual's parent or legal guardian, as appropriate.

D. When a case of suspected child abuse or neglect is reported to child protective services, the individual's record shall include:

1. The date and time the suspected abuse or neglect occurred;

2. A description of the suspected abuse or neglect;

3. Action taken as a result of the suspected abuse or neglect; and

4. The name of the person to whom the report was made at the local child protective services unit.

12VAC35-272-530. Staff quarters.

A. A separate, private bedroom shall be provided for staff and staff family members when a staff member is on duty for 24 consecutive hours or more.

B. A separate private bathroom shall be provided for staff and staff family members when there are more than four persons in the living unit and the staff person is on duty for 24 consecutive hours or more.

C. No staff or family members of staff shall share bedrooms with individuals receiving services.

12VAC35-272-540. Searches.

A. Strip searches and body cavity searches are prohibited.

B. A provider shall develop and implement written policies and procedures governing pat downs that includes the following minimum provisions:

1. A clear written prohibition on pat downs if the provider does not allow them; or

2. If permitted, pat downs shall be:

a. Limited to instances where a pat down is necessary to prohibit contraband;

b. Conducted by personnel of the same gender as the individual being searched;

c. Conducted only by personnel who are specifically authorized to conduct searches by the written policies and procedures; and

d. Conducted in the presence of one or more witnesses and in such a way as to protect the individual's dignity in accordance with the Human Rights Regulations (12VAC35-115).

12VAC35-272-550. Behavioral support.

A. Within 30 days of admission, the provider shall develop and implement a written behavioral support plan that allows the individual to self-manage behaviors. Each individualized behavioral support plan shall derive from functional behavior assessment procedures and, at a minimum, include:

1. Hypothesized functions of problem behavior;

2. Definitions of problem behaviors and functionally equivalent replacement behaviors;

3. Identification and consideration of the individual's preferences or reinforcers;

4. Identification of antecedent strategies;

5. Identification of consequence strategies;

6. Identification of strategies to promote acquisition of functionally equivalent replacement behaviors or alternative adaptive behaviors; and

7. Specification of how data will be collected for both problem and desired behaviors.

B. Individualized behavioral support plans shall be developed in consultation with the following, as applicable:

1. Individual;

2. Legal guardian;

3. Individual's parents, if appropriate;

4. Program director;

5. Placing agency staff, if appropriate; and

6. Other appropriate persons.

C. Prior to working alone with any individual, each staff member shall demonstrate, through examination, knowledge and understanding of that individual's behavioral support plan. The

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provider shall retain documentation of the staff member's tests within the staff member's personnel file.

D. Each provider shall develop and implement written policies and procedures concerning behavioral support plans and emergency, crisis, and safety interventions that are directed toward maximizing the growth and development of the individual consistent with the requirements of 12VAC35-115-105.

E. Respite residential services for children and adolescents shall implement the behavioral support plan of the individual's primary care provider.

12VAC35-272-560. Time out.

A. The provider shall develop and implement written policies and procedures governing the conditions under which an individual may be placed in time out. The policies and procedures shall:

1. Comply with the requirements of the Human Rights Regulations (12VAC35-115), specifically 12VAC35-115-110;

2. Specify the maximum allowable period of time out, which shall not exceed 30 minutes per episode. The conditions and duration of time out shall be based on the individual's chronological age and developmental level;

3. Require that the area in which an individual is placed for time out remains unlocked and that the door is not secured in a manner that prevents the individual from opening it. Staff shall not prevent egress in any other manner during the time out; and

4. Require that an individual in time out be able to communicate with staff.

B. The individual shall be in view at all times while time out procedures are being implemented.

C. Use of time out shall be documented.

D. Respite residential services for children and adolescents shall not use time out.

12VAC35-272-570. Case management services.

A. The facility program shall provide case management services. At the time of the admission of any individual, the provider shall identify in writing the staff member responsible for providing case management services. Case management services shall address:

1. Helping the individual and the parents or legal guardian to understand the effects on the individual of separation from the family and the effect of group living;

2. Assisting the individual and the family to maintain relationships, as appropriate, and prepare for the individual's future care;

3. Utilizing appropriate community resources to provide services and maintaining contacts with those resources;

4. Helping the individual strengthen his capacity to function productively in interpersonal relationships;

5. Conferring with the staff in direct care positions to help those staff members understand the individual's needs in order to promote adjustment to group living; and

6. Working with the individual and with the family or legal guardian or any placing agency that may be involved in planning for the individual's future and in preparing the individual for the return home or to another family for independent living or for other residential care. This shall include working with the individual on discharge in accordance with all of the requirements of 12VAC35-270-430 and 12VAC35-272-650. The case manager shall ensure that the individual's discharge team includes, at a minimum:

a. The individual receiving services;

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- b. The individual's legal guardian or authorized representative, if applicable;
- c. Any additional family members that will assist with the individual's return home;
- d. The individual's placing agency, if appropriate;
- e. Appropriate treatment team members; and
- f. Medical team members, if applicable.
- B. The provision of case management services shall be documented in each individual's record.
- C. This section does not apply to respite residential services for children and adolescents.
- 12VAC35-272-580. Education.**
- A. Each individual of compulsory school age shall be enrolled, as provided in the Code of Virginia, in an appropriate educational program within five school business days. Documentation of the enrollment shall be kept in the individual's record.
- B. The provider shall ensure that educational guidance and counseling in selecting courses is provided for each individual.
1. The provider shall offer such guidance and counseling at the time of enrollment.
2. Additional counseling and guidance shall be provided any time the provider receives additional information about the individual's past education.
- C. The provider shall ensure that education is an integral part of the individual's total program by ensuring that the individual's education is integrated into the individual's ISP.
- D. Providers operating educational programs for children with disabilities shall operate those programs in compliance with applicable state and federal statutes and regulations, including Chapter 16 (§ 22.1-319 et seq) of Title 22.1 of the Code of Virginia and 8VAC20-81, Regulations Governing Special Education Programs for Children with Disabilities in Virginia.
- E. When a child with a disability is placed in a residential facility, the facility shall contact the division superintendent of the individual's home locality in writing. Documentation of the contact with the individual's home school shall be kept in the individual's record.
- F. A provider with an academic or vocational program shall document that teachers meet the qualifications to teach the same subjects in the public schools.
- G. Each provider shall develop and implement written policies and procedures to ensure that each individual has adequate study time.
- H. This section does not apply to respite residential services for children and adolescents.
- 12VAC35-272-590. Recreation.**
- A. The provider shall have a written description of its recreation program that describes activities consistent with the facility's total program and with the ages, developmental levels, interests, and needs of the individuals, including:
1. Opportunities for individual and group activities;
2. Free time for individuals to pursue personal interests that are in addition to a formal recreation program, except that this subdivision 2 does not apply to secure custody facilities;
3. Use of available community recreational resources and facilities, except that this subdivision 3 does not apply to secure custody facilities;
4. Scheduling of activities so that the activities do not conflict with meals, religious services, educational programs, or other regular events; and
5. Regularly scheduled indoor and outdoor recreational activities that are structured to develop skills and attitudes.

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B. The provider shall develop and implement written policies and procedures to ensure the safety of individuals participating in recreational activities that include how:

1. Activities will be directed and supervised by staff knowledgeable in the safeguards required for the activities; and

2. Safeguards for water-related activities are provided, including ensuring that a certified lifeguard supervises all swimming activities.

C. The provider shall document trip planning for all overnight recreational trips away from the facility. The provider shall ensure that the trip planning documents demonstrate how the same level of supervision and safety shall be provided to the individuals receiving services as when the individuals are within the residential facility.

D. All overnight out-of-state or out-of-country recreational trips require written permission from each individual's legal guardian.

E. This section does not apply to respite residential services for children and adolescents.

12VAC35-272-600. Clothing.

A. Provision shall be made for each individual to have an adequate supply of clean, comfortable, and well-fitting clothes and shoes for indoor and outdoor wear.

B. Each individual shall have the opportunity to participate in the selection of the individual's clothing, except that this requirement does not apply to secure custody facilities.

12VAC35-272-610. Allowances and spending money.

A. The provider shall develop and implement written policies for safekeeping and for recordkeeping of any money that belongs to individuals.

B. An individual's personal funds, including any allowance or earnings, shall be used for the individual's benefit.

C. This section does not apply to respite residential services for children and adolescents.

12VAC35-272-620. Work and employment.

A. Assignment of chores whether paid or unpaid work assignments shall be in accordance with the age, health, ability, and service plan of the individual.

B. No chores shall interfere with school programs, study periods, meals, or sleep.

C. Work assignments or employment outside the facility, including reasonable rates of pay, shall be approved by the program director with the knowledge and consent of the parents or legal guardian.

D. The program director shall evaluate the appropriateness of the work and the fairness of the pay in both work assignments and employment.

12VAC35-272-630. Reserved.

12VAC35-272-640. Prohibited acts.

The following actions are prohibited:

1. Deprivation of drinking water or food necessary to meet an individual's daily nutritional needs, except as ordered by a licensed physician for a legitimate medical purpose and documented in the individual's record;

2. Limitation on contacts and visits with the individual's attorney, probation officer, regulators, or placing agency representatives;

3. Bans on contacts and visits with family or legal guardians, except as permitted by other applicable state regulations or by order of a court of competent jurisdiction;

4. Delay or withholding of incoming or outgoing mail, except as permitted by other applicable state and federal regulations or by order of a court of competent jurisdiction;

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- 1718 5. Any action that is humiliating, degrading, or abusive;
1719 6. Corporal punishment;
1720 7. Subjection to unsanitary living conditions;
1721 8. Deprivation of opportunities for bathing or access to toilet facilities, except as ordered
1722 by a licensed physician for a legitimate medical purpose and documented in the
1723 individual's record;
1724 9. Deprivation of health care;
1725 10. Deprivation of appropriate services and treatment;
1726 11. Application of aversive stimuli, except as permitted pursuant to other applicable state
1727 regulations;
1728 12. Administration of laxatives, enemas, or emetics, except as ordered by a licensed
1729 physician or poison control center for a legitimate medical purpose, administered by
1730 appropriate medical personnel, and documented in the individual's record;
1731 13. Deprivation of opportunities for sleep or rest, except as ordered by a licensed
1732 physician for a legitimate medical purpose and documented in the individual's record;
1733 and
1734 14. Limitation on contacts or visits with advocates employed by the department or the
1735 disAbility Law Center of Virginia, the designated protection and advocacy services entity
1736 for the Commonwealth of Virginia established pursuant to § 51.5-39.13 of the Code of
1737 Virginia.

1738 **12VAC35-272-650. Discharge.**

1739 A. In addition to complying with the discharge provisions within 12VAC35-270-430,
1740 providers of residential services to children shall have written criteria for discharge that shall
1741 include:

- 1742 1. Criteria for an individual's completion of the program that are consistent with the
1743 facility's programs and services;
1744 2. Conditions under which an individual may be discharged before completing the
1745 program; and
1746 3. Procedures for assisting placing agencies in placing the individuals if the facility
1747 ceases operation.

1748 B. The provider's criteria for discharge shall be accessible to individuals, parents and legal
1749 guardians, and placing agencies.

1750 C. The record of each individual discharged upon receipt of the order of a court of
1751 competent jurisdiction shall contain a copy of the court order. The copy of the court order
1752 maintained in the individual's record shall satisfy the discharge summary requirement of
1753 12VAC35-270-430 E.

1754 D. Individuals shall be discharged only to the legal guardian or legally authorized
1755 representative.

1756 E. Information concerning current medications, need for continuing therapeutic
1757 interventions, educational status, and other items important to the individual's continuing care
1758 shall be provided to the legal guardian or legally authorized representative, as appropriate.

1759 **12VAC35-272-660. Placement of individuals outside the facility.**

1760 No individual shall be placed outside the facility prior to the facility obtaining a license from
1761 the Department of Social Services as a child-placing agency, except as permitted by statute or
1762 by order of a court of competent jurisdiction.

12VAC35-272-670. Additional physical environment requirements.

A. Smoking shall be prohibited in living areas and in areas where individuals participate in programs.

B. Each living unit shall have a living room or other area for informal use, relaxation, and entertainment. The furnishings shall provide a comfortable, homelike environment that is appropriate to the ages of the individuals.

C. All facilities shall have indoor recreation space that contains indoor recreation materials appropriate to the ages and interests of the individuals.

D. Facilities licensed to care for 13 or more individuals shall have indoor recreation space distant from the living room. Recreation space is not required in every living unit.

E. Facilities serving a school-age population shall provide study space. Study space may be assigned in areas used interchangeably for other purposes.

F. Study space shall be well-lighted, quiet, and equipped with tables or desks and chairs that are size-appropriate and age-appropriate for the individuals receiving services.

G. Meals shall be served in areas equipped with sturdy tables and benches or chairs that are size-appropriate and age-appropriate for the individuals receiving services.

H. Adequate kitchen facilities, equipment, and dining space shall be provided for preparation and serving of meals.

I. Walk-in refrigerators, freezers, and other enclosures shall be equipped to permit emergency exits.

J. Space shall be provided for administrative activities including, as appropriate to the program, confidential conversations and the storage of records and materials.

K. Outdoor recreation space shall be available and appropriately equipped for use by the individuals receiving services.

Part III**Correctional Facilities****12VAC35-272-680. Clinical and security coordination.**

A. The provider shall have formal and informal methods of resolving procedural and programmatic issues arising between the clinical and security employees or contractors. These methods shall ensure individual care.

B. The provider shall demonstrate ongoing communication between clinical and security employees to ensure individual care.

C. The provider shall provide cross-training for the clinical and security employees or contractors that includes:

1. Mental health, substance abuse, and developmental disability education;

2. Use of clinical and security restraints; and

3. Channels of communication.

D. Employees or contractors shall receive periodic in-service training and have knowledge of and be able to demonstrate the appropriate use of clinical and security restraint.

E. Security and behavioral assessments shall be completed at the time of admission to determine service eligibility and at least weekly for the safety of individuals, other persons, employees, and visitors.

F. Personal grooming and care services for individuals shall be a cooperative effort between the clinical and security employees or contractors.

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G. Clinical needs and security level shall be considered when arrangements are made regarding privacy for individual contact with family or attorneys.

H. Living quarters shall be assigned on the basis of the individual's security level and clinical needs.

I. An assessment of the individual's clinical condition and needs shall be made when disciplinary action or restrictions are required for infractions of security measures.

J. Clinical services consistent with the individual's condition and plan of treatment shall be provided when security detention or isolation is imposed.

12VAC35-272-690. Other requirements for correctional facilities.

A. The use of audio equipment, such as televisions, radios, and record players, shall not interfere with therapeutic activities.

B. Aftercare planning for individuals nearing the end of incarceration shall include a provision for continuing medication and follow-up services with area community services to facilitate successful reintegration into the community, including a specific appointment provided to the inmate no later than the day of release.

Part IV

Sponsored Residential Homes

12VAC35-272-700. Sponsored residential home information.

Providers of sponsored residential home services shall maintain the following information:

1. Names and ages of residential sponsors;

2. Date of sponsored residential home agreement;

3. The maximum number of individuals that can be placed in the home at a given time;

4. Names and ages of all other individuals who are not receiving services, but are residing in a sponsored residential home;

5. Address and telephone number of the sponsored residential home; and

6. Names of all staff employed in the home, including on-call and substitute staff.

12VAC35-272-710. Sponsored residential home agreements.

A. The provider shall maintain a written agreement with residential home sponsors. Sponsors are persons who provide the home where the service is located and are directly responsible for the provision of services. The agreement shall include the:

1. Provider's responsibilities;

2. Sponsor's responsibilities;

3. Scope of services;

4. Supervision;

5. Compensation;

6. Training;

7. Reporting requirements and procedures; and

8. A provision stating that the sponsored residential home shall not operate as a group home or Virginia Department of Social Services-approved home or foster home, and shall comply with all applicable local, state, and federal laws and regulations.

B. The agreement shall be available for inspection by the department's licensing specialist and shall include a provision granting the right of entry to state licensing specialists or human rights advocates to conduct inspections.

12VAC35-272-720. Sponsor qualification and approval process.

A. The provider shall evaluate and certify each sponsored residential home other than his own through face-to-face interviews, inspections, and other information documenting compliance with this section. Before individuals are placed in the home, and annually thereafter, the provider shall submit the certification form to the department.

B. The provider shall certify and document that each sponsored residential home meets the criteria for physical environment and residential services in this chapter.

C. The provider shall document the ability of the sponsored residential home staff to meet the needs of the individuals placed in the home by assessing and documenting:

1. The ability of the sponsor and all staff to communicate and understand individuals receiving services;

2. The ability of the sponsor and all staff to provide the care, treatment, training, or habilitation for individuals receiving services in the home;

3. The abilities of all members of the sponsored household to accept individuals with disabilities and their disability-related characteristics, especially the ability of children in the household to adjust to nonfamily members living with them;

4. The financial capacity of the sponsor to meet the sponsor's own expenses for up to 90 days, independent of payments received for individuals living in the home; and

5. The education, qualifications, and experience of the sponsor and staff in working with the population receiving services including driving record, tuberculosis screening, first-aid and CPR certification, and completion of medication administration and behavior interventions training required by 12VAC35-270-280.

D. The provider shall comply with all elements of 12VAC35-270-250 for the sponsor and all staff.

E. The provider shall implement a written policy for obtaining references, criminal background checks, and registry checks for all adults in the home who are neither staff nor individuals receiving services.

1. The policy shall indicate what actions the provider will take if the results returned indicate that any adults in the home have a finding of child abuse or neglect, prior criminal background, has been convicted of a barrier crime or otherwise fails to meet the requirements of this regulation.

2. The actions shall be appropriate for the health and safety of the population served by the provider and the expected duties of the staff.

F. The sponsored residential home shall submit to the provider the results of a physical and mental health examination of family members when requested by the provider based on indications of a physical or mental health issue.

G. No sponsored residential home shall also operate as a group home, Department of Social Services-approved home, or foster home.

H. The provider shall submit a modification application as required by 12VAC35-270-80 prior to adding a sponsored residential home. The provider shall submit the name and address of the sponsored residential home to the department prior to closing a home.

12VAC35-272-730. Supervision.

A. The provider shall have one supervisor for every 15 sponsored residential homes where individuals reside.

B. A responsible adult shall be available to provide supervision to the individual receiving services as specified in the ISP.

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1896 C. Any member of the sponsor family household who transports individuals receiving
1897 services must have a valid driver's license and be covered by automobile liability insurance. The
1898 vehicle used to transport individuals receiving services shall have a valid registration and
1899 inspection sticker.

1900 D. The sponsor shall inform the provider (i) in advance of any anticipated additions or
1901 changes in the sponsored residential home or (ii) as soon as possible after an unexpected
1902 change occurs.

1903 E. In addition to all other current reporting requirements, the sponsor shall report all
1904 hospitalizations of individuals receiving services to the provider and the individual's case
1905 manager within 24 hours.

1906 **12VAC35-272-740. Sponsored residential home service records.**

1907 Providers of sponsored residential home services shall maintain the following records on
1908 each sponsored residential home:

1909 1. Documentation of all elements required within the sponsor qualification and approval
1910 process in 12VAC35-272-720;

1911 2. Orientation and training provided to the sponsor and employees;

1912 3. The log of provider inspections of the sponsored residential home including the date,
1913 the employee conducting the inspection, the purpose of the inspection, and a description
1914 of any significant events or findings; and

1915 4. The daily log maintained by the sponsor of significant events related to individuals
1916 receiving services.

1917 **12VAC35-272-750. Sponsored residential home staff.**

1918 Providers shall certify and document compliance of sponsors with all provisions pertaining to
1919 staff in this part and in 12VAC35-270.

1920 **12VAC35-272-760. Sponsored residential home service policies.**

1921 A. The provider shall implement written policies to provide orientation and supportive
1922 services to the sponsored residential home staff specific to the needs of the individuals
1923 receiving services.

1924 B. The provider shall implement a training plan for the sponsor staff consistent with the
1925 needs of the individuals receiving services.

1926 C. The provider shall specify and ensure adequate staffing arrangements in all sponsored
1927 residential homes, including on-call and substitute care coverage.

1928 D. The provider shall implement a written policy on managing, monitoring, and supervising
1929 sponsored residential homes. This policy shall address changes in supervision arrangements as
1930 the number of homes increase.

1931 E. At least once every quarter, the provider shall conduct inspections of each sponsored
1932 residential home other than his own. A minimum of two quarterly inspections each year shall be
1933 unannounced inspections.

1934 F. On an ongoing basis and at least annually, the provider shall review and document
1935 regulatory compliance by each sponsored residential home and sponsor.

1936 G. The provider shall develop written policies for terminating a sponsored residential home.

1937 H. The individual's support coordinator or case manager shall provide and document that
1938 the individual or the authorized representative is provided informed choice to choose a new
1939 placement when the current placement ends. Prior to moving an individual to another
1940 placement, the support coordinator or case manager shall conduct and document a meeting to

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1941 include the individual and his authorized representative or legal guardian, if applicable; the
1942 current sponsor; and a receiving placement staff, if possible.

1943 **12VAC35-272-770. Maximum number of beds or occupants in sponsored residential**
1944 **homes.**

1945 The maximum number of individuals in a sponsored residential home is two. The maximum
1946 number of occupants in a sponsored residential home is seven.

1947 **12VAC35-272-780. Sponsored residential home services for children.**

1948 In addition to all other regulations applicable to sponsored residential homes, the following
1949 requirements shall be met for homes serving children:

- 1950 1. The provider shall develop a service description based upon evidence-based
1951 practices or an accepted therapeutic model of mental health, substance abuse, or
1952 developmental services, or brain injury care for children.
- 1953 2. The provider shall use a treatment team model consisting of staff who provide
1954 intensive support and consultation to the sponsor.
- 1955 3. Weekly team meetings and supervision shall be held with the sponsor and the
1956 individual's authorized representative or legal guardian to review progress on each case,
1957 review the daily behavioral information collected, and adjust the child's ISP.
- 1958 4. The sponsor shall keep a daily log of behavioral and other child-specific information
1959 and be available for daily Monday through Friday contact from the provider.
- 1960 5. The sponsor shall receive 25 hours per year of in-service training pertaining to
1961 providing services for the child they serve, in addition to the training otherwise required
1962 in this chapter and 12VAC35-270. The sponsor shall also participate in ongoing training
1963 at least once a quarter.
- 1964 6. The provider is not considered a child placing agency. Children are placed with the
1965 provider by licensed child placing agencies, local departments of social services, or
1966 parents or legal guardians.
- 1967 7. The sponsor shall be at least 25 years of age.
- 1968 8. The sponsor shall be able to provide care and supervision during nonschool hours or
1969 when the child is not attending during school hours due to illness or other excused
1970 absence.
- 1971 9. The provider shall have access, either by direct provision or developing agreements,
1972 to 24-hour emergency mental health care for children served with serious emotional
1973 disturbances.

1974 Part V

1975 ASAM

1976 **12VAC35-272-790. Medically managed intensive inpatient (ASAM LOC 4.0) program**
1977 **criteria.**

1978 A medically managed intensive inpatient program shall meet the following programmatic
1979 requirements. The program shall:

- 1980 1. Deliver services in a 24-hour medically managed, acute care setting and shall be
1981 available to all individuals within that setting;
- 1982 2. Provide cognitive, behavioral, motivational, pharmacologic, and other therapies
1983 provided on an individual or group basis, depending on the individual's needs;
- 1984 3. For an individual who has a severe biomedical disorder, provide physical health
1985 interventions to supplement addiction treatment;

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- 1986 4. For an individual who has stable psychiatric symptoms, provide individualized
1987 treatment activities designed to monitor the individual's mental health;
- 1988 5. Provide planned clinical interventions that are designed to enhance the individual's
1989 understanding and acceptance of addiction illness;
- 1990 6. Provide family and caregiver treatment services as deemed appropriate by a licensed
1991 professional and included in an assessment and treatment plan;
- 1992 7. Provide health education services;
- 1993 8. Make MAT available for all individuals admitted to the service. MAT may be provided
1994 by facility staff or coordinated through alternative resources; and
- 1995 9. If the provider is providing MAT within the facility, the provider shall comply with
1996 12VAC35-276-300, 12VAC35-276-340, and 12VAC35-276-360.

1997 **12VAC35-272-800. Medically managed intensive inpatient (ASAM LOC 4.0) admission**
1998 **criteria.**

1999 Before a medically managed intensive inpatient program may admit an individual, the
2000 individual shall meet the criteria for admission as defined by the provider's policies. The
2001 provider's policy regarding admission shall at a minimum require the individual to:

- 2002 1. Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate
2003 to high severity as defined by the DSM; and
- 2004 2. Meet the admission criteria of Level 4.0 of ASAM, including the specific criteria for
2005 adult and adolescent populations.

2006 **12VAC35-272-810. Medically managed intensive inpatient (ASAM LOC 4.0) discharge**
2007 **criteria.**

2008 Before a medically managed intensive inpatient program may discharge or transfer an
2009 individual, the individual shall meet the criteria for discharge or transfer as defined by the
2010 provider's policies, which shall include provisions for the discharge or transfer of individuals who
2011 have:

- 2012 1. Achieved the goals of the treatment services and no longer require ASAM 4.0 level of
2013 care;
- 2014 2. Been unable to achieve the goals of the individual's treatment but could achieve the
2015 individual's goals with a different type of treatment; or
- 2016 3. Achieved the individual's original treatment goals but have developed new treatment
2017 challenges that can only be adequately addressed in a different type of treatment.

2018 **12VAC35-272-820. Medically managed intensive inpatient (ASAM LOC 4.0) co-occurring**
2019 **enhanced programs.**

2020 A. Medically managed intensive inpatient co-occurring enhanced programs shall be staffed
2021 by appropriately credentialed mental health professionals who assess and treat the individual's
2022 co-occurring mental disorders. All clinical staff shall be qualified by training and experience and
2023 appropriately licensed, certified, or registered by the appropriate health regulatory board to
2024 serve individuals admitted to the service.

2025 B. Medically managed intensive inpatient co-occurring enhanced programs shall offer
2026 individualized treatment activities designed to stabilize the individual's active psychiatric
2027 symptoms, including medication evaluation and management.

2028 **12VAC35-272-830. Medically monitored intensive inpatient services (ASAM LOC 3.7)**
2029 **program criteria.**

2030 A medically monitored intensive inpatient treatment program shall meet the following
2031 programmatic requirements. The program shall:

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- 2032 1. Be made available to all individuals within the inpatient setting;
2033 2. Provide a combination of individual and group therapy as deemed appropriate by a
2034 licensed mental health professional and included in an assessment and treatment plan.
2035 Such therapy shall be adapted to the individual's level of comprehension;
2036 3. Make medical and nursing services available on site to provide ongoing assessment
2037 and care of addiction needs;
2038 4. Provide direct affiliations with other easily accessible levels of care or close
2039 coordination through referral to more or less intensive levels of care and other services;
2040 5. Provide family and caregiver treatment services as deemed appropriate by a licensed
2041 mental health professional and included in an assessment and treatment plan;
2042 6. Provide educational and informational programming adapted to individual needs. The
2043 educational and informational programming shall include materials designed to enhance
2044 the individual's understanding of addiction and may include peer recovery support
2045 services as appropriate;
2046 7. Utilize random drug screening to monitor drug use and reinforce treatment gains;
2047 8. Regularly monitor the individual's adherence in taking any prescribed medications;
2048 and
2049 9. If the provider is providing MAT within the facility, the provider shall comply with
2050 12VAC35-276-300, 12VAC35-276-340, and 12VAC35-276-360.

2051 **12VAC35-272-840. Medically monitored intensive inpatient (ASAM LOC 3.7) admission**
2052 **criteria.**

2053 Before a medically monitored intensive inpatient program may admit an individual, the
2054 individual shall meet the criteria for admission as defined by the provider's policies. The
2055 provider's policy regarding admission shall at a minimum require the individual to:

- 2056 1. Meet diagnostic criteria for a substance use disorder of the DSM or addictive disorder
2057 of moderate to high severity; and
2058 2. Meet the admission criteria of Level 3.7 of ASAM, including the specific criteria for
2059 adult and adolescent populations.

2060 **12VAC35-272-850. Medically monitored intensive inpatient (ASAM LOC 3.7) discharge**
2061 **criteria.**

2062 A. Before a medically monitored intensive inpatient program may discharge or transfer an
2063 individual, the individual shall meet the criteria for discharge or transfer as defined by the
2064 provider's policies, which shall include provisions for the discharge or transfer of individuals who
2065 have:

- 2066 1. Achieved the goals of the treatment services and no longer require ASAM 3.7 level of
2067 care;
2068 2. Been unable to achieve the goals of the individual's treatment but could achieve the
2069 individual's goals with a different type of treatment; or
2070 3. Achieved the individual's original treatment goals but have developed new treatment
2071 challenges that can only be adequately addressed in a different type of treatment.

2072 B. Discharge planning shall occur for individuals and include realistic plans for the continuity
2073 of MAT services as indicated.

2074 **12VAC35-272-860. Medically monitored intensive inpatient (ASAM LOC 3.7) co-occurring**
2075 **enhanced programs.**

2076 A. Medically monitored intensive inpatient co-occurring enhanced programs shall offer
2077 psychiatric services, medication evaluation, and laboratory services as indicated by the needs of

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2078 individuals admitted to the service. A psychiatrist shall assess the individual by telephone within
2079 four hours of admission and in person with 24 hours following admission. An LMHP shall
2080 conduct a behavioral health-focused assessment at the time of admission. A registered nurse
2081 shall monitor the individual's progress and administer or monitor the individual's self-
2082 administration of psychotropic medications.

2083 B. Medically monitored intensive inpatient co-occurring enhanced programs shall be staffed
2084 by addiction psychiatrists and appropriately credentialed behavioral health professionals who
2085 are able to assess and treat co-occurring psychiatric disorders and who have specialized
2086 training in behavior management techniques and evidence-based practices. All clinical staff
2087 shall be qualified by training and experience and appropriately licensed, certified, or registered
2088 by the appropriate health regulatory board to serve individuals admitted to the service.

2089 C. Medically monitored intensive inpatient co-occurring enhanced programs shall offer
2090 planned clinical activities designed to promote stabilization of the individual's behavioral health
2091 needs and psychiatric symptoms and to promote such stabilization, including medication
2092 education and management and motivational and engagement strategies.

2093 **12VAC35-272-870. Clinically managed high-intensity residential services (ASAM LOC 3.5)**
2094 **program criteria.**

2095 A clinically managed high-intensity residential care program shall meet the following
2096 programmatic requirements. The program shall:

2097 1. Provide daily clinical services, including a range of cognitive, behavioral, and other
2098 therapies in individual or group therapy; programming; and psychoeducation as deemed
2099 appropriate by a licensed professional and included in an assessment and treatment
2100 plan;

2101 2. Provide counseling and clinical interventions to teach an individual the skills needed
2102 for daily productive activity, prosocial behavior, and reintegration into family and
2103 community;

2104 3. Provide motivational enhancement and engagement strategies appropriate to an
2105 individual's stage of readiness to change and level of comprehension;

2106 4. Have direct affiliations with other easily accessible levels of care or provide
2107 coordination through referral to more or less intensive levels of care and other services;

2108 5. Provide family and caregiver treatment services as deemed appropriate by a licensed
2109 professional and included in an assessment and treatment plan;

2110 6. Provide educational, vocational, and informational programming adaptive to individual
2111 needs;

2112 7. Utilize random drug screening to monitor progress and reinforce treatment gains as
2113 appropriate to an individual treatment plan;

2114 8. Ensure and document that the length of an individual's stay shall be determined by the
2115 individual's condition and functioning;

2116 9. Make a substance use treatment program available for all individuals;

2117 10. Make MAT available for all individuals. Medication-assisted treatment may be
2118 provided by facility staff or coordinated through alternative resources; and

2119 11. If the provider is providing MAT within the facility, the provider shall comply with
2120 12VAC35-276-300, 2VAC35-276-340, and 2VAC35-276-360.

12VAC35-272-880. Clinically managed high-intensity residential services (ASAM LOC 3.5) admission criteria.

A. The individuals receiving 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.

12VAC35-272-890. Clinically managed high-intensity residential services (ASAM LOC 3.5) discharge criteria.

Before a clinically managed high-intensity residential service program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:

1. Achieved the goals of the treatment services and no longer require ASAM 3.5 level of care;

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

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

12VAC35-272-900. Clinically managed high-intensity residential services (ASAM LOC 3.5) 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.

12VAC35-272-910. Clinically managed population-specific high-intensity residential services (ASAM LOC 3.3) program criteria.

A clinically managed, population-specific 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

2168 appropriate by a licensed professional and included in an assessment and treatment
2169 plan;

2170 2. Provide daily professional addiction and mental health treatment services that may
2171 include relapse prevention, exploring interpersonal choices, peer recovery support, and
2172 development of a social network;

2173 3. Provide services to improve the individual's ability to structure and organize the tasks
2174 of daily living and recovery. Such services shall accommodate the cognitive limitations
2175 within this population;

2176 4. Make available medical, psychiatric, psychological, and laboratory and toxicology
2177 services through consultation or referral as indicated by the individual's condition;

2178 5. Provide case management, including ongoing transition and continuing care planning;

2179 6. Provide motivational interventions appropriate to the individual's stage of readiness to
2180 change and designed to address the individual's functional limitations;

2181 7. Have direct affiliations with other easily accessible levels of care or coordinate through
2182 referral to more or less intensive levels of care and other services;

2183 8. Provide family and caregiver treatment services as deemed appropriate by an
2184 assessment and treatment plan;

2185 9. Utilize random drug screening to monitor progress and reinforce treatment gains;

2186 10. Regularly monitor the individual's adherence to taking prescribed medications;

2187 11. Make the substance use treatment program available to all individuals receiving the
2188 residential care service;

2189 12. Make MAT available for all individuals. Medication-assisted treatment may be
2190 provided by facility staff or coordinated through alternative resources; and

2191 13. If the provider is providing MAT within the facility, the provider shall comply with
2192 12VAC35-276-300, 12VAC35-276-340, and 12VAC35-276-360.

2193 **12VAC35-272-920. Clinically managed population-specific high-intensity residential**
2194 **services (ASAM LOC 3.3) admission criteria.**

2195 Before a clinically managed, population-specific, high-intensity residential service program
2196 may admit an individual, the individual shall meet the criteria for admission as defined by the
2197 provider's policies. The provider's policy regarding admission shall at a minimum require the
2198 individual to:

2199 1. Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate
2200 to high severity as defined by the DSM; and

2201 2. Meet the admission criteria of Level 3.3 of ASAM.

2202 **12VAC35-272-930. Clinically managed population-specific high-intensity residential**
2203 **services (ASAM LOC 3.3) discharge criteria.**

2204 A. Before a clinically managed, population-specific, high-intensity residential service
2205 program may discharge or transfer an individual, the individual shall meet the criteria for
2206 discharge or transfer as defined by the provider's policies, which shall include provisions for the
2207 discharge or transfer of individuals who have:

2208 1. Achieved the goals of the treatment services and no longer require ASAM 3.3 level of
2209 care;

2210 2. Been unable to achieve the goals of the individual's treatment, but could achieve the
2211 individual's goals with a different type of treatment; or

2212 3. Achieved the individual's original treatment goals, but have developed new treatment
2213 challenges that can only be adequately addressed in a different type of treatment.

2214 B. Discharge planning shall occur for individuals and include realistic plans for the continuity
2215 of MAT services as indicated.

2216 **12VAC35-272-940. Clinically managed population-specific high-intensity residential**
2217 **services (ASAM LOC 3.3) co-occurring enhanced programs.**

2218 A. Clinically managed population-specific high-intensity residential services co-occurring
2219 enhanced programs shall offer psychiatric services, medication evaluation, and laboratory
2220 services. Such services shall be available by telephone within eight hours and onsite or closely
2221 coordinated off site within 24 hours, as appropriate to the severity and urgency of the
2222 individual's mental condition.

2223 B. Clinically managed population-specific high-intensity residential services co-occurring
2224 enhanced programs shall be staffed by appropriately credentialed psychiatrists and licensed
2225 mental health professionals who are able to assess and treat co-occurring mental disorders and
2226 who have specialized training in behavior management techniques. All clinical staff shall be
2227 qualified by training and experience and appropriately licensed, certified, or registered by the
2228 appropriate health regulatory board to serve individuals admitted to the service.

2229 C. Clinically managed population-specific high-intensity residential services co-occurring
2230 enhanced programs shall offer planned clinical activities designed to stabilize the individual's
2231 mental health problems and psychiatric symptoms and to maintain such stabilization, including
2232 medication education and management and motivational and engagement strategies. Goals of
2233 therapy shall apply to both the substance use disorder and any co-occurring mental health
2234 disorder.

2235 **12VAC35-272-950. Clinically managed low-intensity residential services (ASAM LOC 3.1)**
2236 **program criteria.**

2237 A clinically managed low-intensity residential services program shall meet the following
2238 programmatic requirements. The program shall:

- 2239 1. Offer a minimum of five hours a week of professionally directed treatment in addition
2240 to other treatment services offered to individuals, such as partial hospitalization or
2241 intensive outpatient treatment the focus of which is stabilizing the individual's substance
2242 use disorder. Services shall be designed to improve the individual's ability to structure
2243 and organize the tasks of daily living and recovery;
- 2244 2. Ensure collaboration with care providers to develop an individual treatment plan for
2245 each individual with time-specific goals and objectives;
- 2246 3. Provide counseling and clinical monitoring to support successful initial involvement in
2247 regular, productive daily activity;
- 2248 4. Provide case management services;
- 2249 5. Provide motivational interventions appropriate to the individual's stage of readiness to
2250 change and level of comprehension;
- 2251 6. Have direct affiliations with other easily accessible levels of care or coordinate through
2252 referral to more or less intensive levels of care and other services;
- 2253 7. Include the ability to arrange for needed procedures as appropriate to the severity and
2254 urgency of the individual's condition;
- 2255 8. Provide family and caregiver treatment and peer recovery support services as
2256 deemed appropriate by a licensed professional and included in an assessment and
2257 treatment plan;
- 2258 9. Provide addiction pharmacotherapy and the ability to arrange for pharmacotherapy for
2259 psychiatric medications;
- 2260 10. Utilize random drug screening to monitor progress and reinforce treatment gains;

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- 2261 11. Make a substance abuse treatment program available to all individuals;
2262 12. Make MAT available for all individuals. Medication-assisted treatment may be
2263 provided by facility staff or coordinated through alternative resources; and
2264 13. If the provider is providing MAT within the facility, the provider shall comply with
2265 12VAC35-276-300, 12VAC35-276-340, and 12VAC35-276-360.
- 2266 **12VAC35-272-960. Clinically managed low-intensity residential services (ASAM LOC 3.1)**
2267 **admission criteria.**
- 2268 Before a clinically managed low-intensity residential service program may admit an
2269 individual, the individual shall meet the criteria for admission as defined by the provider's
2270 policies. The provider's policy regarding admission shall at a minimum require the individual to:
- 2271 1. Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate
2272 to high severity as defined by the DSM; and
2273 2. Meet the admission criteria of Level 3.1 of ASAM.
- 2274 **12VAC35-272-970. Clinically managed low-intensity residential services (ASAM LOC 3.1)**
2275 **discharge criteria.**
- 2276 Before a clinically managed low-intensity residential service program may discharge or
2277 transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by
2278 the provider's policies, which shall include provisions for the discharge or transfer of individuals
2279 who have:
- 2280 1. Achieved the goals of the treatment services and no longer require ASAM 3.1 level of
2281 care;
2282 2. Been unable to achieve the goals of the individual's treatment, but could achieve the
2283 individual's goals with a different type of treatment; or
2284 3. Achieved the individual's original treatment goals, but have developed new treatment
2285 challenges that can only be adequately addressed in a different type of treatment.
- 2286 **12VAC35-272-980. Clinically managed low-intensity residential services (ASAM LOC 3.1)**
2287 **co-occurring enhanced programs.**
- 2288 A. Clinically managed low-intensity residential services co-occurring enhanced programs
2289 shall offer psychiatric services, including medication evaluation and laboratory services. Such
2290 services shall be provided on site or closely coordinated offsite, as appropriate to the severity
2291 and urgency of the individual's mental condition.
- 2292 B. Clinically managed low-intensity residential services co-occurring enhanced programs
2293 shall be staffed by appropriately credentialed licensed mental health professionals who are able
2294 to assess and treat co-occurring disorders with the capacity to involve addiction-trained
2295 psychiatrists. All clinical staff shall be qualified by training and experience and appropriately
2296 licensed, certified, or registered by the appropriate health regulatory board to serve individuals
2297 admitted to the service.
- 2298 C. Clinically managed low-intensity residential services co-occurring enhanced programs
2299 shall offer planned clinical activities that are designed to stabilize the individual's mental health
2300 problems and psychiatric symptoms and to maintain such stabilization, including medication
2301 education and management and motivational and engagement strategies. Goals of therapy
2302 shall apply to both the substance use disorder and any co-occurring mental disorder.

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Project 8154 - NOIRA

Department of Behavioral Health And Developmental Services

Regulatory Restructuring - NonCenter-Based Services (Part 3 of 7)

Chapter 274

Regulations for Noncenter-Based Services

Part I

General

12VAC35-274-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed in 12VAC35-270-20:

"Abuse"

"Admission"

"Assertive community treatment service" or "ACT"

"Authorized representative"

"Behavior intervention"

"Commissioner"

"Contractor"

"Community Psychiatric Support and Treatment" or "CPST"

"Crisis"

"Day support"

"Department"

"Developmental disability"

"Discharge"

"Discharge plan"

"Emergency services" or "crisis intervention"

"Individual" or "individual receiving services"

"Individualized services plan" or "ISP"

"Informed choice"

"Initial assessment"

"Location"

"Medication"

"Medication administration"

"Mental health skill building" or "MHSS"

"Mental illness"

"Neglect"

"Noncenter-based"

"Person-centered"

"Provider"

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"Referral"

"Restraint"

"Restriction"

"Screening"

"Service"

"Supportive in-home"

"Written," "writing," and "in writing"

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

"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.

"Behavioral Health Technician" or "BHT" means a person who has completed, at a minimum, an associate degree and registered with the Board of Counseling to practice in accordance with the provisions of § 54.1-3518 of the Code of Virginia and regulations of the Board of Counseling and provides collaborative behavioral health services.

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

"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.

"Comprehensive assessment" means a comprehensive and written assessment that updates and finalizes the initial assessment. The comprehensive assessment shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context and shall be completed in a time period appropriate to the nature and scope of the service provided. The comprehensive assessment includes all relevant social, psychological, medical, and level of care information as the basis for the development of the person-centered comprehensive ISP. The comprehensive assessment may be completed at the time of initial assessment if it includes all elements of the comprehensive assessment. In the event a comprehensive assessment is completed at the time of an initial assessment the provider is not required to update the assessment.

"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.

"Early serious mental illness" means the initial onset of a diagnosable mental, behavioral, or emotional disorder that significantly impacts an individual's functioning, potentially hindering their ability to achieve expected levels of interpersonal, academic or occupational success.

"Face-to-face" means encounters that occur in person unless explicitly indicated by a specific regulatory provision.

"Full-time employee" means, with respect to any month, an individual who is employed on average at least 30 hours of service per week.

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85 "Individual support plan" means a comprehensive, person-centered plan for an individual
86 receiving developmental disability services that sets out the supports and actions to be taken
87 during the year by each provider, as detailed in each provider's plan for supports to achieve the
88 desired outcomes and goals. The individual support plan shall be developed collaboratively by
89 the individual; the individual's family or caregiver, as appropriate; providers; the support
90 coordinator; and other interested parties.

91 "Initial ISP" means a written plan developed and implemented within one business day of
92 admission to address immediate service, health, and safety needs as identified within the
93 individual's initial assessment.

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

99 "Licensed mental health professional-resident" or "LMHP-R" means the same as "resident"
100 as defined in 18VAC115-20-10 for licensed professional counselors, 18VAC115-50-10 for
101 licensed marriage and family therapists, or 18VAC115-60-10 for licensed substance abuse
102 treatment practitioners. An LMHP-R shall be in continuous compliance with the regulatory
103 requirements of the applicable counseling profession for supervised practice.

104 "LMHP-resident in psychology" or "LMHP-RP" means an individual in a residency, as that
105 term is defined in 18VAC125-20-10, for clinical psychologists. An LMHP-RP shall be in
106 continuous compliance with the regulatory requirements for supervised experience as found in
107 18VAC125-20-65.

108 "LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as
109 "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-S
110 shall be in continuous compliance with the regulatory requirements for supervised practice as
111 found in 18VAC140-20-50.

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

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

119 "Noncenter-based day support" means structured programs that prepare adults with a
120 developmental disability for typical activities of community life equal to those available to the
121 general population, including opportunities for peer interaction and community integration.
122 Noncenter-based day support services promote the individual's inclusion and independent
123 participation in his community and focus on enabling the individual to attain or maintain his
124 highest potential level of functioning.

125 "Noncenter-based respite care" means providing temporary, short-term, time-limited
126 substitute care on an episodic or routine basis of an individual for the purpose of providing relief
127 to the individual's unpaid primary caregiver. Persons providing respite care are recruited,
128 trained, and supervised by a licensed provider. Respite services are provided in the individual's
129 home or place of residence, in the community.

130 "Plan for supports" means a provider's plan for supporting the individual in achieving the
131 individual's desired outcomes and facilitating the individual's health and safety. The provider's
132 plan for supports is one component of the individual support plan.

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

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

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

"Rehabilitation skills practice" means a subcomponent of restorative evidenced-based therapeutic interventions for individuals who need individualized, collaborative, hands-on training to build developmentally appropriate skills.

"Restorative evidence-based therapeutic interventions" means evidence-based practices designed to decrease symptoms of the individual's mental health diagnosis, restore functional skills of daily living, build natural supports, and achieve identified person-centered goals and objectives as set forth in the ISP. Restorative evidence-based therapeutic interventions is focused on the individual's ability to succeed in the community and to show improvement in school, work, and home functioning.

"School-based therapeutic day treatment for children and adolescents" or "school-based TDT" means individualized and structured therapeutic interventions that serve (i) children and adolescents from birth through age 17, and under certain circumstances through age 21, with serious emotional disturbances, substance use, or co-occurring disorders; or (ii) children and adolescents from birth through age seven who are at risk of serious emotional disturbance, or substance use disorder, or co-occurring disorders. Therapeutic day treatment interventions are provided within a school setting and in coordination with school programming during the school day or to supplement the school day or year, such as after school hours or during summer school. School-based TDT combines psychotherapeutic interventions with education and mental health or substance abuse treatment to provide supports so at-risk children maintain

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placement within their school and home. This service shall include assessment; interventions to build daily living skills and to enhance social and interpersonal skills; care coordination; and individual, group, or family counseling.

"Serious emotional disturbance" or "SED" means an individual under the age of 18 having within the past year a diagnosable mental, behavioral, or emotional disorder resulting in functional impairment that substantially interferes with or limits the individual's role or functioning in family, school, or community activities.

"Serious mental illness" or "SMI" means an individual over the age of 18 having within the past year a diagnosable mental, behavioral, or emotional disorder that substantially interferes with the individual's life and ability to function.

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

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

12VAC35-274-20. License required.

Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. The following services shall require a noncenter-based license:

1. Assertive community treatment;
2. Intensive in-home;
3. Mental health skill building;
4. Noncenter-based day support;
5. Noncenter-based respite care;
6. Supportive in-home; and
7. School-based therapeutic day treatment for children and adolescents.

12VAC35-274-30. Service descriptions.

A. Assertive community treatment (ACT) includes comprehensive, coordinated person-centered services delivered to individuals with severe and persistent mental illness that address the breadth of their needs and help achieve their personal goals. Services are provided collaboratively by a self-contained interdisciplinary community-based team of medical, behavioral health, and rehabilitation professionals. ACT services include ongoing assessment; medical, nursing, psychiatric, and psychosocial evaluation, care, and monitoring; skills restoration, crisis intervention, and case management; co-occurring substance use disorder services that are non-confrontational, trauma-informed, and person-centered that consider interactions of mental illness and substance use; skill-teaching to family members, significant others, and broader natural support systems that are directed exclusively to the well-being and benefit of the individual; direct support to help individuals obtain legal and advocacy services, and natural supports in the community; assistance in developing and maintaining natural supports and social relationships; and peer support services.

B. Noncenter-based day support includes routine assistance, skill-building, and safety supports in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills for adults with a developmental disability. Services are provided to groups or individuals in non-center based or home-based settings and include community coaching and community engagement. Activities are conducted at naturally occurring times and in a variety of natural settings in which the individual may actively interact with persons without disabilities, other than

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those who are paid to support the individual. The activities shall enhance the individual's involvement with the community and facilitate the development of relationships and natural supports.

C. Intensive in-home includes family preservation interventions for children and adolescents who have or are at risk of serious emotional disturbance. This service is offered to increase functional and therapeutic interpersonal relations between family members and must include at least one parent, legal guardian, or responsible adult living in the home, with the goal of keeping the individual with the family. Services include modeling; 24-hour per day emergency response; crisis treatment; individual and family counseling; life, parenting, and communication skills; and case management and coordination.

D. Mental health skill building (MHSS) includes direct, face-to-face, goal-directed training for adults in the following areas: (i) functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring health, nutrition, and physical condition, with goals towards self-monitoring and self-regulation of all of these activities. Services offered include symptom management; assistance with adherence to psychiatric and physical health medication treatment plans; and skills training to promote the individual's management of personal hygiene, food preparation, adequate nutrition, budgeting, and use of community resources. MHSS training usually takes place in a community setting.

E. Noncenter-based respite care includes trained, supervised supports delivered in an individual's home or place of residence for the purpose of providing temporary, substitute care. Services offered include assistance with ADLs; monitoring of health status or physical condition; prescribed use of medication and other medical needs; meal preparation; housekeeping activities such as bed-making, cleaning, or the individual's laundry; safety; participation in social, recreational, or community activities; and accompanying the individual to appointments or meetings.

F. Supportive in-home includes assistance, training, and community supports based on the needs of the individual that are necessary to attain and sustain independent community residential living. Services range from drop-in or friendly-visitor support and counseling to more intensive monitoring, training, respite care, and family services. 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.

G. School-based therapeutic day treatment for children and adolescents (school-based TDT) includes assessment; interventions to build daily living skills or enhance social skills; care coordination; and individual, group, or family counseling. School-based TDT includes services offered during standard instructional hours during the calendar school year in the school setting; services offered after instructional hours during the calendar school year as an after-school program; and services offered outside of the school year during summer school.

12VAC35-274-40. Screening.

A. Providers shall implement screening policies and procedures that include:

1. Identification, qualification, training, and duties of employees responsible for screening;

2. The following minimum required elements of screening for a noncenter-based setting:

a. Date of contact;

b. Legal name, preferred name, date of birth, sex, and gender of the individual;

c. Contact information including: address, telephone number, and email address of the individual, if applicable;

d. Reasons why the individual is requesting services;

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- 277 e. Current reported diagnoses and medical conditions;
278 f. Medical symptoms;
279 g. Psychoactive or other medications currently being used, including recent
280 increases, decreases, discontinuation, misuse, or overdose of prescription
281 medication;
282 h. Recent or current substance use or dependence including risk for intoxication or
283 substance withdrawal; and
284 i. Status of the individual including his referral to other services for further
285 assessment, placement on a waiting list for services, or admission to the service.
286 3. Methods to identify other appropriate services for referral to assist individuals who are
287 not admitted to the service after screening.

288 B. The provider shall retain documentation of the individual's screening for six months. For
289 individuals who are admitted to the service, documentation shall be included in the individual's
290 record in accordance with 12VAC35-270-580.

291 C. The provider shall review all elements of the screening at the time of initial assessment
292 and update as necessary.

293 **12VAC35-274-50. Assessments.**

294 A. The provider shall implement a written assessment policy. The policy shall define how
295 assessments will be conducted and documented.

296 B. The provider shall actively involve the individual and the individual's authorized
297 representative, if applicable, in the preparation of initial and comprehensive assessments. In
298 these assessments, the provider shall consider the individual's needs, strengths, goals,
299 preferences, and abilities within the individual's cultural context.

300 C. The assessment policy shall designate appropriately qualified employees or contractors
301 who are responsible for conducting, obtaining, or updating assessments and medical
302 screenings. These employees or contractors shall have experience in working with the needs of
303 individuals who are being assessed, the assessment tools being utilized, and the provision of
304 services that the individuals may require.

305 D. Assessment is an ongoing activity. The provider shall make reasonable attempts to
306 obtain previous assessments or relevant history. The provider shall use previous assessments
307 or relevant history in order to complete an individual's initial or comprehensive assessment. The
308 provider shall use previous assessments or relevant history within the course of treatment, if
309 applicable.

310 E. Providers shall utilize an assessment tool that meets the requirements in subsection F of
311 this section for initial assessments, and subsection G of this section for comprehensive
312 assessments. Providers may utilize a standardized state or federally sanctioned assessment
313 tool that does not meet the criteria in these regulations if the tool is approved by the department
314 prior to use.

315 F. Providers shall conduct an individual's initial assessment prior to or at admission to the
316 service. The provider shall complete, or obtain information from other qualified providers in
317 order to complete, an initial assessment detailed enough to determine whether the individual
318 qualifies for admission and to initiate an ISP for those individuals who are admitted to the
319 service.

320 1. The initial assessment shall assess immediate service, health, and safety needs and shall
321 be conducted using an assessment tool that evaluates at a minimum the following criteria
322 concerning the individual:

323 a. Diagnosis;

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b. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of needs;

c. Current medical issues;

d. Current medications;

e. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders;

f. At-risk behavior to self and others; and

g. Risk factors that may impact the individual's ability to seek treatment or continue to participate in services.

2. The comprehensive assessment may be completed at the time of initial assessment if it includes all elements noted within subsection G of this section. In the event a comprehensive assessment is completed at the time of an initial assessment, the provider is not required to update the assessment unless a reassessment is medically or clinically indicated.

G. Providers shall conduct a comprehensive assessment for each individual who is admitted to the service. A comprehensive assessment shall update and finalize the initial assessment, unless the comprehensive assessment is completed at the time of initial assessment as provided in subdivision F 2 of this section.

1. Completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than (i) 30 days after admission for providers of mental health and substance abuse services and (ii) 60 days after admission for providers of developmental services.

2. The comprehensive assessment may be completed at the time of initial assessment only if it includes all elements enumerated in subdivision 3 of this subsection. In the event a comprehensive assessment is completed at the time of an individual's initial assessment, the provider is not required to update the assessment unless a reassessment is medically or clinically indicated.

3. The comprehensive assessment shall be conducted using an assessment tool that evaluates, at a minimum, the following criteria:

a. Onset and duration of needs;

b. Social, behavioral, developmental, and family history and supports;

c. Cognitive functioning, including strengths and weaknesses;

d. Employment, vocational, and educational background;

e. Previous interventions and outcomes including interventions and outcomes that were unsuccessful, with the provider ensuring previous assessments are utilized to note prior interventions as required by subsection D of this section;

f. Overall financial situation, including resources, support and benefits, and whether the individual has the means to meet the individual's financial needs;

g. Health history and current medical care needs, to include:

(1) Allergies, including allergies to food and medications;

(2) Recent physical complaints and medical conditions;

(3) Nutritional needs;

(4) Chronic conditions;

(5) Communicable diseases;

(6) Restrictions on physical activities if any;

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- (7) Restrictive protocols or special supervision requirements;
- (8) Past serious illnesses, serious injuries, and hospitalizations;
- (9) Serious illnesses and chronic conditions of the individual's parents, siblings, and significant others in the same household; and
- (10) Current and past substance use, including alcohol, prescription and nonprescription medications, and illicit drugs.
- h. Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or dependence, and circumstances that increase the individual's risk for mental illness or substance use issues;
- i. History of abuse, neglect, sexual or domestic violence, or other trauma, including psychological trauma;
- j. Legal competency, including authorized representative, commitment, and representative payee status;
- k. Relevant criminal charges or convictions and probation or parole status;
- l. Daily living skills;
- m. Housing arrangements;
- n. Ability to access services, including transportation needs; and
- o. As applicable, fall risk, communication needs, and mobility and adaptive equipment needs.
- H. The provider shall retain documentation of the individual's assessments in the individual's record for a minimum of six years after the individual's discharge in accordance with § 54.1-2910.4 of the Code of Virginia and its written records management policy in accordance with 12VAC35-270-580.
- 12VAC35-274-60. Individualized services plan (ISP); service planning.**
- A. The provider shall actively involve the individual and the individual's authorized representative, as appropriate, in the development, review, and revision of a person-centered ISP. The individualized services planning process shall be consistent with laws protecting confidentiality, privacy, human rights of individuals receiving services, and rights of minors.
1. Providers of developmental services shall collaborate with the individual's planning team to develop and implement the initial plan for supports, which is a component of the comprehensive ISP, no later than 24 hours after admission. The initial plan for supports shall address the individual's immediate health and safety needs for the first 60 days, may include assessment activities, and shall continue in effect until the ongoing comprehensive plan for supports is developed or the individual is discharged, whichever occurs first. An ongoing comprehensive plan for supports shall be completed within 60 days of admission.
2. Providers of mental health or substance abuse services shall develop and implement an initial person-centered ISP no later than 24 hours after admission. The initial ISP shall address the individual's immediate service, health, and safety needs for the first 30 days and shall continue in effect until the comprehensive ISP is developed or the individual is discharged, whichever occurs first. An ongoing comprehensive ISP based upon the nature and scope of services shall be completed as soon as possible, but no later than 30 days after admission.
- B. If an individual has a case manager, informed choice shall be governed by the service-specific requirements governing case management providers (12VAC35-280). If the individual does not have a case manager, development of the initial ISP and the comprehensive ISP shall

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be based on the respective assessment with the participation and informed choice of the individual receiving services.

1. To ensure the individual's participation and informed choice, the following shall be explained to the individual or his authorized representative, as applicable, in a reasonable and comprehensible manner:

a. The proposed services to be delivered;

b. Any alternative services that might be advantageous for the individual; and

c. Any accompanying risks or benefits of the proposed alternative services.

2. If no alternative services are available to the individual, it shall be clearly documented within the ISP or within documentation attached to the ISP, that alternative services were not available as well as the steps taken to identify alternative services.

3. Whenever there is a change to an individual's ISP it shall be clearly documented within the ISP or within documentation attached to the ISP that:

a. The individual participated in the development of or revision to the ISP;

b. The proposed and alternative services and their respective risks and benefits were explained to the individual or the individual's authorized representative, and

c. The reasons the individual or the individual's authorized representative chose the option included in the ISP.

12VAC35-274-70. ISP minimum requirements.

A. The initial ISP shall be based on the individual's immediate service, health, and safety needs identified in the initial assessment. The initial ISP shall include:

1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing needs and preferences documented within the individual's initial assessment, including documentation that the individual's needs and preferences are consistent with a noncenter-based setting;

2. Services, supports, and frequency of services planned to accomplish the individual's goals, including relevant psychological, mental health, substance abuse, behavioral, developmental, medical, rehabilitation, training, and nursing needs and supports;

3. The role of the individual and others, including the individual's family, if appropriate, in implementing the initial ISP; and

4. Target dates for accomplishment of goals and objectives.

B. The comprehensive ISP shall be based on the individual's needs, strengths, abilities, personal preferences, goals, and natural supports identified in the comprehensive assessment. The comprehensive ISP shall include the following minimum provisions:

1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing each need documented within the individual's comprehensive assessment, including documentation that the individual's needs require a noncenter-based setting;

2. Services and supports required to accomplish the goals, including relevant psychological, mental health, substance abuse, behavioral, developmental, medical, rehabilitation, training, and nursing needs and supports;

3. The frequency at which services and supports must be provided to accomplish the individual's goals;

4. The role of the individual and others, including the individual's family, if appropriate, in implementing the comprehensive ISP;

5. A communication plan for individuals with communication barriers, including language barriers;

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6. A behavioral support or treatment plan, if applicable;
7. A physical safety plan that addresses identified risks to the individual or to others, including a fall risk plan, if indicated by the individual's assessment;
8. A crisis or recovery plan, if applicable;
9. Target dates for accomplishment of goals and objectives;
10. Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies, if applicable;
11. A transportation plan, if applicable;
12. Services the individual elects to self-direct, if applicable; and
13. Projected discharge plan and estimated length of stay within the service.

C. Both the initial ISP and the comprehensive ISP shall be signed and dated, at a minimum, by (i) the person responsible for implementing the plan and (ii) the individual receiving services or the individual's authorized representative, if applicable, in order to document agreement.

1. If the signature of the individual receiving services or the individual's authorized representative cannot be obtained, the provider shall document attempts to obtain the necessary signature and the reason it was unobtainable. The provider shall attempt to obtain the necessary signature, on a periodic basis, while each ISP is in effect. An attempt to obtain the necessary signature shall occur at a minimum each time the provider reviews the ISP as required by 12VAC35-274-80 E.

2. Each ISP shall be distributed to the individual and others authorized to receive it prior to implementation. The provider shall document dates of the distribution within the individual's record.

D. The provider shall designate an employee or contractor who shall be responsible for developing, implementing, reviewing, and revising each individual's comprehensive ISP in collaboration with the individual or the individual's authorized representative, as appropriate.

E. Employees or contractors who are responsible for implementing the ISP shall demonstrate a working knowledge of the objectives and strategies contained in the individual's current ISP, including an individual's detailed health and safety protocols.

1. Providers shall educate and train employees or contractors who are responsible for ISP implementation, based on the employee's or contractor's duties, on the objectives and strategies contained within the individual's current ISP.

2. When changes occur to an individual's ISP, the provider shall notify and train the appropriate employees or contractors who are responsible for ISP implementation, as applicable to their duties, for competency to implement the revised ISP.

3. After each training on the individual's current ISP, providers shall maintain documentation of the employee's or contractor's education, training, and competency as demonstrated through supervision.

F. When a provider provides more than one service to an individual, the provider may maintain a single ISP document that contains individualized objectives and strategies for each service provided.

G. Whenever possible the identified goals in the ISP shall be written in the words of the individual receiving services.

H. The provider shall use signed and dated progress notes to document the implementation of the goals and objectives contained within the ISP.

I. A copy of the individual's most current ISP shall be readily accessible at all times, including by staff providing direct care services, while services are being provided.

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12VAC35-274-80. Reassessments and quarterly ISP reviews.

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

Reassessment shall include documentation justifying that the individual's needs continue to require a provider-operated noncenter-based setting.

B. The provider shall actively involve the individual and the individual's authorized representative, if applicable, in reassessments. The provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

C. Providers shall revise the ISP, if the reassessment supports changes or if desired by the individual. If a reassessment does not support changes to the ISP, the provider shall document that no revisions are necessary and the reasoning.

D. If necessary as a result of a reassessment, providers shall complete changes to medical protocols or collaborate with other providers to ensure changes are made to medical, medical equipment, behavioral, or other corresponding protocols, if appropriate.

E. The provider shall complete quarterly reviews of the ISP in writing every three months from (i) the date of the implementation of the most recent comprehensive ISP or (ii) the most recent reassessment, whichever occurs later. Documentation of the quarterly ISP review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed.

F. The quarterly ISP review shall be conducted in a person-centered manner, to determine if services are being delivered as described within the ISP. The individual receiving services and the individual's authorized representative, if applicable, shall be included in the ISP review, to determine if the individual's treatment needs and preferences are being met and the individual is satisfied with the services provided.

1. A quarterly review of the ISP shall evaluate the individual's progress toward meeting the ISP's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made.

2. A quarterly review of the ISP shall document evidence of progress toward or achievement of a specific targeted outcome for each goal and objective.

3. For goals and objectives that were not accomplished by the identified target date, or for which the individual did not demonstrate sufficient progress, the provider shall meet and collaborate with other service providers and support team members to review the reasons for lack of progress and provide the individual an opportunity to make an informed choice of how to proceed. The provider shall retain documentation of this meeting and the individual's informed choice within the individual's record.

4. A quarterly review of the ISP shall note:

a. the individual's family involvement, if any, in the individual's treatment;

b. whether the individual no longer needs the intensity of care provided within a noncenter-based setting;

c. the individual's progress towards discharge; and

d. the status of the individual's discharge planning.

G. The provider shall ensure after each reassessment that the individual's most current ISP is easily accessible by the provider at all times, including by direct care staff while services are being provided to the individual.

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12VAC35-274-90. Progress notes.

A. The documentation system implemented by the provider pursuant to subdivision E of 12VAC35-270-580 shall ensure that progress notes are (i) maintained in a consistent format that satisfies the minimum provisions of subsection B of this section and (ii) entered into the individual's record in accordance with the provider's record management policy.

B. The provider shall use signed and dated progress notes or other documentation to document the services provided to the individual. Progress notes shall at a minimum:

1. Be legible and readable;

2. Record the individual's interaction with the staff writing the progress note, including care provided and events relevant to diagnosis and treatment or care of the individual;

3. Provide a narrative or descriptive component;

4. Describe needed follow-up care or note which objective within the ISP will receive focus the next time the individual receives services; and

5. Be signed and dated by the staff member who rendered the service.

C. The provider shall document whether the individual no longer needs the intensity of care provided within a noncenter-based setting.

D. Communication logs, information notes, and supervision notes shall not be considered progress notes.

12VAC35-274-100. Health care policy.

A. The provider shall implement a policy that addresses provision of adequate and appropriate medical and dental care. This policy shall describe to what extent and how:

1. Medical and dental care needs will be assessed and the circumstances that will prompt the decision to obtain a medical assessment.

2. ISPs will address any medical and dental care needs appropriate to the scope and level of service.

3. The provider will provide or arrange for, or support the individual with, the provision of medical and dental care needs identified at admission.

4. The provider will provide, arrange, or support the individual with the provision of routine, ongoing, and follow-up medical and dental care services after admission.

5. The provider will communicate the results of physical examinations, medical assessments, diagnostic tests, treatments, or examinations conducted by the provider to the individual and the individual's authorized representative, as appropriate.

6. The provider will keep accessible to staff and contractors on duty the names, addresses, and telephone numbers of the individual's medical and dental providers.

7. The provider will ensure a means for facilitating and arranging, as appropriate, transportation to medical and dental appointments and medical tests.

8. The provider will ensure the provision of emergency medical services for each individual.

B. The provider shall identify any individuals who are at risk for falls and develop and implement a fall prevention and management plan and program for each at-risk individual.

C. The provider shall implement written infection control measures including the use of universal precautions.

D. The provider shall report outbreaks of infectious diseases to the Virginia Department of Health pursuant to § 32.1-37 of the Code of Virginia.

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12VAC35-274-110. Provider staffing plan; supervision requirement.

In addition to the provisions of 12VAC35-270-300, providers of noncenter-based services shall incorporate the following service-specific supervision requirements into the provider staffing plan:

1. Supervision of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature such as intensive in-home or school-based therapeutic day treatment shall be provided by a licensed mental health professional or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions.

2. Supervision of mental health, substance abuse, or co-occurring services that are of a supportive or maintenance nature, such as mental health supports, shall be provided by a QMHP, a licensed mental health professional, or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions. A QMHP-T may not provide this type of supervision.

12VAC35-274-120. Staffing.

A. Assertive community treatment (ACT) services shall meet the following staffing requirements:

1. ACT services are delivered by interdisciplinary teams. Each ACT team shall have sufficient staffing composition to meet the varying needs of individuals receiving services as required by this subdivision.

a. Team leader. One team leader shall oversee all aspects of team operations and provide direct services to individuals in the community. The team leader shall be a full-time LMHP with three years of experience in the provision of mental health services to adults with serious mental illness; or a full-time registered QMHP with at least three years of experience in the provision of mental health services to adults with serious mental illness who was employed by a provider as a team leader prior to July 1, 2020.

b. Nurses. ACT nurses shall be full-time employees or contractors of the provider. ACT nurses shall have the following minimum qualifications: a registered nurse (RN) shall have at least one year of experience in the provision of mental health services to adults with serious mental illness. A licensed practical nurse (LPN) shall have at least 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 RN or LPN;

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

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

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

d. Co-occurring disorder specialist. At least one full-time co-occurring disorder specialist, who shall be a LMHP; registered QMHP; or certified substance abuse specialist (CSAC) with training or experience working with adults with co-occurring serious mental illness and substance use disorder.

e. ACT peer specialists. At least one full-time equivalent peer recovery specialist who is or has been a recipient of mental health services for severe and persistent mental

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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 (i) peer support directly to individuals receiving services and (ii) provides guidance to other team members in understanding and supporting individuals' recovery goals.

f. Program assistant. A full-time person with skills and abilities in medical records management who shall operate and coordinate information systems, maintain accounts and budget records for individual and program expenditures, and perform administrative support activities.

g. Psychiatric care provider. A 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. The psychiatric care provider shall maintain an equivalent ratio of 16 hours of psychiatric time per 50 individuals receiving services. The psychiatric care provider shall be a fully integrated team member who attends team meetings and actively participates in developing and implementing each individual's ISP.

h. Generalist clinical staff. ACT teams shall have additional clinical staff with the knowledge, skill, and ability required, based on the population and age of individuals receiving services, to carry out rehabilitation and support functions. At least 50 percent of the total number of generalist clinical staff shall be LMHPs, QMHPs, QMHP-Ts, or QPPMHs.

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

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

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

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

a. Small ACT teams shall maintain an overall caseload of no more than 50 individuals with at least one staff member per eight individuals. The psychiatric care provider and a program assistant shall not count toward the staffing ratio.

b. Medium ACT teams shall maintain an overall caseload of no more than 74 individuals with at least one staff member per nine individuals. The psychiatric care provider and a program assistant shall not count toward the staffing ratio.

c. Large ACT teams shall maintain an overall caseload of no more than 120 individuals with at least one staff member per nine individuals. The psychiatric care provider and a program assistant shall not count toward the staffing ratio.

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

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

5. The ACT team shall operate an after-hours on-call system and be available to individuals by telephone or in person.

6. The ACT team shall have 24-hour responsibility for responding directly to psychiatric crises, including meeting the following criteria:

a. 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.

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- b. The team shall be the first-line crisis evaluator and responder for individuals receiving services from the team.
- c. The team shall have access to the practical, individualized crisis plans developed to help them address crises for each individual receiving services.
- B. Noncenter-based day support providers shall have sufficient staffing to meet the requirements of the ISPs of the individuals served.
- C. Intensive in-home providers shall meet the following staffing requirements:
1. Have an LMHP who is responsible for clinical oversight of the program.
 2. Provide individual and family counseling by a LMHP, LMHP-S, LMHP-R, or LMHP-RP.
 3. Make emergency assistance available 24 hours a day, seven days a week.
- D. Mental health skill building providers shall only render services by (i) a LMHP, LMHP-S, LMHP-R, or LMHP-RP or (ii) a QMHP, QMHP-T, or QPPMH under the supervision of a QMHP, QMHP-T, LMHP, LMHP-S, LMHP-R, or LMHP-RP.
- E. Noncenter-based respite care providers shall serve individuals at a one-to-one ratio.
- F. Supportive in-home providers may render services individually or simultaneously to more than one individual living in the home, depending on the individual's needs.
- G. School-based therapeutic day treatment providers shall meet the following staffing requirements:
1. Render services by (i) a LMHP, LMHP-S, LMHP-R, or LMHP-RP or (ii) a QMHP or QMHP-T under the supervision of a LMHP, LMHP-R, LMHP-RP, or LMHP-S.
 2. Provide individual, group, and family counseling by a LMHP, LMHP-S, LMHP-R, or LMHP-RP.
- 12VAC35-274-130. Medication errors and drug reactions.**
- In the event of a medication error or adverse drug reaction:
1. First aid shall be administered if indicated.
 2. Employees or contractors shall promptly contact a poison control center, pharmacist, nurse, or physician and shall take actions as directed.
 3. The individual's physician shall be notified as soon as possible unless the situation is addressed in standing orders.
 4. All actions taken by employees or contractors shall be documented, such as in incident reports or progress notes.
 5. The provider shall review medication errors at least quarterly as part of the quality assurance in 12VAC35-270-570.
 6. Medication errors and adverse drug reactions shall be recorded in the individual's medication log.
- 12VAC35-274-140. Crisis or emergency interventions; required elements.**
- A. The provider shall implement written policies and procedures, as approved by the department, for prompt intervention in the event of a crisis or a behavioral, medical, or psychiatric emergency that may occur during screening and referral, at admission, or during the period of service provision. For the purposes of this section, a crisis or behavioral, medical, or psychiatric emergency is a situation that poses an imminent risk to the individual or others and cannot be addressed within the scope of the provider's services, but does not include events that require the use of restrictive behavior intervention and supports as referenced within 12VAC35-270-500.
- B. The policies and procedures shall include:

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1. Procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the crisis or emergency;

2. Employee or contractor responsibilities;

3. Location of the face sheets with emergency medical information as required by 12VAC35-270-460; and

4. How and to what extent the provider will respond to any crisis that occurs after hours, based on the provider's licensed service type.

12VAC35-274-150. (Reserved).

12VAC35-274-160. Emergency preparedness and response plan.

A. The scope of emergency preparedness in relation to this section applies to disasters and emergencies as defined by § 44-146.16 of the Code of Virginia.

B. The provider shall develop a written emergency preparedness and response plan for all services and locations, which shall include specifics for preserving critical services at each location to allow for proper continuity of care. At a minimum, this plan shall address:

1. Policy and procedures for evacuating or relocating individuals receiving services, to include consideration of individuals with medical, functional, or accessibility needs.

2. Procedures for conducting fire, evacuation, and emergency medical drills on a regular basis.

3. The process for communicating during emergencies with individuals receiving services; their family members or authorized representatives; employees and contractors; local and state authorities, including the department; and community responders as appropriate.

12VAC35-274-170. (Reserved.).

Part II

Assertive Community Treatment (ACT) Service

12VAC35-274-180. ACT 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 use disorder, developmental disability, personality disorder, or brain injury are not eligible for services.

2. Significant challenges to community integration without intensive community support including persistent or recurrent difficulty with one or more of the following:

a. Performing practical daily living tasks;

b. Maintaining employment at a self-sustaining level or consistently carrying out homemaker roles; or

c. Maintaining a safe living situation.

3. High service needs indicated due to one or more of the following:

a. Residence in a state hospital or other psychiatric hospital but clinically assessed to be able to live in a more independent situation if intensive services were provided or anticipated to require extended hospitalization, if more intensive services are not available;

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- 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 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 participate consistently in traditional office-based services.

B. Individuals receiving ACT services may not be discharged for failure to comply with treatment plans or other expectations of the provider, except in certain circumstances as outlined. Individuals shall meet at least one of the following criteria to be discharged:

1. Change in the individual's residence to a location out of the service area;
2. Death of the individual;
3. Incarceration or long-term hospitalization of the individual for a period to exceed a year; however, the provider is expected to prioritize the individual for 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. Choice of the individual to discharge, only after the provider responsible for revising the ISP documents all attempts to meet any concerns of the individual leading to the choice of discharge; or
5. Significant sustained recovery by the individual in all major role areas with minimal team contact and support for at least two years as determined by both the individual and ACT team.

12VAC35-274-190. ACT contacts.

A. The 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 an average of at least two contacts per individual per week. A minimum aggregate average of one hour per individual per week shall be face to face.

B. Each individual receiving ACT services shall be seen face to face by an employee or contractor as specified in the individual's ISP. Telemedicine may be appropriate to fulfill the face-to-face contact requirement if clinically indicated and if utilized for the convenience of the individual. Providers shall document all attempts to make contact, and if contact is not made, the reasons why contact was not made.

12VAC35-274-200. ACT daily operation and progress notes.

A. ACT teams shall conduct daily organizational meetings Monday through Friday, or at least four days a 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 in the ACT services program and documentation of services provided and contacts made with them shall be maintained and utilized in the daily organizational team meeting. For each individual served, there shall also be

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at least a weekly individual progress note documenting services provided in accordance with the individual's ISP or attempts to engage the individual in services.

12VAC35-274-210. ACT self-assessment.

The provider shall solicit the individual's own assessment of his needs, strengths, goals, preferences, and abilities to identify the need for recovery-oriented treatment, rehabilitation, and support services and the status of his environmental supports within the individual's cultural context. With the participation of the individual, the provider shall assess:

1. Psychiatric history, mental status and diagnosis, including the content of an advance directive;

2. Medical, dental, and other health needs;

3. Extent and effect of drug or alcohol use;

4. Education and employment, including current daily structured use of time, school or work status, interests and preferences, and supports and barriers to educational and employment performance;

5. Social development and functioning, including childhood and family history, religious beliefs, leisure interests, and social skills;

6. Housing and daily living skills, including the support needed to obtain and maintain decent, affordable housing integrated into the broader community; the current ability to meet basic needs such as personal hygiene, food preparation, housekeeping, shopping, money management, and the use of public transportation and other community-based resources;

7. Family and social network, including the current scope and strength of an individual's network of family, peers, friends, and co-workers, and their understanding and expectations of the team's services;

8. Finances and benefits, including the management of income, the need for and eligibility for benefits, and the limitations and restrictions of those benefits; and

9. Legal and criminal justice involvement, including guardianship, commitment, representative payee status, and experience as either a victim or an accused person.

12VAC35-274-220. ACT service requirements.

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. 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

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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-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.

Part III

Community Psychiatric Support and Treatment (CPST)

12VAC35-274-230. Admission Criteria.

A. Before a CPST provider may admit an individual to Tier 1 CPST, the individual shall meet the criteria for admission as defined by this chapter and the provider's policies. The provider's policy regarding admission to Tier 1 CPST shall, at a minimum, meet the requirements of 12VAC35-274-50 and the assessment required by that section shall document that the individual:

1. Has a primary ICD diagnosis or DSM diagnosis for mental illness; or

2. An unspecified or provisional diagnosis indicating behavioral health needs; and

3. For children and adolescents, an identified caregiver who lives in the same household shall be willing to participate in the service, as clinically appropriate.

B. Before a CPST provider may admit an individual to Tier 2 CPST, the individual shall meet the criteria for admission as defined by this chapter and the provider's policy. The provider's policy regarding admission to Tier 2 CPST shall, at a minimum, meet the requirements of 12VAC35-274-50 and the assessment required by that section shall document that the individual:

1. Has a primary ICD diagnosis or DSM diagnosis for mental illness;

2. Meets the criteria for early serious mental illness, serious mental illness, or serious emotional disturbance; and

3. For children and adolescents, an identified caregiver who lives in the same household shall be willing to participate in the service, as clinically appropriate.

12VAC35-274-240. Discharge Criteria.

Before a CPST provider may discharge an individual, the individual shall meet the criteria for discharge as defined by this chapter and the provider's policies, which shall meet all the

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requirements of 12VAC35-270-430. The provider's policy regarding discharge shall, at a minimum, also require the individual to:

1. No longer meet admission criteria; or
2. Successfully met the specific goals outlined in the treatment plan for discharge; or
3. Have not made progress on established service goals, nor is there expectation of any progress with continued service; or
4. No longer be engaged in the service, despite multiple attempts on the part of the provider to apply engagement strategies as defined within their policies; or
5. No longer need the service, as the individual is obtaining similar benefit through other services and resources.

12VAC35-274-250. Treatment team and staffing.

A. CPST providers shall have sufficient staffing composition to meet the varied needs of individuals served by the provider as required by this section. Each CPST provider shall meet the following minimum position requirements:

1. A full-time clinical director who is a LMHP.
2. A LMHP with a minimum of two years experience working with individuals experiencing SMI or SED shall be available for consultation 24 hours a day, seven days a week.

B. Each CPST team shall meet the following minimum staffing requirements:

1. A LMHP who shall supervise the team, oversee the assessment and the ISP, and authorize the ISP. Assessments and ISPs may be completed by an LMHP, LMHP-R, LMHP-RP or LMHP-S; and
2. Every LMHP, LMHP-R, LMHP-RP, LMHP-S, and QMHP shall be trained in evidence-based practices and decision models for assessment, treatment planning, and implementation of behavioral health interventions.

C. All CPST staff shall provide services under the direct supervision of an LMHP.

D. Applicants for an initial conditional CPST license may submit a transition plan to the department for approval that will allow for "start-up" when newly forming providers are not in full compliance with the CPST model relative to staffing patterns and individuals receiving services capacity. A transition plan must be approved prior to the issuance of the license. Approved transition plans shall be limited to a six-month period.

12VAC35-274-260. Service delivery and location.

A. CPST Tier 1 and Tier 2 programs shall meet the following programmatic requirements. The program shall provide:

1. Crisis support 24 hours a day, seven days per week. Crisis support shall include the development and implementation of a crisis mitigation plan, any additional crisis planning necessary for the individual, crisis avoidance, and crisis intervention. The crisis mitigation plan shall not include referral to a crisis provider (CRC, CSU, or community-based crisis stabilization, including mobile crisis response) as a means of addressing the crisis. Crisis support shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, or QMHP.

a. Crisis support may occur via telephone or telemedicine. The individual's needs and preferences shall be the determining factor regarding whether crisis support is provided in person, via telemedicine, or via telephone.

b. If the individual's condition progresses and requires a higher level of care the individual shall be referred to the appropriate level of care.

2. Restorative evidence-based therapeutic interventions by a LMHP, LMHP-R, LMHP-RP, LMHP-S, or QMHP. If restorative evidence-based therapeutic Interventions is provided in

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a group with multiple individuals the ratio of team members to individuals served shall not exceed 1:6 for children and adolescents and 1:10 for adults.

3. Psychotherapy or counseling by a LMHP, LMHP-S, LMHP-R, or LMHP-RP acting within his scope of practice. If psychotherapy or counseling is provided in a group with multiple individuals the ratio of team members to individuals served shall not exceed 1:6 for children and adolescents and 1:10 for adults.

4. Care coordination on an individual basis by an LMHP, LMHP-R, LMHP-RP, LMHP-S, or QMHP.

B. CPST Tier 2 programs shall provide all the programmatic elements within A 1-4 and rehabilitation skills practice by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, or BHT. Rehabilitation skills practice shall be provided on an individual basis.

C. CPST programming shall take place in:

1. An individual's home;

2. An individual's community or natural settings; or

3. A provider's department-licensed office location. Services provided in the provider's department-licensed office location shall not exceed one hour a week per individual served and shall be for the benefit of the individual.

12VAC35-274-270. Location requirements.

A. All CPST providers shall have an office location. The office location shall be within the Commonwealth of Virginia and have regular business hours. The office location shall be staffed during regular business hours.

B. The CPST office location shall be appropriate for storage of records and group programming. Records storage space shall meet the requirements of 12VAC35-270-580. Programming space shall ensure the privacy of individuals served.

Project 8128 - NOIRA

Department of Behavioral Health And Developmental Services

Regulatory Restructuring- Center-Based Services (Part 4 of 7)

Chapter 276

Regulations for Center-Based Services

Part I

General

12VAC35-276-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed in 12VAC35-270-20:

"Abuse"

"Admission"

"Case management service"

"Commissioner"

"Complaint"

"Contractor"

"Crisis"

"Crisis receiving center"

"Crisis stabilization unit"

"Day support"

"Department"

"Developmental disability"

"Discharge"

"Discharge plan"

"Individual" or "individual receiving services"

"Individualized services plan" or "ISP"

"Informed choice"

"Initial assessment"

"Location"

"Medication"

"Medication administration"

"Mental health intensive outpatient service"

"Mental health outpatient service"

"Mental health partial hospitalization service"

"Mental illness"

"Neglect"

"Person-centered"

"Provider"

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"Psychosocial rehabilitation service"

"Referral"

"Respite care"

"Restriction"

"Screening"

"Service"

"Substance abuse (substance use disorders)"

"Substance abuse intensive outpatient service"

"Substance abuse outpatient service"

"Substance abuse partial hospitalization services"

"Volunteer"

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

"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.

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

"Center-based" means providing a service in a centralized provider-controlled building or facility, where individuals do not reside. Any overnight stays at a center-based location will be temporary and short term.

"Center-based therapeutic day treatment for children and adolescents" or "center-based TDT" means a treatment program that serves (i) children and adolescents from birth through age 17 and under certain circumstances up to 21, with serious emotional disturbances, substance use, or co-occurring disorders; or (ii) children from birth through age seven who are at risk of serious emotional disturbance. This service combines psychotherapeutic interventions with education and mental health or substance abuse treatment to provide supports so that at-risk children maintain placement within their school and home. Services are provided within an office or clinical setting and include assessment; interventions to build daily living skills and to enhance social and interpersonal skills; care coordination; and individual, group, or family counseling.

"Comprehensive assessment" means a comprehensive and written assessment that updates and finalizes the initial assessment. The comprehensive assessment shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context and shall be completed in a time period appropriate to the nature and scope of the service provided. The comprehensive assessment includes all relevant social, psychological, medical, and level of care information as the basis for the development of the person-centered comprehensive ISP. The comprehensive assessment may be completed at the time of initial assessment if it includes all elements of the comprehensive assessment. In the event a comprehensive assessment is completed at the time of an initial assessment the provider is not required to update the assessment.

"Conveyance" means a motor vehicle that serves as the mobile component of a mobile MAT program.

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84 "Individually identifiable health information" means information that is a subset of health
85 information, including demographic information collected from an individual, as defined by 45
86 C.F.R. §160.103 and:

87 1. is created or received by a health care provider, health plan, employer, or health care
88 clearinghouse; and

89 2. relates to the past, present, or future physical or mental health or condition of an
90 individual; the provision of health care to an individual; or the past, present, or future
91 payment for the provision of health care to an individual; and (i) that identifies the
92 individual; or (ii) with respect to which there is a reasonable basis to believe the
93 information can be used to identify the individual.

94 "Initial ISP" means a written plan developed and implemented within one business day of
95 admission to address immediate service, health, and safety needs as identified within the
96 individual's initial assessment.

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

102 "Licensed mental health professional-resident" or "LMHP-R" means the same as "resident"
103 as defined in 18VAC115-20-10 for licensed professional counselors, 18VAC115-50-10 for
104 licensed marriage and family therapists, or 18VAC115-60-10 for licensed substance abuse
105 treatment practitioners. An LMHP-R shall be in continuous compliance with the regulatory
106 requirements of the applicable counseling profession for supervised practice.

107 "LMHP-resident in psychology" or "LMHP-RP" means an individual in a residency, as that
108 term is defined in 18VAC125-20-10, for clinical psychologists. An LMHP-RP shall be in
109 continuous compliance with the regulatory requirements for supervised experience as found in
110 18VAC125-20-65.

111 "LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as
112 "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-S
113 shall be in continuous compliance with the regulatory requirements for supervised practice as
114 found in 18VAC140-20-50.

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

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

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

125 "Protected health information" or "PHI" as defined by 45 C.F.R. §160.103 means individually
126 identifiable health information that is: (i) transmitted by electronic media; (ii) maintained in
127 electronic media; or (iii) transmitted or maintained in any other form or medium. Protected health
128 information excludes individually identifiable health information: (i) in education records covered
129 by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) in records
130 described at 20 U.S.C.1232g(a)(4)(B)(iv); (iii) in employment records held by a covered entity in

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its role as employer; and (iv) regarding a person who has been deceased for more than 50 years.

"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. Experience may be substituted for education if the person has five years of paid experience in providing direction, development, and implementation, direct supervision, and monitoring to the service provided. QDDPs are responsible for approving assessments and individual service plans or treatment plans to ensure appropriate services are provided to meet the needs of individuals receiving services. The QDDP shall have documented experience developing, conducting, and approving assessments and individual service plans or treatment plans.

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

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

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

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

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

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

12VAC35-276-20. License required.

Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. The following services shall require a center-based license:

1. Center-based day support;

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2. Center-based respite;

3. Center-based therapeutic day treatment for children and adolescents;

4. Medication for opioid use disorder treatment;

5. Mental health intensive outpatient;

6. Mental health outpatient;

7. Mental health partial hospitalization;

8. Psychosocial rehabilitation;

9. Substance abuse intensive outpatient or Level of care 2.1;

10. Substance abuse outpatient or Level of care 1.0; and

11. Substance abuse partial hospitalization or Level of care 2.5.

12VAC35-276-30. Service descriptions.

A. Center-based day support services are for individuals with developmental disabilities that focus on enabling the individual to attain or maintain his highest potential level of functioning. Day support services shall offer opportunities for peer interaction and community integration and are designed to enhance the following: self-care and hygiene, eating, task learning, community resource utilization, environmental and behavioral skills, social skills, medication management, and transportation skills.

1. Providers of center-based day support services shall afford individuals receiving services opportunities to participate in community activities and to utilize community resources based on their personal interests or preferences. Services are provided to groups or individuals in nonresidential, community-based settings.

2. Center-based day support includes the following services:

a. Developing problem-solving abilities; sensory, gross, and fine motor control abilities; and communication and personal care skills;

b. Developing self, social, and environmental awareness skills;

c. Developing skills as needed in positive behavior, using community resources, community safety, and positive peer interactions, volunteering and participating in educational programs in integrated settings, and forming community connections or relationships;

d. Supporting older adults in participating in meaningful retirement activities in their communities, such as clubs and hobbies;

e. Skill-building and providing routine supports related to activities of daily living and instrumental ADLs;

f. Monitoring the individual's health and physical condition and providing supports with medication and other medical needs;

g. Providing safety supports in a variety of community settings;

h. Career planning and resume development based on career goals, personal interests, and community experiences; and

i. Providing routine supports and safety supports with transportation to and from community locations and resources.

B. Center-based therapeutic day treatment services for children and adolescents include assessment; interventions to build daily living skills or enhance social skills, care coordination; and individual, group, or family counseling. center-based TDT includes services provided within an office or clinic setting.

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C. Center-based respite services include providing for a short-term, time-limited period of care of an individual for the purpose of providing relief to the individual's family, guardian, or regular caregiver within a center-based setting. Persons providing respite care are recruited, trained, and supervised by a licensed provider. Providers who offer center-based respite services shall have both the service and the site licensed.

D. Medication for opioid use disorder treatment programs shall include services that treat substance use disorders using U.S. Food and Drug Administration approved medications in combination with counseling and behavioral therapies.

E. Mental health intensive outpatient services are provided within a highly structured clinical program provided on an hourly schedule. The program shall include 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 less intensive interventions than partial hospitalization programs but more intensive services than an outpatient service can provide. This service involves the use of multiple, concurrent interventions and treatment modalities.

1. Individuals receiving mental health intensive outpatient services shall be seeking primary treatment for a mental health diagnosis. Individuals may receive services for a co-occurring disorder at the same time. Individuals receiving mental health intensive outpatient services require a minimum of six hours per week for children or nine hours per week for adults, not to exceed a maximum of 19 service hours per week.

2. Mental health intensive outpatient services 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.

F. Mental health partial hospitalization includes time-limited active treatment interventions that are more intensive than intensive 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.

1. 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. These programs typically have direct access to psychiatric, medical, and laboratory services.

2. Individuals receiving mental health partial hospitalization services shall be seeking primary treatment for a mental health diagnosis. Individuals may receive services for a co-occurring disorder at the same time.

G. Mental health outpatient services include treatment provided on an hourly schedule used to sustain behavioral or emotional gains or to restore cognitive functional levels that have been impaired. Individuals receiving mental health outpatient services shall have a primary diagnosis of a mental health disorder. Mental health outpatient services shall include diagnosis and evaluation, screening and intake, and counseling, as defined in § 54.1-3500 of the Code of Virginia. Counseling may be individual counseling, family counseling, or group counseling.

1. Mental health outpatient services may include individual, family, or group counseling; psychotherapy; behavior management; psychological testing and assessment; laboratory and other ancillary services; medical services; and medication management.

2. Mental health outpatient services shall be for a maximum of six hours per week for children and nine hours per week for adults. Mental health outpatient services include services provided within a practitioner's office or a mental health clinic. Individuals

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receiving mental health outpatient services shall be seeking primary treatment for a mental health diagnosis. Individuals may receive services for a co-occurring disorder at the same time.

3. Mental health outpatient services shall not include practitioners who hold a license issued by a health regulatory board of the Department of Health Professions or who are exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601 or 54.1-3701 of the Code of Virginia.

H. Psychosocial rehabilitation services include a program of two or more consecutive hours per day provided to groups of individuals in a community setting who require a reduction of impairments due to a mental illness and restoration to the best possible functional level in order to remain in the community. The service provides a consistent, structured environment to restore an individual's ability to manage mental illness. The service provides education about mental illness, substance use disorders, and appropriate medication to avoid complication and relapse, and independent living skills. Services offered include peer support, vocational rehabilitation, community resource development, and training to use independent, social and interpersonal skills.

I. Substance abuse partial hospitalization includes short-term, non-residential interventions that are more intensive than intensive outpatient services. These services are a minimum of 20 hours per week of skilled treatment services. Services offered include individual and group counseling, medication management, family therapy, educational groups, and occupational and recreational therapy. Individuals receiving substance abuse partial hospitalization services shall have a primary diagnosis of a substance use disorder. Individuals receiving substance abuse partial hospitalization services shall be seeking primary treatment for a substance use disorder. Individuals may receive services for a co-occurring disorder at the same time. Providers of co-occurring enhanced programs shall comply with the provisions of 12VAC35-276-450.

J. Substance abuse intensive outpatient services include structured programming for 6-19 hours per week for children and 9-19 hours per week for adults, consisting primarily of counseling and education about addiction, mental illness, and recovery. Individuals receiving substance abuse intensive outpatient services shall be seeking primary treatment for a substance use disorder. Individuals receiving substance abuse intensive outpatient services shall have a primary diagnosis of a substance use disorder. Individuals may receive services for a co-occurring disorder at the same time. Providers of co-occurring enhanced programs shall comply with the provisions of 12VAC35-276-490.

K. Substance abuse outpatient services are addiction services provided in regularly scheduled sessions of not to exceed six hours per week for children or nine hours per week for adults. Individuals receiving substance abuse outpatient services shall be seeking primary treatment for a substance use disorder. Individuals may receive services for a co-occurring disorder at the same time. Providers of co-occurring enhanced programs shall comply with the provisions of 12VAC35-276-530. Outpatient services shall not include practitioners who hold a license issued by a health regulatory board of the Department of Health Professions or who are exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601 or 54.1-3701 of the Code of Virginia.

12VAC35-276-40. Screening.

A. Providers shall implement screening policies and procedures that include:

1. Identification, qualification, training, and duties of employees responsible for screening;

2. The following minimum required elements of screening for a center-based setting:

a. Date of contact;

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- b. Legal name, preferred name, date of birth, sex, and gender of the individual;
- c. Contact information including: address, telephone number, and email address of the individual, if applicable;
- d. Reasons why the individual is requesting services;
- e. Current reported diagnoses and medical conditions;
- f. Medical symptoms;
- g. Psychoactive or other medications currently being used, including recent increases, decreases, discontinuation, misuse, or overdose of prescription medication;
- h. Recent or current substance use or dependence including risk for intoxication or substance withdrawal; and
- i. Status of the individual including his referral to other services for further assessment, placement on a waiting list for services, or admission to the service.
3. Methods to identify other appropriate services for referral to assist individuals who are not admitted to the service after screening.
- B. The provider shall retain documentation of the individual's screening for six months. For individuals who are admitted to the service, documentation shall be included in the individual's record in accordance with 12VAC35-270-580.
- C. The provider shall review all elements of the screening at the time of initial assessment and update as necessary.
- 12VAC35-276-50. Assessments.**
- A. The provider shall implement a written assessment policy. The policy shall define how assessments will be conducted and documented.
- B. The provider shall actively involve the individual and the individual's authorized representative, if applicable, in the preparation of initial and comprehensive assessments. In these assessments, the provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.
- C. The assessment policy shall designate appropriately qualified employees or contractors who are responsible for conducting, obtaining, or updating assessments and medical screenings. These employees or contractors shall have experience in working with the needs of individuals who are being assessed, the assessment tools being utilized, and the provision of services that the individuals may require.
- D. Assessment is an ongoing activity. The provider shall make reasonable attempts to obtain previous assessments or relevant history. The provider shall use previous assessments or relevant history in order to complete an individual's initial or comprehensive assessment. The provider shall use previous assessments or relevant history within the course of treatment, if applicable.
- E. Providers shall utilize an assessment tool that meets the requirements in subsection F of this section for initial assessments, and subsection G of this section for comprehensive assessments. Providers may utilize a standardized state or federally sanctioned assessment tool that does not meet the criteria in these regulations if the tool is approved by the department prior to use.
- F. Providers shall conduct an individual's initial assessment prior to or at admission to the service. The provider shall complete, or obtain information from other qualified providers in order to complete, an initial assessment detailed enough to determine whether the individual qualifies for admission and to initiate an ISP for those individuals who are admitted to the service.

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1. The initial assessment shall assess immediate service, health, and safety needs and shall be conducted using an assessment tool that evaluates at a minimum the following criteria concerning the individual:

a. Diagnosis;

b. Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of needs;

c. Current medical issues;

d. Current medications;

e. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders;

f. At-risk behavior to self and others; and

g. Risk factors that may impact the individual's ability to seek treatment or continue to participate in services.

2. For individuals presenting with substance use disorders, at the time of the initial assessment the provider shall:

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

b. Assess substances used and time of last use.

3. The comprehensive assessment may be completed at the time of initial assessment if it includes all elements noted within subsection G of this section. In the event a comprehensive assessment is completed at the time of an initial assessment, the provider is not required to update the assessment unless a reassessment is medically or clinically indicated.

G. Providers shall conduct a comprehensive assessment for each individual who is admitted to the service. A comprehensive assessment shall update and finalize the initial assessment, unless the comprehensive assessment is completed at the time of initial assessment as provided in subdivision F 3 of this section.

1. Completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than (i) 30 days after admission for providers of mental health and substance abuse services and (ii) 60 days after admission for providers of developmental services.

2. The comprehensive assessment may be completed at the time of initial assessment only if it includes all elements enumerated in subdivision 3 of this subsection. In the event a comprehensive assessment is completed at the time of an individual's initial assessment, the provider is not required to update the assessment unless a reassessment is medically or clinically indicated.

3. The comprehensive assessment shall be conducted using an assessment tool that evaluates, at a minimum, the following criteria:

a. Onset and duration of needs;

b. Social, behavioral, developmental, and family history and supports;

c. Cognitive functioning including strengths and weaknesses;

d. Employment, vocational, and educational background;

e. Prior interventions and outcomes, including interventions and outcomes that were unsuccessful, with the provider utilizing previous assessments and relevant history to note prior interventions as required by subsection D of this section. Center-based respite providers are exempt from this requirement;

- 412 f. Overall financial situation, including resources, support and benefits, and whether
413 the individual has the means to meet his financial needs;
- 414 g. Health history and current medical care needs, to include:
415 (1) Allergies, including allergies to food and medications;
416 (2) Recent physical complaints and medical conditions;
417 (3) Nutritional needs;
418 (4) Chronic conditions;
419 (5) Communicable diseases;
420 (6) Restrictions on physical activities if any;
421 (7) Restrictive protocols or special supervision requirements;
422 (8) Past serious illnesses, serious injuries, and hospitalizations;
423 (9) Serious illnesses and chronic conditions of the individual's parents, siblings, and
424 significant others in the same household; and
425 (10) Current and past substance use including alcohol, prescription and
426 nonprescription medications, and illicit drugs.
- 427 h. Psychiatric and substance use issues including current mental health or substance
428 use needs, presence of co-occurring disorders, history of substance use or
429 dependence, and circumstances that increase the individual's risk for mental illness
430 or substance use issues;
- 431 i. History of abuse, neglect, sexual or domestic violence, or other trauma including
432 psychological trauma;
- 433 j. Legal competency including authorized representative, commitment, and
434 representative payee status;
- 435 k. Relevant criminal charges or convictions and probation or parole status;
- 436 l. Daily living skills;
- 437 m. Housing arrangements;
- 438 n. Ability to access services including transportation needs; and
- 439 o. As applicable, fall risk, communication needs, and mobility and adaptive
440 equipment needs.
- 441 H. The provider shall retain documentation of the individual's assessments in the individual's
442 record for a minimum of six years after the individual's discharge in accordance with § 54.1-
443 2910.4 of the Code of Virginia and its written records management policy in accordance with
444 12VAC35-270-580.
- 445 **12VAC35-276-60. Individualized services plan (ISP); service planning.**
- 446 A. The provider shall actively involve the individual and the individual's authorized
447 representative, as appropriate, in the development, review, and revision of a person-centered
448 ISP. The individualized services planning process shall be consistent with laws protecting
449 confidentiality, privacy, human rights of individuals receiving services, and rights of minors.
- 450 1. Providers of developmental services shall collaborate with the individual's planning
451 team to develop and implement the initial plan for supports, which is a component of the
452 comprehensive ISP, no later than 24 hours after admission. The initial plan for supports
453 shall address the individual's immediate health and safety needs for the first 60 days,
454 may include assessment activities, and shall continue in effect until the ongoing
455 comprehensive plan for supports is developed or the individual is discharged, whichever

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occurs first. An ongoing comprehensive plan for supports shall be completed within 60 days of admission.

2. Providers of mental health or substance abuse services shall develop and implement an initial person-centered ISP no later than 24 hours after admission. The initial ISP shall address the individual's immediate service, health, and safety needs for the first 30 days and shall continue in effect until the comprehensive ISP is developed or the individual is discharged, whichever occurs first. An ongoing comprehensive ISP based upon the nature and scope of services shall be completed as soon as possible, but no later than (i) 48 hours after admission by providers of short-term intensive services typically provided for less than 30 days or (ii) 30 days after admission.

B. If an individual has a case manager, informed choice shall be governed by the service-specific requirements governing case management providers (12VAC35-280). If the individual does not have a case manager, development of the initial ISP and the comprehensive ISP shall be based on the respective assessment with the participation and informed choice of the individual receiving services.

1. To ensure the individual's participation and informed choice, the following shall be explained to the individual or the individual's authorized representative, as applicable, in a reasonable and comprehensible manner:

a. The proposed services to be delivered;

b. Any alternative services that might be advantageous for the individual; and

c. Any accompanying risks or benefits of the proposed alternative services.

2. If no alternative services are available to the individual, it shall be clearly documented within the ISP or within documentation attached to the ISP, that alternative services were not available as well as the steps taken to identify alternative services.

3. Whenever there is a change to an individual's ISP it shall be clearly documented within the ISP or within documentation attached to the ISP that:

a. The individual participated in the development of or revision to the ISP;

b. The proposed and alternative services and their respective risks and benefits were explained to the individual or the individual's authorized representative; and

c. The reasons the individual or the individual's authorized representative chose the option included in the ISP.

12VAC35-276-70. ISP minimum requirements.

A. The initial ISP shall be based on the individual's immediate service, health, and safety needs identified in the initial assessment. The initial ISP shall include:

1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing needs and preferences documented within the individual's initial assessment, including documentation that the individual's needs and preferences are consistent with a center-based setting;

2. Services, supports, and frequency of services planned to accomplish the individual's goals, including relevant psychological, mental health, substance abuse, behavioral, developmental, medical, rehabilitation, training, and nursing needs and supports;

3. The role of the individual and others, including the individual's family, if appropriate, in implementing the initial ISP; and

4. Target dates for accomplishment of goals and objectives.

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B. The comprehensive ISP shall be based on the individual's needs, strengths, abilities, personal preferences, goals, and natural supports identified in the comprehensive assessment.

The comprehensive ISP shall include the following minimum provisions:

1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing each need documented within the individual's comprehensive assessment, including documentation that the individual's needs require a provider-operated center-based setting;

2. Services and supports required to accomplish the goals, including relevant psychological, mental health, substance abuse, behavioral, developmental, medical, rehabilitation, training, and nursing needs and supports;

3. The frequency at which services and supports must be provided to accomplish the individual's goals;

4. The role of the individual and others, including the individual's family, if appropriate, in implementing the comprehensive ISP;

5. A communication plan for individuals with communication barriers, including language barriers;

6. A behavioral support or treatment plan, if applicable;

7. A physical safety plan that addresses identified risks to the individual or to others, including a fall risk plan, if indicated by the individual's assessment;

8. A crisis or recovery plan, if applicable;

9. Target dates for accomplishment of goals and objectives;

10. Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies, if applicable;

11. A transportation plan, if applicable;

12. Services the individual elects to self-direct, if applicable; and

13. Projected discharge plan and estimated length of stay within the service.

C. Both the initial ISP and the comprehensive ISP shall be signed and dated, at a minimum, by (i) the person responsible for implementing the plan and (ii) the individual receiving services or the individual's authorized representative, if applicable, in order to document agreement.

1. If the signature of the individual receiving services or the individual's authorized representative cannot be obtained, the provider shall document attempts to obtain the necessary signature and the reason it was unobtainable. The provider shall attempt to obtain the necessary signature, on a periodic basis, while each ISP is in effect. An attempt to obtain the necessary signature shall occur at a minimum each time the provider reviews the ISP as required by 12VAC35-276-80 E.

2. Each ISP shall be distributed to the individual and others authorized to receive it prior to implementation. The provider shall document dates of the distribution within the individual's record.

D. The provider shall designate an employee or contractor who shall be responsible for developing, implementing, reviewing, and revising each individual's comprehensive ISP in collaboration with the individual or the individual's authorized representative, as appropriate.

E. Employees or contractors who are responsible for implementing the ISP shall maintain a working knowledge of the objectives and strategies contained in the individual's current ISP, including an individual's detailed health and safety protocols.

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1. Providers shall educate and train employees or contractors who are responsible for ISP implementation, based on the employee's or contractor's duties, on the objectives and strategies contained within the individual's current ISP.

2. When changes occur to an individual's ISP, the provider shall notify and train the appropriate employees or contractors who are responsible for ISP implementation, as applicable to their duties, for competency to implement the revised ISP.

3. After each training on the individual's current ISP, providers shall maintain documentation of the employee's or contractor's education, training, and competency as demonstrated through supervision.

F. When a provider provides more than one service to an individual, the provider may maintain a single ISP document that contains individualized objectives and strategies for each service provided.

G. Whenever possible, the identified goals in the ISP shall be written in the words of the individual receiving services.

H. The provider shall use signed and dated progress notes to document the implementation of the goals and objectives contained within the ISP.

I. A copy of the individual's most current ISP shall be readily accessible at the center where the individual receives services.

12VAC35-276-80. Reassessments and quarterly ISP reviews.

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

Reassessment shall include documentation justifying that the individual's needs continue to require a provider-operated center-based setting.

B. The provider shall actively involve the individual and the individual's authorized representative, if applicable, in reassessments. The provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

C. Providers shall revise the ISP, if the reassessment supports changes or if desired by the individual. If a reassessment does not support changes to the ISP, the provider shall document that no revisions are necessary and the reasoning.

D. If necessary as a result of a reassessment, providers shall complete changes to medical protocols or collaborate with other providers to ensure changes are made to medical, medical equipment, behavioral, or other corresponding protocols, if appropriate.

E. The provider shall complete quarterly reviews of the ISP in writing every three months from (i) the date of the implementation of the most recent comprehensive ISP or (ii) the most recent reassessment, whichever occurs later. Documentation of the quarterly ISP review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed. This subsection only applies to center-based respite services if the individual has utilized the service within the quarter.

F. The quarterly ISP review shall be conducted in a person-centered manner, to determine if services are being delivered as described within the ISP. The individual receiving services and the individual's authorized representative, if applicable, shall be included in the ISP review, to determine if the individual's treatment needs and preferences are being met and the individual is satisfied with the services provided.

1. A quarterly review of the ISP shall evaluate the individual's progress toward meeting the ISP's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made.

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2. A quarterly review of the ISP shall document evidence of progress toward or achievement of a specific targeted outcome for each goal and objective.

3. For goals and objectives that were not accomplished by the identified target date, or for which the individual did not demonstrate sufficient progress, the provider shall meet and collaborate with other service providers and support team members to review the reasons for lack of progress and provide the individual an opportunity to make an informed choice of how to proceed. The provider shall retain documentation of this meeting and the individual's informed choice within the individual's record.

4. A quarterly review of the ISP shall note:

a. the individual's family involvement, if any, in the individual's treatment;

b. whether the individual no longer needs the intensity of care provided within a center- based setting;

c. the individual's progress towards discharge; and

d. the status of the individual's discharge planning.

G. The provider shall ensure after each reassessment that the individual's most current ISP is easily accessible at the center at which the individual receives services.

12VAC35-276-90. Progress notes.

A. The documentation system implemented by the provider pursuant to subdivision E of 12VAC35-270-580 shall ensure that progress notes are (i) maintained in a consistent format that satisfies the minimum provisions of subsection B of this section and (ii) entered into the individual's record in accordance with the provider's record management policy.

B. The provider shall use signed and dated progress notes or other documentation to document the services provided to the individual. Progress notes shall at a minimum:

1. Be legible and readable;

2. Record the individual's interaction with the staff writing the progress note, including care provided and events relevant to diagnosis and treatment or care of the individual;

3. Provide a narrative or descriptive component;

4. Describe needed follow-up care or note which objective within the ISP will receive focus the next time the individual receives services; and

5. Be signed and dated by the staff member who rendered the service.

C. The provider shall document whether the individual no longer needs the intensity of care provided within a center-based setting.

D. Communication logs, information notes, and supervision notes shall not be considered progress notes.

12VAC35-276-100. Staffing.

A. For the purposes of this section, the term supervision shall mean the ongoing process performed by a direct supervisor who monitors the performance of direct care staff and provides regular documented consultation and instruction with respect to the skills and competencies of the direct care staff. Supervision may be delegated to an employee or contractor who meets the qualifications for supervision as defined within this section.

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

1. Supervisors of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature, such as outpatient or day treatment, shall be a licensed mental health professional or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions.

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2. Supervisors of mental health, substance abuse, or co-occurring services that are of a supportive or maintenance nature, such as psychosocial rehabilitation, shall be a QMHP, a licensed mental health professional, or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions. A QMHP-T may not provide this type of supervision.

3. Supervisors of developmental services who are responsible for ensuring appropriate services are provided to meet the needs of individuals who have developmental disabilities shall have documented experience developing, conducting, and approving (i) assessments and ISPs or (ii) treatment plans. The experience shall meet the requirements enumerated in the supervisor's job description required by 12VAC35-270-270.

C. Center-based day support providers shall meet the following staffing requirements:

1. Have a QDDP.

2. Have additional staff sufficient in number and expertise to meet the needs of the individuals receiving services.

D. Mental health partial hospitalization providers shall meet the following staffing requirements:

1. A board-certified or board-eligible psychiatrist shall provide services for individuals age 14 and older. For providers serving children under the age of 14, the psychiatrist must be a board- certified or board-eligible child and adolescent psychiatrist.

2. Have a licensed nurse practitioner.

3. Have a licensed mental health professional.

4. Have a peer recovery specialist (PRS) certified in accordance with 12VAC35-250.

5. Staff shall be cross-trained to understand mental illness; to recognize signs and symptoms of substance use disorders; and to explain the uses of psychotropic medications and the interactions substance use and other addictive disorders have on mental illness.

6. Individual, group, and family therapy and crisis intervention shall be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.

7. Health literacy counseling or psychoeducational interventions shall be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S; a nurse practitioner or physician assistant; an occupational therapist, or a registered nurse (RN) or licensed practical nurse (LPN) with at least one year of clinical experience.

8. Crisis treatment shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, or QMHP-T.

9. Skills restoration, skills development, and care coordination shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, or QMHP-T.

E. Mental health intensive outpatient providers shall meet the following staffing requirements:

1. Have a clinical director who shall be a licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or a licensed marriage and family therapist.

2. Have a physician, nurse practitioner, or physician assistant.

3. Have a licensed mental health professional.

4. Have a QMHP.

5. Have a peer recovery specialist certified in accordance with 12VAC35-250.

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6. Staff shall be cross-trained to understand mental illness; to recognize signs and symptoms of substance use disorders; and to explain the uses of psychotropic medications and the interactions substance use and other addictive disorders have on mental illness.

7. Staffing ratios shall not exceed one staff member for every five individuals receiving services. The ratio for clinical supervision of staff shall not exceed one supervisor for six direct care workers. This provision shall not supersede 12VAC35-270-300.

8. Staff shall have education, training, and experience working with individuals receiving services, including diagnosis and age and in providing the services outlined in the service description.

9. Individual, group, and family therapy shall be provided by a LMHP LMHP-R, LMHP-RP, or LMHP-S.

10. Skills restoration, skills development, crisis treatment, and care coordination shall be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S, QMHP, or QMHP-T.

11. Health literacy counseling and psychoeducation interventions shall be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S; a nurse practitioner or physician assistant; an occupational therapist; or an RN or LPN with at least one year of clinical experience.

F. Mental health outpatient providers shall meet the following staffing requirements:

1. Have a LMHP, LMHP-R, LMHP-RP, or LMHP-S who shall conduct an intake interview with the individual, record medical history, conduct an intake assessment, record a diagnosis, and develop the ISP.

2. Have staff sufficient to fulfill the services described within the provider's service description.

G. Opioid treatment providers shall meet the following staffing requirements:

1. Have a program sponsor, program director, medical director, and pharmacist who meet the credential requirements of 12VAC35-276-210 E.

2. Have nurses and counselors who meet the credential requirements of 12VAC35-276-210 E.

3. Personnel shall be sufficient in number and expertise to provide support services.

4. Linkage or access to psychological, psychiatric, and medical consultation shall be available.

H. Psychosocial rehabilitation providers shall meet the following staffing requirements:

1. A LMHP, LMHP-R, LMHP-RP, or LMHP-S shall conduct a comprehensive assessment.

2. Services shall be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S; a QMHP or QMHP-T; or a QPPMH under the supervision of a QMHP or LMHP.

3. A LMHP, LMHP-R, LMHP-RP, or LMHP-S shall review services provided to an individual for longer than six months to determine and document the continued need for the service.

I. Substance abuse partial hospitalization providers shall meet the following staffing requirements:

1. Have an interdisciplinary team of addiction treatment professionals, which may include counselors, psychologists, social workers, or addiction-credentialed physicians. Physicians treating individuals in this level shall have specialty training or experience in addiction medicine.

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2. Have staff able to obtain and interpret information regarding the individual's biopsychosocial needs.

3. Program staff shall be trained to understand the signs and symptoms of mental illness and to explain the uses of psychotropic medications and their interactions with substance-related disorders.

4. All clinical staff shall be qualified by training and experience and appropriately credentialed by the applicable health regulatory board to serve individuals admitted to the service.

J. Substance abuse intensive outpatient services shall meet the following staffing requirements:

1. Have an interdisciplinary team of appropriately credentialed addiction treatment professionals, which may include counselors, psychologists, social workers, or addiction-credentialed physicians. Physicians shall have specialty training or experience in addiction medicine or addiction psychiatry.

2. Have program staff able to obtain and interpret information regarding the individual's biopsychosocial needs.

3. Program staff shall be trained to understand the signs and symptoms of mental illness and to explain the uses of psychotropic medications and their interactions with substance use and other addictive disorders.

4. All clinical staff shall be qualified by training and experience and appropriately credentialed by the applicable health regulatory board to serve individuals admitted to the service.

K. Substance abuse outpatient providers shall meet the following staffing requirements:

1. Have appropriately credentialed treatment professionals who assess and treat substance-related mental and addictive disorders.

2. Have program staff capable of monitoring stabilized mental health problems and recognizing any instability of individuals with co-occurring mental health conditions.

3. A licensed independent practitioner with prescribing authority shall provide medication management.

4. All clinical staff shall be qualified by training and experience and appropriately credentialed by the applicable health regulatory board to serve individuals admitted to the service.

L. Center-based TDT providers for children and adolescents shall meet the following staffing requirements:

1. Have a licensed clinician or a LMHP, LMHP-R, LMHP-RP, or LMHP-S.

2. Have a QMHP.

M. Center-based respite providers shall meet the following staffing requirements:

1. Have a QDDP.

2. Staff shall meet the qualification requirements of 12VAC35-270-280.

12VAC35-276-110. Health care policy.

A. The provider shall implement a policy that addresses provision of adequate and appropriate medical and dental care. This policy shall describe to what extent and how:

1. Medical and dental care needs will be assessed and the circumstances that will prompt the decision to obtain a medical assessment.

2. ISPs will address any medical and dental care needs appropriate to the scope and level of service.

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3. The provider will provide or arrange for, or support the individual with, the provision of medical and dental care needs identified at admission.

4. The provider will provide, arrange, or support the individual with the provision of routine, ongoing, and follow-up medical and dental care services after admission.

5. The provider will communicate the results of physical examinations, medical assessments, diagnostic tests, treatments, or examinations conducted by the provider to the individual and the individual's authorized representative, as appropriate.

6. The provider will keep accessible to staff and contractors on duty the names, addresses, and telephone numbers of the individual's medical and dental providers.

7. The provider will ensure a means for facilitating and arranging, as appropriate, transportation to medical and dental appointments and medical tests.

8. The provider will ensure the provision of emergency medical services for each individual.

B. The provider shall identify any individuals who are at risk for falls and develop and implement a fall prevention and management plan and program for each at-risk individual.

C. The provider shall implement written infection control measures including the use of universal precautions.

D. The provider shall report outbreaks of infectious diseases to the Department of Health pursuant to § 32.1-37 of the Code of Virginia.

E. All employees, contractors, students, or volunteers in substance abuse outpatient services shall receive tuberculosis education as part of initial orientation and thereafter on an annual basis. The education shall focus on self-presentation in the event of exposure to active tuberculosis or the development of symptoms of active tuberculosis disease.

12VAC35-276-120. Emergency preparedness and response plan.

A. The scope of emergency preparedness in relation to this section applies to disasters and emergencies as defined by § 44-146.16 of the Code of Virginia.

B. The provider shall develop a written emergency preparedness and response plan for all of its services and locations. This plan shall include specifics for each location and shall include the following:

1. An analysis and prioritization of vulnerability of all services and locations to various hazards that may impact the provider. Vulnerability is a combination of the likelihood and severity of hazard occurrence.

2. A base-level response plan that is applicable to all hazards and includes:

a. Documentation of preparedness activities such as emergency planning team meetings, incident reviews, plan revisions, etc.

b. Maintenance of a 24-hour phone line which can be used for communication during emergencies.

c. Documented procedure for activation of the emergency plan including a description of various triggers for activation, who may activate, and overall situation assessment, response escalation, situation stabilization, and life and property preservation as first priority during any response.

d. Documented procedure to notify the department of activation of the emergency plan as soon as possible, but no later than 24 hours after incident occurrence.

e. Documented policies, outlining specific responsibilities for incident command and the necessary incident management team including operations, logistics, planning and finance.

- 819 f. Documented policies and procedures to ensure, to the extent possible, the life safety
820 of employees, contractors, volunteers, visitors, and individuals served.
- 821 g. Policy and procedures for building access and security to include both provision of
822 a secure building under adverse circumstances and appropriate access to the building
823 by emergency responders.
- 824 h. Documented policies and procedures for the resumption of normal activities
825 following service disruption by and emergency including any necessary site
826 inspections required before repatriation can take place.
- 827 i. Documented identification, consideration and mitigation activities related to high-
828 priority vulnerabilities as identified by a vulnerability analysis.
- 829 3. An evacuation plan that includes:
- 830 a. Documented, current consideration of local and regional sites that could function
831 as evacuation locations or stop-over points, including documentation of any
832 arrangements the provider has made with such sites.
- 833 b. Policy and procedures for executing an evacuation or relocation of individuals
834 receiving services to include individual and staff location tracking and preservation of
835 all critical services (pharmacy, feeding, etc.).
- 836 c. Policy and procedures for handling personal health information during an
837 evacuation or relocation, when necessary, to ensure the PHI is both properly
838 secured and accessible at the new location or by new service providers to allow for
839 proper continuity of care.
- 840 C. The provider shall develop a written communication plan detailing:
- 841 1. The process for notifying local and state authorities of an emergency, including the
842 department.
- 843 2. The process for notifying and communicating with employees, contractors, volunteers,
844 and community responders during emergencies.
- 845 3. The process for warning, notifying, and communicating with individuals receiving
846 services.
- 847 4. The process for notifying and communicating with family members or authorized
848 representatives during emergencies.
- 849 D. The provider shall develop a written Continuity of Operations Plan detailing:
- 850 1. Delegation of authority under emergency conditions.
- 851 2. Succession planning for emergency conditions including in the event of the license
852 holder's death or incapacitation as required by subsection B 1 of 12VAC35-270-40.
853 Community service boards are not required to have a succession plan.
- 854 3. Indication of which services are critical to the health and well-being of the individuals
855 being served and therefore must be continued; services less critical that may be
856 delayed; ancillary services that may be discontinued during emergency circumstances;
857 and triggers with regard to the continuity of these services.
- 858 4. Documented plans for continuity of activities related to the provision of care,
859 treatment, and services including scheduling, modifying, or discontinuing services; PII
860 and PHI access and security; providing medication; and transportation services.
- 861 5. Contingency planning for supply chain disruptions of critical supplies such as
862 pharmaceuticals, food, water, toiletries, linens, and any other supplies required for
863 subsistence.

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E. The provider shall maintain documentation of outreach to local emergency officials to include local emergency managers at least annually.

F. The provider shall implement annual emergency preparedness and response training for all employees, contractors, students, and volunteers pursuant to 12VAC35-270-290. This training shall also be provided during the onboarding of new employees. This training shall include:

1. Activation and notification for the emergency plan;
2. Evacuation procedures that include consideration of individuals with medical, functional, and access needs;
3. Use, maintenance, and operation of any emergency equipment;
4. Medical record stewardship during emergencies; and
5. Utilization of community support services in emergencies.

G. The provider shall document review of the emergency preparedness plan and continuity of operations plan annually and make necessary revisions. Such revisions shall be (i) communicated to employees, contractors, students, volunteers, and individuals receiving services and (ii) incorporated into training for employees, contractors, students, and volunteers and into the orientation of individuals to services.

H. The provider shall schedule for testing the implementation of the emergency preparedness plan and conducting emergency preparedness drills. A fire, evacuation, or emergency medical drill shall be conducted at least once a month on a schedule that ensures that a fire, evacuation, and emergency medical drill shall be conducted at least quarterly.

12VAC35-276-130. Food service and nutrition.

A. Any location where the provider is responsible for preparing or serving food shall request inspection and shall obtain approval by state or local health authorities regarding food service and general sanitation at the time of the original application and annually thereafter in accordance with Food Regulations (12VAC5-421). Documentation of the most recent inspection and approval shall be kept on file.

B. A provider preparing and serving food shall implement a service protocol for the provision of food services that ensures access to nourishing, well-balanced, varied, and healthy meals; which shall, at a minimum:

1. Ensure the provider learns through reasonable efforts to consider the cultural background, personal preferences, religious requirements, and food habits of the individuals receiving services and prepares meals in a manner that considers these preferences; and
2. Lists steps staff shall take to assist individuals who require assistance feeding themselves in a manner that effectively addresses any deficits while maintaining the dignity of individuals.

C. Providers shall implement protocols to monitor each individual's food consumption and nutrition for:

1. Warning signs of changes in physical or mental status related to nutrition; and
2. Compliance with any needs determined by the ISP or prescribed by a physician, nutritionist, or health care professional.

12VAC35-276-140. Laundry areas.

A. Appropriate space and equipment in good repair shall be provided if laundry is done at the location.

B. For all services in which it is appropriate:

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1. An adequate quality of clean linens shall be available at all times to provide for proper care and comfort of individuals receiving services.

2. Linens and other laundry must be handled, stored, and processed to control the spread of infection.

3. Clean linens shall be stored in a clean and dry area accessible to staff.

4. Soiled linens shall be stored in covered containers in separate, well-ventilated areas and shall not accumulate.

5. Soiled linen shall not be sorted, laundered, rinsed, or stored in bathrooms, kitchens, or food storage areas.

6. Arrangements for laundering individuals' personal clothing shall be provided. If laundry facilities are not provided on premises, commercial laundry services shall be utilized.

12VAC35-276-150. Building inspection and classification.

All locations shall be inspected and approved as required by the appropriate building regulatory entity. Documentation of approval shall be a Certificate of Use and Occupancy indicating the building is classified for its proposed licensed purpose. The provider shall submit a copy of the Certificate of Use and Occupancy to the department for new locations.

12VAC35-276-160. Physical environment.

A. The physical environment, design, structure, furnishings, and lighting shall be appropriate to the individuals receiving services and the services provided.

B. The physical environment shall be accessible to individuals with physical or sensory disabilities, if applicable.

C. The exterior and interior physical environment and furnishings shall be kept clean and in good repair to (i) protect against dust, dirt, mold, or transmission of disease, and (ii) prevent the entrance or harboring of insects, rodents, vermin, and other pests. Exterior and interior furnishings shall be dry, free of foul odors, safe, and well-maintained.

D. Floor surfaces and floor coverings shall promote mobility in areas used by individuals and shall promote maintenance of sanitary conditions. There shall be clear pathways through the service setting, free of tripping hazards, to ensure that all individuals can move about the setting safely. Any electrical cords, extension cords, or power strips utilized by the provider shall be properly secured and shall not be placed anywhere that the cord or strip can cause trips or falls.

E. Unless otherwise mandated by state or federal authorities, heat shall be evenly distributed in all rooms occupied by individuals such that a temperature no less than 68°F is maintained. Natural or mechanical ventilation to the outside shall be provided in all rooms used by individuals receiving services. Individual or mechanical ventilating systems shall be provided in all rooms occupied by individuals receiving services when the temperature in those rooms exceeds 80°F.

F. Plumbing shall be maintained in good operational condition. Adequate hot and cold running water of a safe and appropriate temperature shall be available. Hot water accessible to individuals receiving services shall be maintained within a range of 100° to 120° F. The provider shall take precautions to prevent scalding from running water.

G. Adequate provision shall be made for the collection and legal disposal of garbage and waste materials.

H. If smoking is permitted, the provider shall make provisions for alternate smoking areas that are separate from the service environment.

I. For all program areas added after September 19, 2002, minimum room height shall be 7-1/2 feet.

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J. All provider locations shall have an appropriate number of properly installed smoke detectors based on the size of the location, which shall include at a minimum:

1. At least one smoke detector on each level of multi-level buildings, including the basement; and

2. Any additional smoke detectors necessary to comply with all applicable federal and state laws and regulations and local ordinances.

K. Smoke detectors shall be tested monthly for proper operation.

12VAC35-276-170. Building and grounds.

A. The interior and exterior of all buildings shall be safe, properly maintained, clean, and in good working order. This includes required locks, mechanical devices, indoor and outdoor equipment, recreational spaces, and furnishings.

B. The provider shall implement policies for infrastructure concerns including building and site maps to shut off utilities when necessary.

12VAC35-276-180. Building modifications.

The provider shall submit a plan to the department addressing safety and continued service delivery for any planned construction involving (i) changes in the use of existing locations or (ii) structural modifications to new or existing buildings.

12VAC35-276-190. Sewer and water inspections.

A. Service locations shall be on a public water and sewage system or on a nonpublic water and sewage system. Prior to a location being licensed, the provider shall obtain the report from the building inspector pertaining to the sewage disposal system and its capacity. Nonpublic water and sewer systems shall be maintained in good working order and in compliance with local and state laws.

B. Service locations that are not on a public water system shall have a water sample tested by an accredited, independent laboratory for the absence of coliform (i) prior to being licensed and (ii) on an annual basis thereafter. The water sample shall also be tested for lead or nitrates if recommended by the local health department. Documentation of the three most recent test samples shall be kept on file.

12VAC35-276-200. (Reserved.).

Part II

Additional Requirements for Medication for Opioid Use Disorder Treatment Providers

12VAC35-276-210. 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 use as an office and compatible with 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:

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- 1002 1. The proposed site complies with the requirements of the local building regulatory
1003 entity;
- 1004 2. The proposed site complies with local zoning laws or ordinances, including any
1005 required business licenses;
- 1006 3. In the absence of local zoning ordinances, the proposed site is suitable for use as
1007 offices and compatible with the delivery of health care services;
- 1008 4. In jurisdictions where there are no parking ordinances, the proposed site has sufficient
1009 off-street parking to accommodate the needs of the individuals receiving services and
1010 prevent the disruption of traffic flow;
- 1011 5. The proposed site can accommodate individuals during periods of inclement weather;
- 1012 6. The proposed site complies with the Virginia Statewide Fire Prevention Code; and
- 1013 7. The applicant has a written plan to ensure security for storage of methadone at the
1014 site, which complies with regulations of the U.S. Drug Enforcement Agency (DEA), and
1015 the Virginia Board of Pharmacy.

1016 E. Applicants shall submit information to demonstrate that there are sufficient personnel
1017 available to meet the following staffing requirements and qualifications:

- 1018 1. The program sponsor means the person named in the application for licensing and
1019 shall have relevant training or experience in the treatment of individuals with opioid
1020 addiction.
- 1021 2. The program director or manager shall be licensed or certified by the applicable
1022 Virginia health regulatory board or registered as eligible for this license or certification
1023 with relevant training or experience in the treatment of individuals with opioid addiction.
- 1024 3. The medical director shall be a physician licensed to practice medicine in the
1025 Commonwealth of Virginia with relevant training or experience in the treatment of
1026 individuals with opioid addiction.
- 1027 4. A minimum of one health care professional who is appropriately licensed by the
1028 Commonwealth of Virginia to prescribe and dispense medications for opioid use
1029 disorders.
- 1030 5. A minimum of one registered nurse (RN) to supervise a nursing staff of licensed
1031 practical nurses (LPNs), sufficient in number to meet the needs and number of
1032 individuals served.
- 1033 6. Counselors shall be licensed or certified by the applicable Virginia health regulatory
1034 board or eligible for this license or certification.
- 1035 7. Personnel to provide support services which shall include at least one security guard.
- 1036 8. Have linkage with or access to psychological, medical, and psychiatric consultation.
- 1037 9. Have access to emergency medical, psychological, and psychiatric care through
1038 affiliations with providers of more intensive levels of care.
- 1039 10. Have the ability to conduct or arrange for appropriate laboratory and toxicology tests.
- 1040 11. Ensure all clinical staff, whether employed by the provider or available through
1041 consultation, contract, or other means, are qualified by training and experience and
1042 appropriately licensed, certified, or registered by the appropriate health regulatory board
1043 to serve individuals admitted to the service.
- 1044 12. All staff shall be trained in first aid, CPR, and naloxone administration.

1045 F. The applicant may provide peer recovery specialists. A PRS shall be professionally
1046 qualified by education and experience in accordance with 12VAC35-250. A registered peer
1047 recovery specialist shall be a PRS registered with the Board of Counseling in accordance with

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1048 18VAC115-70 and provide such services as an employee or independent contractor of the
1049 Department, a provider licensed by the Department, a practitioner licensed by or holding a
1050 permit issued from the Department of Health Professions, or a facility licensed by the
1051 Department of Health.

1052 G. If there is a change in or loss of any staff in the positions listed in subsections E 1-4 of
1053 this section, the department requires written notification and a plan for immediate coverage
1054 within one week.

1055 H. Applicants shall submit written job descriptions for positions in subsection E of this
1056 section that reflect, at a minimum, the following responsibilities:

1057 1. The program sponsor shall be responsible for the operation of the medication for
1058 opioid use disorder treatment program and shall assume responsibility for all its
1059 employees, including any practitioners, agents, or other persons providing medical,
1060 behavioral health, or social services services at the program at any of its medication
1061 units. The program sponsor is responsible for ensuring the program is in continuous
1062 compliance with all federal, state, and local laws and regulations.

1063 2. The program director shall be responsible for the day-to-day management of the
1064 program.

1065 3. The medical director shall be:

1066 a. Responsible for ensuring all medical and behavioral health services offered by the
1067 medication for opioid use disorder treatment provider are conducted in compliance
1068 with federal regulations at all times; and

1069 b. Physically present at the program at least one hour per week for every 50 enrolled
1070 individuals receiving services to ensure regulatory compliance and carry out those
1071 duties specifically assigned to the medical director.

1072 4. Counselors shall be responsible for primary caseloads that are determined based on
1073 the specific needs of the individuals receiving services. Programs shall allow individuals
1074 access to the primary counselor more frequently if needed or requested by the
1075 individual. The ratio of full-time equivalent counselors to individuals receiving services
1076 shall not exceed one to 50.

1077 I. Applicants shall submit a description for the proposed service that includes:

1078 1. Proposed mission, philosophy, and goals of the provider;

1079 2. Care, treatment, and services to be provided, including a comprehensive discussion
1080 of levels of care provided and alternative treatment strategies offered;

1081 3. Proposed hours and days of operation;

1082 4. Plans for onsite security and services adequate to ensure the safety of patients, staff,
1083 and property; and

1084 5. A diversion control plan for dispensed medications, including policies for use of drug
1085 screens.

1086 J. In addition to the requirements of 12VAC35-270-480 C 2, applicants shall provide
1087 documentation of their capability to provide the following services and support, directly or by
1088 arrangement with other specified providers, when such services and supports are (i) requested
1089 by an individual receiving services or (ii) identified as an individual need based on the
1090 assessment conducted in accordance with 12VAC35-276-50 and included in the individualized
1091 services plan:

1092 1. General services,

1093 a. Medical;

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- 1094 b. Counseling;
1095 c. Social;
1096 d. Vocational;
1097 e. Educational, including HIV/AIDS education and other health education services;
1098 and
1099 f. Employment.
- 1100 2. Initial medical examination services.
1101 3. Special services for pregnant patients.
1102 4. Initial and periodic, individualized, patient-centered assessment and treatment
1103 services.
1104 5. Drug abuse testing services.
1105 6. Case management services, including medical monitoring and coordination, with
1106 onsite and offsite treatment services provided as needed.
- 1107 K. Applicants shall submit documentation of contact with community services boards or
1108 behavioral health authorities in their service areas to discuss their plans for operating in the area
1109 and to develop joint agreements, as appropriate.
- 1110 L. Applicants shall provide policies and procedures that address assessment,
1111 administration, and regulation of medication including dose levels appropriate to the individual.
1112 The policies and procedures shall at a minimum require that each individual receiving services
1113 be assessed every six months by the treatment team to determine if that individual is
1114 appropriate for safe and voluntary medically supervised withdrawal from opioid analgesics,
1115 including methadone or buprenorphine, alternative therapies including other medication-
1116 assisted treatments (MATs), or continued federally approved pharmacotherapy treatment for
1117 opioid addiction.
- 1118 M. Applicants shall submit policies and procedures describing services the applicant will
1119 provide to individuals who wish to discontinue medication for opioid use disorder treatment
1120 services.
- 1121 N. Applicants shall provide assurances that the service will have a community liaison
1122 responsible for developing and maintaining cooperative relationships with community
1123 organizations, other service providers, local law enforcement, local government officials, and the
1124 community at large.
- 1125 O. The department shall conduct announced and unannounced reviews and complaint
1126 investigations in collaboration with the Virginia Board of Pharmacy and DEA to determine
1127 compliance with the regulations.
- 1128 **12VAC35-276-220. Registration, certification, or accreditation.**
- 1129 A. The medication for opioid use disorder treatment program shall maintain current
1130 registration or certification with:
- 1131 1. The federal Drug Enforcement Administration;
1132 2. The federal Department of Health and Human Services; and
1133 3. The Virginia Board of Pharmacy.
- 1134 B. A provider of medication for opioid use disorder treatment shall maintain accreditation
1135 with an entity approved under federal regulations.
- 1136 **12VAC35-276-230. Criteria for patient admission.**
- 1137 A. Before a medication for opioid use disorder treatment provider may admit an individual,
1138 the individual shall meet the criteria for admission as defined by the provider's policies. The
1139 provider's policy regarding admission shall at a minimum require the individual to (i) meet

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1140 diagnostic criteria for opioid use disorder as defined within the DSM; and (ii) meet the admission
1141 criteria of Level 1.0 of ASAM. The policies shall be consistent with subsections B through D of
1142 this section.

1143 B. A medication for opioid use disorder treatment provider's qualified personnel shall assess
1144 individuals to determine if the individuals are appropriate for treatment by applying established
1145 diagnostic criteria, documented in the program's procedures.

1146 C. A medication for opioid use disorder treatment provider shall maintain current procedures
1147 designed to ensure that individuals are admitted to maintenance treatment by qualified
1148 personnel who have determined, using accepted medical criteria, that the person currently has
1149 an addiction to an opioid drug. In addition, an opioid treatment practitioner shall ensure that
1150 each individual voluntarily chooses maintenance treatment, that all relevant facts concerning the
1151 use of the opioid drug are clearly and adequately explained to the individual, and that each
1152 individual provides informed written consent to treatment.

1153 D. No individual under 18 years of age may be admitted to maintenance treatment without
1154 written consent from a parent, legal guardian, or responsible adult designated by the relevant
1155 state authority.

1156 **12VAC35-276-240. Involuntary termination from treatment.**

1157 A. The provider shall establish criteria for involuntary termination from treatment that
1158 describe the rights of the individual receiving services and the responsibilities and rights of the
1159 provider.

1160 B. The provider shall establish a complaint procedure as part of the rights of the individual.

1161 C. On admission, the individual shall be given a copy of the criteria and shall sign a
1162 statement acknowledging receipt of same. The signed acknowledgement shall be maintained in
1163 the individual's service record.

1164 **12VAC35-276-250. Criteria for patient discharge.**

1165 Before a medication for opioid use disorder treatment provider discharges or transfers an
1166 individual, the individual shall meet the criteria for discharge or transfer as defined by the
1167 provider's policies. The discharge policies shall include provisions for the discharge or transfer
1168 of individuals who have:

1169 1. Achieved the goals of the treatment services and no longer require medication for
1170 opioid use disorder treatment level of care;

1171 2. Been unable to achieve the goals of the individual's treatment but could achieve the
1172 individual's goals with a different type of treatment; or

1173 3. Achieved the individual's original treatment goals but have developed new treatment
1174 challenges that can only be adequately addressed in a different type of treatment.

1175 **12VAC35-276-260. Operating schedule.**

1176 A. The service's days of operation shall meet the needs of the individuals receiving services.
1177 If the service dispenses or administers a medication requiring daily dosing, the service shall
1178 operate seven days a week, 12 months a year, except for official state holidays. Prior approval
1179 from the state methadone authority shall be required for additional closed days.

1180 B. The service shall remain open on Sundays unless the following criteria are met:

1181 1. The provider develops and implements policies and procedures that address (i)
1182 recently inducted individuals receiving services; (ii) individuals not currently on a stable
1183 dose of medication; (iii) individuals who present noncompliant treatment behaviors; (iv)
1184 individuals who previously picked up take-home medications on Sundays, (v) security of
1185 take-home medication doses in accordance with the provisions of 12VAC35-276-310;
1186 and (vi) the overall health and safety of individuals receiving services.

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

3. If approved, 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 individuals' 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 regular business hours of 9 a.m. until 5 p.m. The SOTA may approve an alternative schedule that meets the needs of the population served.

12VAC35-276-270. Initial and periodic assessment services.

A. The provider shall require each individual to undergo an initial medical examination. The initial medical examination is comprised of two parts:

1. A screening examination to ensure the individual meets the criteria for admission in accordance with 12VAC35-276-230 and that there are no contraindications to treatment with medication for opioid use disorder; and

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

B. Both the screening examination and the full history and examination shall be completed by an appropriately licensed practitioner. When the examination is performed outside of the provider's service:

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

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

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

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

F. An evaluation of an individual for treatment shall occur in person or use audio-visual telemedicine platforms. When not available, a provider may use audio-only devices, but only when the individual is in the presence of a licensed practitioner who is registered to prescribe and dispense controlled medications. The licensed practitioner shall document being physically

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1235 present during the audio-only evaluation through signature in the individual's record. The
1236 provider's physician shall review the initial medical examination results and order MOUD as
1237 indicated.

1238 G. A complete physical examination shall be conducted annually, or more frequently if there
1239 is a change in the individual's physical or mental condition.

1240 H. Qualified personnel shall review a consent-to-treatment form with the individual and shall
1241 document informed written consent prior to the individual receiving the first dose of MOUD.

1242 I. As a condition of admission and annually thereafter, all individuals shall sign an
1243 authorization for disclosure of information to allow programs access to the Virginia Prescription
1244 Monitoring Program (PMP) (§ 54.1-2519 et seq. of the Code of Virginia). Programs shall run a
1245 PMP report at admission, every quarter, and more frequently as needed. The program physician
1246 shall provide this report. The reports shall be marked "DO NOT DUPLICATE" and stored in
1247 each individual's file in accordance with the provisions of 12VAC35-270-580.

1248 J. The program shall implement a policy with the following minimum provisions to ensure
1249 coordination of care with prescribing physicians:

1250 1. The provider shall coordinate treatment services for individuals who are prescribed
1251 benzodiazepines and prescription narcotics with its treating physician.

1252 2. The coordination shall be the responsibility of the provider's treating physician and
1253 shall be documented.

1254 K. On admission, all individuals shall be offered testing for HIV/AIDS, viral hepatitis, and
1255 other sexually transmitted infections. The individual may sign a notice of refusal without
1256 prejudice. The individual shall be certified as tuberculosis (TB) free upon admission and
1257 annually by a qualified licensed professional.

1258 **12VAC35-276-280. Special services for pregnant individuals.**

1259 A. The program shall ensure that every pregnant woman has the opportunity for prenatal
1260 care, prenatal education, and postpartum follow-up, either:

1261 1. Onsite; or

1262 2. By referral to appropriate healthcare providers.

1263 B. The program shall provide or make referrals to pregnant individuals for resources on:

1264 1. Breastfeeding;

1265 2. Basic infant development and child care;

1266 3. Neonatal abstinence syndrome;

1267 4. Dangers of continued illicit substance abuse on the developing fetus;

1268 5. Parenting skills; and

1269 6. Family planning.

1270 C. The program shall document all attempts and refusals to get the individual to comply with
1271 prenatal care. If prenatal care is not available onsite, or the pregnant woman refuses care or
1272 referral, the program shall offer basic prenatal instruction on:

1273 1. Maternal care;

1274 2. Physical care;

1275 3. Diet and nutrition;

1276 4. Care coordination with the OB/GYN, specifically to address pain management needs
1277 for post-delivery;

1278 5. Risks of not seeking prenatal care; and

1279 6. A resource list of prenatal care providers and hospitals.

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D. When providing medication use for women who are pregnant, opioid-addicted, and in opioid treatment, the program shall:

1. Maintain women who become pregnant during treatment on their pre-pregnancy dosage, if effective, and apply the same dosing principles as used with any other woman who is not pregnant.

2. Ensure the initial methadone dose and the subsequent induction and maintenance dosing strategy for a woman who is newly admitted and pregnant reflect the same effective dosing protocol used for all other individuals receiving services.

3. Monitor the methadone dose carefully, especially during the third trimester.

4. Ensure that if a pregnant woman elects to withdraw from methadone:

a. A physician experienced in addiction medicine supervises the withdrawal process; and

b. Regular fetal assessments, as appropriate for gestational age, are part of the withdrawal.

12VAC35-276-290. Counseling sessions.

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

B. The provider shall offer face-to-face counseling sessions (either individual, group, or family) at a frequency tailored to each individual based on an individualized assessment and the individual's care plan that was created after shared decision-making between the individual and the clinical team. At a minimum, the provider shall conduct one in-person session once a month for the first year of an individual's treatment and on a quarterly basis during the second year.

B. The failure of an individual to participate in counseling sessions shall be addressed as part of the overall treatment process.

C. Counseling may be provided directly or through referral. If counseling is provided through referral the provider shall verify and include counseling notes within individual records.

12VAC35-276-300. Drug screens.

The provider shall:

1. Perform at least eight random drug screens per year unless the conditions in subdivision 2 of this section apply;

2. Perform random drug screens at a frequency that is in accordance with generally accepted clinical practice and as indicated by the individual's response to stability in treatment, whenever an individual's drug screen indicates continued illicit drug use or when clinically or environmentally indicated;

3. Analyze drug screens for opiates, methadone (if ordered), benzodiazepines, and cocaine. In addition, drug screens for other drugs that have the potential for addiction shall be performed when clinically or environmentally indicated; and

4. Implement a written policy on how the results of drug screens shall be used to direct treatment.

12VAC35-276-310. Take-home medication.

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

B. Prior to dispensing regularly scheduled take-home medication, the medical director or opioid treatment practitioner shall ensure the individual demonstrates that the therapeutic benefits of unsupervised doses outweigh the risk as evidenced by the following criteria:

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- 1325 1. Absence of active substance use disorders, other physical or behavioral health
1326 conditions that increase the risk of harm as it relates to the potential for overdose, or the
1327 ability to function safely;
- 1328 2. Regularity of attendance for supervised medication administration;
1329 3. Absence of serious behavioral problems that endanger the individual, the public, or
1330 others;
- 1331 4. Absence of known recent diversion activity;
1332 5. Whether take-home medications can be safely transported and stored; and
1333 6. Any other criteria that the medical director or opioid treatment practitioner considers
1334 relevant to the individual's safety and the public's health.
- 1335 C. Any individual in comprehensive maintenance treatment who is assessed to be
1336 appropriate to handle take-home medication shall undergo continued assessment and
1337 management to ensure suitability.
- 1338 D. If it is determined that an individual in comprehensive maintenance treatment is
1339 appropriate for handling take-home medication, including take-home medication for provider
1340 closures, the amount of take-home medication shall not exceed:
- 1341 1. A single take-home dose for one day when the clinic is closed for business, including
1342 Sundays and state or federal holidays, for the first seven days of treatment.
- 1343 2. A maximum of a five-day consecutive supply of take-home doses from eight days of
1344 treatment to 30 days of treatment.
- 1345 3. A maximum of a 14-day consecutive supply of take-home doses from 31 days of
1346 treatment to 60 days of treatment.
- 1347 4. A maximum of a 28-day consecutive supply of take-home doses after 60 days of
1348 treatment.
- 1349 E. Exceptions to the take-home schedule enumerated in subsection D of this section may be
1350 made if approved by the SOTA or designee.
- 1351 F. No medication shall be dispensed to individuals in short-term withdrawal management
1352 treatment or interim maintenance treatment for unsupervised take-home use.
- 1353 G. MOUD treatment providers shall maintain current procedures adequate to identify the
1354 theft or diversion of take-home medications. These procedures shall require the labeling of
1355 containers with the MOUD treatment provider's name, address, and telephone number.
1356 Providers shall ensure that the take-home supplies are packaged in a manner that is designed
1357 to reduce the risk of accidental ingestion, including child-proof containers.
- 1358 H. The provider shall educate the individual on the safe transportation and storage of take-
1359 home medication.
- 1360 **12VAC35-276-320. Prevention of duplication of medication services.**
- 1361 A. To prevent duplication of medication for opioid use disorder treatment services, the
1362 provider shall implement a written policy and procedures for contacting every medication-
1363 assisted opioid treatment service within a 50-mile radius before admitting an individual to the
1364 service.
- 1365 B. If the individual lives more than 50 miles from the program location, the provider shall also
1366 conduct an assessment for dual enrollment within a 50-mile radius of the where the individual
1367 lives prior to admission.
- 1368 C. All licensed medication for opioid use disorder treatment services shall enroll and
1369 participate in a central registry selected by the Department.

12VAC35-276-330. Medication services for guests.

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

B. The provider shall adopt a policy that identifies whether or not it will provide guest dosing to individual guests.

C. If the program provides guest dosing, the provider shall adopt a policy that includes:

1. Exclusionary or ineligibility criteria, if applicable;

2. The right to refuse to guest dose;

3. Financial arrangements;

4. Drug testing requirements, if applicable;

5. Documentation needed from the referring program or the guest; and

6. Notification of the arrangements made back to the referring program.

D. Providers offering guest dosing shall implement written procedures that include:

1. Staff time for making arrangements for guest dosing;

2. Number of days guest dosing will be allowed;

3. Additional services to be provided to the guests, if applicable; and

4. Other considerations, as appropriate.

E. 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.

F. Guests shall not receive medication for more than 28 days. To continue receiving medication after 28 days, the guest must be admitted to the service.

G. The provider shall implement policy and procedures that address the transfer of individuals from one program to another.

12VAC35-276-340. Withdrawal management prior to involuntary discharge.

A. Providers of MAT shall give an individual who is being involuntarily discharged from service an opportunity to withdraw from opioid agonist medication. The withdrawal period shall begin at least 10 days, but not earlier than 30 days, prior to discharge or termination from the service, unless the SOTA grants an exception.

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

12VAC35-276-350. Opioid agonist medication renewal.

Providers of medication for opioid use disorder treatment shall ensure that physician orders for opioid agonist medication are reevaluated and renewed at least every six months.

12VAC35-276-360. Security of opioid agonist medication supplies.

A. At a minimum, the provider shall secure opioid agonist medication supplies by restricting access to medication areas to medical or pharmacy personnel.

B. The provider shall reconcile the medication inventory monthly.

C. The provider shall keep inventory records, including the monthly reconciliation, for three years.

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D. The provider shall maintain a current plan to control the diversion of medication to unprescribed or illegal uses.

Part III

Additional Requirements for Mobile Medication-Assisted Treatment Programs

12VAC35-276-370. Application for operation of a mobile medication-assisted treatment program.

Each mobile medication-assisted treatment program shall operate as a component of a licensed MAT location and shall be listed on the provider's license addendum.

12VAC35-276-380. Physical security controls; mobile MAT programs; storage areas.

A. For any conveyance operated as a mobile MAT program, a safe must be installed and used to store narcotic drugs in Schedules II through V for the purpose of maintenance or detoxification treatment, when not located at the provider's U.S. Drug Enforcement Administration (DEA) registered location. The safe shall:

1. Meet the following specifications or the equivalent: 30 man-minutes against surreptitious entry, 10 man-minutes against forced entry, 20 man-hours against lock manipulation, and 20 man-hours against radiological techniques;

2. If it weighs less than 750 pounds, be bolted or cemented to the floor or wall in such a way that it cannot be readily removed; and

3. Be equipped with an alarm system that, upon attempted unauthorized entry, shall transmit a signal directly to (i) a central protection company or a local or state police agency that has a legal duty to respond or (ii) a 24-hour control station operated by the DEA registrant.

B. The controlled substance storage areas shall be accessible only to an absolute minimum number of specifically authorized employees. When it is necessary for employee maintenance personnel, nonemployee maintenance personnel, business guests, or visitors to be present in or pass through controlled substance storage areas, the registrant shall provide for adequate observation of the area by an employee specifically authorized to do so in writing.

C. The storage area for controlled substances in a mobile MAT program shall not be accessible from outside of the vehicle.

D. Personnel transporting controlled substances on behalf of the mobile MAT program are required to retain control over all controlled substances (i) when transferring the controlled substances between the DEA-registered location and the conveyance, (ii) en route to and from the dispensing locations, and (iii) when dispensing at the dispensing location. At all other times during transportation, all controlled substances shall be properly secured in the safe.

E. Upon completion of the operation of the mobile MAT program on a given day, the conveyance shall be immediately returned to the DEA-registered location, and all controlled substances shall be removed from the conveyance and secured within the DEA-registered location. After the conveyance has returned to the DEA-registered location and the controlled substances have been removed, the conveyance may be parked until its next use at the DEA-registered location or in any secure, fenced-in area once the local DEA office has been notified of the location of the secure, fenced-in area.

F. All mobile MAT programs shall establish a standard written operating procedure to ensure, if the mobile MAT program becomes inoperable, that all controlled substances on the inoperable conveyance are accounted for, removed from the inoperable conveyance, and secured at the DEA-registered location.

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G. With regard to the requirement within subsection E of this section, a mobile MAT program may apply to the DEA for an exception to this requirement. The application for such an exception must be submitted to the DEA in accordance with 21 CFR 1307.03. If the DEA grants an exception, the provider shall be permitted to operate in accordance with that exception. The provider shall maintain a record of the exception at the DEA-registered location and in the mobile MAT program conveyance.

12VAC35-276-390. Other security controls for mobile MATs.

A. Individuals enrolled in a mobile MAT program shall wait in an area that is physically separated from the narcotic storage and dispensing area by a physical entrance, such as a door or other entryway. Individuals receiving services must wait outside of a mobile MAT program component if that conveyance does not have seating or a reception area that is separated from the narcotic storage and dispensing area. This requirement shall be enforced by the provider and all provider employees.

B. All mobile MAT programs shall comply with standards established by the U.S. Secretary of Health and Human Services respecting the quantities of narcotic drugs that may be provided to persons enrolled in a mobile MAT program for unsupervised use.

C. Provider personnel who are authorized to dispense controlled substances for narcotic treatment shall ensure proper security measures and patient dosage. The mobile MAT program shall comply with DEA security requirements.

D. Any controlled substances transported for disposal from the dispensing location of a mobile MAT program shall be secured and disposed of in compliance with 21 CFR Part 1317 and all other applicable federal, state, tribal, and local laws and regulations.

E. A conveyance used as part of a mobile MAT program may only be supplied with narcotic drugs by the DEA-registered MAT that operates the conveyance. No persons permitted to dispense controlled substances to a mobile MAT shall:

1. Receive controlled substances from other mobile MAT programs or any other entity;
2. Deliver controlled substances to other mobile MAT programs or any other entity; or
3. Conduct reverse distribution of controlled substances on a mobile MAT program.

12VAC35-276-400. Records for mobile MATs.

A. A provider of a mobile MAT program shall maintain records with the following information for each narcotic controlled substance:

1. Name of substance;
2. Strength of substance;
3. Dosage form;
4. Date dispensed;
5. Adequate identification of individuals served;
6. Amount consumed;
7. Amount and dosage form taken home by individuals served; and
8. Dispenser's initials.

B. The records required by subsection A of this section shall be maintained in a dispensing log at the DEA-registered site of the mobile MAT program in compliance with 21 CFR 1304.22 without reference to 21 CFR 1304.03.

C. As an alternative to maintaining a paper dispensing log, a mobile MAT program may also use an automated or computerized data processing system for the storage and retrieval of program dispensing records if the following conditions are met:

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- 1503 1. The automated system maintains the information required in subsection A of this
1504 section;
- 1505 2. The automated system has the capability of producing a hard copy printout of the
1506 program's dispensing records;
- 1507 3. The mobile MAT program prints a hard copy of each day's dispensing log, which is
1508 then initialed appropriately by each person who dispensed medication to individuals
1509 served;
- 1510 4. The automated system is approved by DEA;
- 1511 5. The mobile MAT program maintains an offsite back-up of all computer-generated
1512 program information; and
- 1513 6. The automated system is capable of producing accurate summary reports for both the
1514 DEA-registered site of the mobile MAT program and any mobile MAT program for any
1515 timeframe selected by department personnel during an investigation. If these summary
1516 reports are maintained in hard copy form, they must be kept in a systematically
1517 organized file located at the DEA-registered site of the mobile MAT program.

1518 D. The provider shall retain all records for a minimum of six years following the last patient
1519 encounter in accordance with § 54.1-2910.4 of the Code of Virginia.

1520 **12VAC35-276-410. Physical plant exemption for mobile MATs.**

1521 Mobile MAT program locations are exempt from physical plant requirements located within
1522 12VAC35-276-130 through 12VAC35-276-200.

1523 Part IV

1524 Additional Requirements for ASAM Providers

1525 **12VAC35-276-420. Substance abuse partial hospitalization services program criteria.**

1526 A substance abuse partial hospitalization program shall meet the following programmatic
1527 requirements. The program shall:

- 1528 1. Offer no fewer than 20 hours of programming per week in a structured program.
1529 Services may include individual and group counseling, medication management, family
1530 therapy, peer recovery support services, educational groups, or occupational and
1531 recreational therapy;
- 1532 2. Provide a combination of individual and group therapy as deemed appropriate by a
1533 licensed professional and included in an assessment and treatment plan;
- 1534 3. Provide medical and nursing services as deemed appropriate by a licensed
1535 professional and included in an assessment and treatment plan;
- 1536 4. Provide motivational enhancement and engagement strategies appropriate to an
1537 individual's stage of readiness to change and level of comprehension;
- 1538 5. Have direct affiliations with other easily accessible levels of care or coordinate through
1539 referral to more or less intensive levels of care and other services;
- 1540 6. Provide family and caregiver treatment services as deemed appropriate by a licensed
1541 professional and included in an assessment and treatment plan;
- 1542 7. Provide educational and informational programming adaptable to individual needs;
- 1543 8. Ensure and document that the length of service shall be determined by the individual's
1544 condition and functioning;
- 1545 9. Make emergency services available by telephone 24 hours a day, seven days a week
1546 when the program is not in session; and

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1547 10. Make MAT available for all individuals. MAT may be provided by facility staff or
1548 coordinated through alternative resources.

1549 **12VAC35-276-430. Substance abuse partial hospitalization admission criteria.**

1550 Before a substance abuse partial hospitalization program may admit an individual, the
1551 individual shall meet the criteria for admission as defined by the provider's policies. The
1552 provider's policy regarding admission shall require the individual to, at a minimum:

1553 1. Meet diagnostic criteria for a substance use disorder or addictive disorder as defined
1554 by the DSM; and

1555 2. Meet the admission criteria of Level 2.5 of ASAM, including the specific criteria for
1556 adult or adolescent populations.

1557 **12VAC35-276-440. Substance abuse partial hospitalization discharge criteria.**

1558 Before a substance abuse partial hospitalization program may discharge or transfer an
1559 individual, the individual shall meet the criteria for discharge or transfer as defined by the
1560 provider's policies, which shall include provisions for the discharge or transfer of individuals who
1561 have:

1562 1. Achieved the goals of the treatment services and no longer require ASAM 2.5 level of
1563 care;

1564 2. Been unable to achieve the goals of the individual's treatment but could achieve the
1565 individual's goals with a different type of treatment; or

1566 3. Achieved the individual's original treatment goals but have developed new treatment
1567 challenges that can only be adequately addressed in a different type of treatment.

1568 **12VAC35-276-450. Substance abuse partial hospitalization co-occurring enhanced**
1569 **programs.**

1570 A. Substance abuse partial hospitalization co-occurring enhanced programs shall offer
1571 psychiatric services appropriate to the individual's mental health condition. Such services shall
1572 be available by telephone and onsite or closely coordinated offsite, within a shorter time than in
1573 a co-occurring capable program.

1574 B. Substance abuse partial hospitalization co-occurring enhanced programs shall be staffed
1575 by appropriately credentialed mental health professionals who assess and treat co-occurring
1576 mental disorders. Intensive case management shall be delivered by cross-trained,
1577 interdisciplinary staff through mobile outreach and shall involve engagement-oriented addiction
1578 treatment and psychiatric programming. All clinical staff shall be qualified by training and
1579 experience and appropriately licensed, certified, or registered by the appropriate health
1580 regulatory board to serve individuals admitted to the service.

1581 C. Substance abuse partial hospitalization co-occurring enhanced programs shall offer
1582 intensive case management, assertive community treatment, medication management, and
1583 psychotherapy.

1584 **12VAC35-276-460. Substance abuse intensive outpatient services program criteria.**

1585 A substance abuse intensive outpatient program shall meet the following programmatic
1586 requirements. The program shall:

1587 1. Offer a minimum of three service hours per service day for adults and a minimum of
1588 two service hours per service day for children and adolescents. Total weekly service
1589 hours shall be no fewer than nine hours for adults and no fewer than six hours for
1590 children and adolescents and shall not exceed a maximum of 19 hours. Service hours
1591 shall be offered in a structured environment;

1592 2. Ensure psychiatric and other medical consultation shall be available within 24 hours
1593 by telephone and within 72 hours in person;

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- 1594 3. Offer consultation in case of emergency related to an individual's substance use
1595 disorder by telephone 24 hours a day, seven days a week when the treatment program
1596 is not in session;
- 1597 4. Provide a combination of individual and group therapy as deemed appropriate by a
1598 licensed professional and included in an assessment and treatment plan;
- 1599 5. Have direct affiliations with other easily accessible levels of care or coordinate through
1600 referral to more or less intensive levels of care and other services;
- 1601 6. Provide family and caregiver treatment and peer recovery support services as
1602 deemed appropriate by a licensed professional and included in an assessment and
1603 treatment plan;
- 1604 7. Provide education and informational programming adaptable to individual needs and
1605 developmental status;
- 1606 8. Ensure and document that the length of service shall be determined by the individual's
1607 condition and functioning; and
- 1608 9. Make MAT available for all individuals. MAT may be provided by facility staff or
1609 coordinated through alternative resources.

12VAC35-276-470. Substance abuse intensive outpatient services admission criteria.

1611 Before a substance abuse intensive outpatient service program may admit an individual, the
1612 individual shall meet the criteria for admission as defined by the provider's policies. The
1613 provider's policy regarding admission shall require the individual to, at a minimum:

- 1614 1. Meet diagnostic criteria for a substance use disorder or addictive disorder as defined
1615 by the DSM; and
- 1616 2. Meet the admission criteria of Level 2.1 of ASAM, including the specific criteria for
1617 adult or adolescent populations.

12VAC35-276-480. Substance abuse intensive outpatient services discharge criteria.

1619 Before a substance abuse intensive outpatient service program may discharge or transfer
1620 an individual, the individual shall meet the criteria for discharge or transfer as defined by the
1621 provider's policies, which shall include provisions for the discharge or transfer of individuals who
1622 have:

- 1623 1. Achieved the goals of the treatment services and no longer require ASAM 2.1 level of
1624 care;
- 1625 2. Been unable to achieve the goals of the individual's treatment but could achieve the
1626 individual's goals with a different type of treatment; or
- 1627 3. Achieved the individual's original treatment goals but have developed new treatment
1628 challenges that can only be adequately addressed in a different type of treatment.

12VAC35-276-490. Substance abuse intensive outpatient services co-occurring enhanced programs.

1631 A. Substance abuse intensive outpatient services co-occurring enhanced programs shall
1632 offer psychiatric services appropriate to the individual's mental health condition. Such services
1633 shall be available by telephone and onsite or closely coordinated offsite, within a shorter time
1634 than in a co-occurring capable program.

1635 B. Substance abuse intensive outpatient services co-occurring enhanced programs shall be
1636 staffed by appropriately credentialed mental health professionals who assess and treat co-
1637 occurring mental disorders. Capacity to consult with an addiction psychiatrist shall be available.
1638 All clinical staff shall be qualified by training and experience and appropriately licensed.

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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.

12VAC35-276-500. Substance abuse outpatient services 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 for adults and no more than six hours per week for children and adolescents;

2. Ensure emergency services are 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.

12VAC35-276-510. Substance abuse outpatient services 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.

12VAC35-276-520. 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;

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.

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12VAC35-276-530. 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.

Part V

Additional Requirements for Mental Health Providers

12VAC35-276-540. Mental health partial hospitalization program criteria.

Mental health partial hospitalization programs shall meet the following programmatic requirements. The program shall:

1. Have a multidisciplinary team under the direction of a physician, to provide structured schedules for individuals receiving services;
2. Offer no fewer than 20 hours of programming per week, at least four hours per day, five days per week;
3. Provide emergency assistance 24 hours a day, seven days a week;
4. Provide individualized treatment planning; daily individual, group and family therapy; skills restoration and development; and health literacy counseling and psychoeducation interventions;
5. Provide medication management as well as clinically indicated psychiatric and medical consultation services. Referrals for consultation to external prescribing providers shall be made via formal agreement. The provider shall coordinate medication management with all existing providers;
6. Provide medical, psychological, psychiatric, laboratory, and toxicology services by consult or referral; and
7. Provide care coordination through referrals to higher and lower levels of care, as well as community and social supports.

12VAC35-276-550. Mental health intensive outpatient program criteria.

A mental health intensive outpatient services program shall meet the following programmatic requirements. The program shall:

1. Have a multidisciplinary team that, at a minimum, consists of one licensed clinical psychologist, licensed professional counselor, licensed clinical social worker (LCSW), or licensed marriage and family therapist (LMFT); one physician, nurse practitioner, or physician assistant; one LMHP, LMHP-R, LMHP-RP, or LMHP-S; one QMHP or QMHP-T; one PRS certified in accordance with 12VAC35-250; and occupational therapists;

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- 1729 2. Offer a minimum of three service days a week, to achieve no fewer than nine hours
1730 and no more than 19 hours a week for adults, and no fewer than six hours and no more
1731 than 19 hours a week for children and adolescents;
- 1732 3. Provide structured schedules for individuals receiving services;
- 1733 4. Provide care coordination activities that seek to support recovery and movement into
1734 a lower level of care;
- 1735 5. Identify additional needs to support recovery and refer the individual and his natural
1736 supports to appropriate referrals and resources to meet these needs; and
- 1737 6. Provide assessment; treatment planning; individual, family, and group therapy; skills
1738 restoration and development; health literacy counseling and psychoeducation activities;
1739 crisis treatment; and peer recovery support services.
- 1740 **12VAC35-276-560. Mental health outpatient services program criteria.**
- 1741 Mental health outpatient services programs shall ensure the LMHP, LMHP-R, LMHP-RP or
1742 LMHP-S conducts an intake interview, records the individual's medical history, conducts the
1743 intake assessment, records a diagnosis, and develops the individual's ISP.

Project 8115 - NOIRA

Department of Behavioral Health And Developmental Services

Regulatory Restructuring - Crisis Services (Part 5 of 7)

Chapter 278

Regulations for Crisis Services

Part I

Services and Supports

12VAC35-278-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed in 12VAC35-270-20:

"Abuse"

"Admission"

"Authorized representative"

"Commissioner"

"Contractor"

"Crisis"

"Department"

"Developmental disability"

"Discharge"

"Discharge plan"

"Individual" or "individual receiving services"

"Medication"

"Medication administration"

"Person-centered"

"Provider"

"Referral"

"Residential" or "residential service"

"Restraint"

"Restriction"

"Screening"

"Service"

"Succession plan"

"Volunteer"

"Written," "writing," and "in writing"

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

"Community-based crisis stabilization" means services that are short-term and designed to support an individual and the individual's natural support system following contact with an initial

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crisis response service or as a diversion to a higher level of care. Providers deliver community-based crisis stabilization services in an individual's natural environment and provide referrals and linkage to other community-based services at the appropriate level of care. Interventions may include mobile crisis response, brief therapeutic and skill-building interventions, integration of natural supports into the de-escalation and stabilization of the crisis, and coordination of follow-up services. Coordination of specialized services to address the needs of co-occurring developmental disabilities or substance use disorders are also available through this service. Services include advocacy and networking to provide linkages and referrals to appropriate community-based services and assist the individual and the individual's family or caregiver in accessing other benefits or assistance programs for which the individual may be eligible. The goal of community-based crisis stabilization services is to stabilize the individual within the community and support the individual and, as appropriate, the individual's support system (i) as a transitional step-down from a higher level of care if the next level of care service is identified but not immediately available for access; or (ii) as a diversion to a higher level of care.

"Crisis education and prevention plan" or "CEPP" means a standardized, department-approved, individualized, client-specific written document that provides a concise, clear, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist an individual who may be experiencing a behavioral crisis. The goal of the CEPP is to identify problems that arose in the past or are emergent in order to (i) teach the individual skills to apply independently and (ii) plan strategies that offer the individual and the individual's support system assistance in addressing and de-escalating problems in a healthy way.

"Crisis individualized services plan" or "crisis ISP" means a written plan that is developed by community-based crisis stabilization and crisis stabilization unit providers as soon as possible but no later than 48 hours after an individual's admission to the service. A crisis ISP describes the individual's needs, attainable goals and measurable objectives to address those needs, and strategies to reach the individual's goals. A crisis ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The crisis ISP is developed through a partnership between the individual and the provider. Due to the acute nature of crisis services, a crisis ISP will focus on shorter term needs, goals, and objectives that will help stabilize the individual so that the individual is able to move out of crisis services. Longer term needs, goals, and objectives may be noted and worked on in treatment, yet the goal is stabilization and movement out of crisis care to a more sustainable treatment plan.

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

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

"Crisis stabilization" means direct, intensive nonresidential or residential care and treatment to nonhospitalized individuals experiencing an acute crisis that may jeopardize their current

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community living situation. Crisis stabilization is intended to avert hospitalization or rehospitization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis; and mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.

"Crisis stabilization unit" or "CSU" means a community-based, short-term 24-hour crisis service unit. CSUs serve as primary alternatives to inpatient hospitalization for individuals who are in need of a safe, secure environment for assessment and crisis treatment. CSUs also serve as a step-down option from psychiatric inpatient hospitalization and function to stabilize and reintegrate individuals who meet medical necessity criteria back into their communities. This service meets the requirements of a "residential crisis stabilization unit" of § 38.2-3412.1 of the Code of Virginia.

"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.

"Licensed mental health professional-resident" or "LMHP-R" means the same as "resident" as defined in 18VAC115-20-10 for licensed professional counselors, 18VAC115-50-10 for licensed marriage and family therapists, or 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-R shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice.

"LMHP-resident in psychology" or "LMHP-RP" means an individual in a residency, as that term is defined in 18VAC125-20-10, for clinical psychologists. An LMHP-RP shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-S shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50.

"Ligature risk" means any element of the environment that could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation.

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

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

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

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

"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.

"Renovation" means any replacement or upgrade of materials that will change the purpose or level of activities of a space.

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

12VAC35-278-20. Licenses.

Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. The following services shall require a crisis license:

1. Community-based crisis stabilization;
2. Crisis receiving center; and
3. Crisis stabilization units.

12VAC35-278-30. Zoning.

A. Crisis providers shall not operate their services within a property zoned as a single-family residence. This provision does not apply to providers operating prior to September 19, 2002.

B. Every crisis facility shall be in a location suitable to meet the physical environment requirements of Part II of this chapter. Each facility shall allow for clear access by law enforcement, emergency services, and other appropriate crisis partners. This shall include appropriate parking and a dedicated drop off area at a door of the facility. Zoning placement within each community shall be a primary consideration and providers shall be required to submit a certificate of occupancy to document appropriate zoning to the Office of Licensing during the application process (12VAC35-270-40).

12VAC35-278-40. Service descriptions.

A. The crisis receiving center service includes ongoing assessment, crisis intervention, and clinical determination for the appropriate level of care to individuals experiencing a behavioral health crisis. Services are provided in a community-based, non-hospital setting for a period of up to 23 hours per day. This service shall be accessible 24 hours per day, seven days per week and is indicated when an individual is in an acute crisis and requires a safe environment for observation and assessment prior to determination of the next level of care. Services offered shall include assessment, psychiatric evaluation, a nursing assessment, and coordination of follow-up services. This service is required to meet physical environment requirements as listed within this chapter. Programs within this service for adults and children shall be separate and distinct. The provider shall provide for the physical separation of children and adults and shall maintain separate group programming for adults and children. Providers of both children's and adult services shall ensure that children receiving services and adults receiving services are not mixed in shared spaces. The provider shall provide for the safety of children accompanying parents receiving services. A crisis receiving center shall not be considered residential occupancy for the purposes of § 15.2-2291 of the Code of Virginia.

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B. Community-based crisis stabilization includes short-term assessment, crisis intervention including mobile crisis response, and coordination of follow-up services to individuals experiencing a behavioral health crisis. Services shall be provided in the individual's home, workplace, or other convenient and appropriate setting and shall be accessible 24 hours per day, seven days per week. Offering crisis stabilization in an office-based setting shall be based on the individual's documented clinical needs, documented individual preference, or relation to the coordination of follow-up services. Services shall include assessment and screening, including explicit screening for suicidal or homicidal ideation; brief therapeutic and skill-building interventions; integration of natural supports into the de-escalation and stabilization of the crisis; crisis education; and coordination of follow-up services. The provider shall develop an immediate plan to maintain safety in order to prevent the need for a higher level of care. Coordination of follow-up services shall include advocacy on behalf of the individual, networking to provide linkages and referrals to appropriate community-based services or resources, and assisting the individual and the individual's natural support system in accessing other benefits or assistance programs for which the individual may be eligible. When clinically necessary, crisis stabilization is also the mechanism by which pre-admission screenings for hospitalization may be performed by clinicians trained by the department in pre-admission screening.

C. The crisis stabilization unit service includes short-term psychiatric and substance-related assessment and brief intervention services to individuals experiencing abrupt and substantial changes in behavior noted by severe impairment or acute decompensation in functioning. Services are provided in a non-hospital, community-based unit. This service shall be accessible 24 hours per day, seven days per week, and is indicated when an individual requires a safe environment for assessment and stabilization. CSUs may also provide medically monitored residential services for the purpose of providing psychiatric stabilization and substance withdrawal management services on a short-term basis. Services offered shall include assessment; medical, nursing, psychiatric, and psychosocial evaluation; medical and nursing care; treatment planning; medication management; skills restoration; individual and group therapy; crisis intervention; and coordination of follow-up services. Programs within this service for adults and children shall be separate and distinct. The provider shall provide for the physical separation of children and adults and shall provide separate group programming for adults and children. Providers of both children's and adult services shall ensure that children receiving services and adults receiving services are not mixed in shared spaces. The provider shall provide for the safety of children accompanying parents receiving services.

12VAC35-278-50. Staffing.

A. In addition to the provisions of 12VAC35-270-300, providers of crisis services shall incorporate the following minimum provisions into the provider staffing plan.

B. Crisis receiving center providers shall meet the following staffing requirements:

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

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

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

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

5. Adequate qualified direct care staff necessary to meet the needs of the individuals receiving services shall be on-site.

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

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

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

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

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

(1) One licensed staff member; or

(2) One certified pre-screener.

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

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

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

(3) One licensed staff member and one QMHP or QMHP-T;

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

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

(6) Two QMHPs or one QMHP and one QMHP-T. A licensed staff member shall be required to be available via telemedicine for the assessment;

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

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

D. Crisis stabilization unit providers shall meet the following staffing requirements:

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

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

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

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

5. Adequate qualified direct care staff necessary to meet the needs of the individuals receiving services shall be on-site.

12VAC35-278-60. Initial contacts.

A. Providers shall implement an initial contact policy that includes:

1. Identification, qualification, training and duties of employees responsible for initial contact with individuals.

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2. To the best of the provider's ability, the following minimum required elements of initial contact for a crisis setting:

a. Date of contact;

b. Legal name, preferred name, date of birth, sex, and gender of the individual;

c. Contact information, including address, telephone number, and email address of the individual, if applicable;

d. The individual's local community services board and any other community services board providing services; and

e. Reason why the individual is requesting services.

3. Methods the provider will utilize to identify other appropriate services or resources to assist individuals who are not admitted to the provider's service.

B. The provider shall retain documentation of the individual's initial contacts for six months. For individuals admitted to the service, documentation shall be retained in accordance with the provider's written records management policy pursuant to 12VAC35-270-580.

C. Providers may complete the individual's initial contacts and crisis assessment at the same time, if appropriate.

12VAC35-278-70. Assessment.

A. The provider shall implement a written crisis assessment policy. The policy shall define how crisis assessments will be conducted and documented.

B. The provider shall actively involve the individual and the individual's authorized representative, if applicable, and any family members or other identified persons as desired by the individual, in the preparation of crisis assessments. In these crisis assessments, the provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

C. The crisis assessment policy shall designate appropriately qualified employees or contractors who are responsible for conducting, obtaining, or updating assessments including nursing assessments. These employees or contractors shall have experience in working with the needs of individuals who are being assessed, with the crisis assessment tools being utilized and the provision of services that the individuals may require. The crisis assessment policy shall include methods the provider will utilize to identify other appropriate services to assist individuals who are not admitted to the provider's service.

D. Assessment is an ongoing activity. The provider shall make reasonable attempts to obtain previous assessments or history relevant to the crisis. The provider shall use the individual's previous assessments or other relevant history within the course of treatment, if applicable, as noted within subsection F of this section.

E. Providers shall utilize standardized state-sanctioned or federally sanctioned crisis assessment tools as approved by the department or utilize their own crisis assessment tools that shall meet the requirements in subsection F of this section.

F. A crisis assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall complete, or obtain information from other qualified providers in order to complete, a crisis assessment detailed enough to (i) determine whether the individual qualifies for admission and (ii) initiate a safety plan or crisis ISP as required by this chapter for those individuals who are admitted to the service.

1. The crisis assessment shall assess the individual's service, health and safety needs and, at a minimum, include:

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- a. Diagnosis, including current and past substance use or dependence and risk for intoxication or substance withdrawal, and co-occurring mental illness or developmental disability;
- b. Risk of harm, including elements that may make an individual a danger to self or others;
- c. Cognitive functional status, including the individual's ability to protect self from harm and provide for basic human needs;
- d. Precipitating issues, including recent stressors or events;
- e. Presenting needs, including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of needs. The assessor shall record:
- (1) Any physical reaction to the presenting crisis, if these issues are mentioned by the individual or observed during the assessment. Examples include issues with sleep, appetite, or daily activities;
- (2) The individual's housing arrangements and living situation, if mentioned by the individual; and
- (3) Any trauma, such as sexual abuse, physical abuse, or natural disaster, if appropriate, including whether a traumatic experience relates to the current crisis or is mentioned by the individual.
- f. Additional current medical issues and symptoms, if applicable;
- g. Current medications, including recent changes to medications. The assessor shall review current medications to the best of the individual's ability;
- h. Barriers or risk factors that will impact the individual's ability to seek treatment or continue to participate in services, including the individual's mood, ability, and willingness to engage in treatment, and access to transportation;
- i. The individual's recovery environment and circle of support; and
- j. Communication modality and language preference.
2. For crisis stabilization units and community-based crisis stabilization providing services other than mobile crisis, the assessment shall also include:
- a. Relevant treatment history and health history, to include as applicable:
- (1) Past prescribed medications;
- (2) Hospitalizations for challenging behaviors, mental illness, or substance use;
- (3) Other treatments for challenging behaviors, mental illness, or substance use;
- (4) Allergies, including allergies to food or medications;
- (5) Recent physical complaints and medical conditions;
- (6) Nutritional needs;
- (7) Chronic conditions;
- (8) Communicable diseases;
- (9) Restrictions on physical activities if any;
- (10) Restrictive protocols or special supervision requirements;
- (11) Preferred interventions in the event behaviors or symptoms become a danger to self or others;
- (12) All known contraindications to the use of seclusion, time out, or any form of physical or mechanical restraint, including medical contraindications and history of trauma;

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(13) Past serious illnesses, serious injuries, and hospitalizations;

(14) Serious illnesses and chronic conditions of the individual's parents, siblings, and significant others in the same household; and

(15) Other interventions and outcomes, including interventions and outcomes that were unsuccessful, with the provider ensuring previous assessments are utilized to note these interventions.

b. The individual's housing arrangements or living situation;

c. Trauma, such as sexual abuse, physical abuse, or natural disaster; and

d. Current or previous involvement in justice, welfare, or public benefit systems, such as legal proceedings, adult or child protective services, or social services departments.

3. If applicable to the individual's crisis, the assessment shall also include:

a. The individual's social, behavioral, developmental, and family history and supports;

b. Employment, vocational, and educational background;

c. Cultural and heritage considerations; and

d. Financial stressors.

G. Completion of the crisis assessment shall be as soon as possible after admission but no later than 24 hours after admission.

12VAC35-278-80. Safety plans and crisis individualized services plans (ISPs).

A. The provider shall actively involve the individual and the individual's authorized representative, as appropriate, in the development, review, and revision of a person-centered safety plan and, if appropriate, a crisis ISP. The individualized planning process shall be consistent with laws protecting confidentiality, privacy, human rights of individuals receiving services, and rights of minors. To the extent possible, the provider shall collaborate with the individual's crisis planning team to develop, review and revise, and implement, as appropriate, the individual's safety plan or crisis ISP.

B. Providers of developmental services shall collaborate with the individual's support coordinator to develop, or review and revise, and implement, as appropriate, a provisional person-centered crisis education and prevention plan (CEPP) within 15 days of admission. An updated CEPP shall be completed within 45 days of admission. Developmental services providers may utilize a CEPP as an individual's safety plan, if appropriate. If a CEPP is to be used as a safety plan, the provider shall meet the deadline listed in subsection C of this section.

C. Providers of mental health and substance abuse services shall develop, or review and revise, and implement, as appropriate, a person-centered safety plan immediately after admission that shall continue in effect until discharge from the provider's crisis service.

D. Providers of crisis services shall develop and implement a crisis ISP, in addition to a safety plan, as soon as possible but no later than 48 hours after admission. This provision does not apply to mobile crisis response or crisis receiving centers.

E. Development of the safety plan and crisis ISP shall be based on the crisis assessment with the participation and informed choice of the individual receiving services.

1. To ensure the individual's participation and informed choice, the following shall be explained to the individual or the individual's authorized representative, as applicable, in a reasonable and comprehensible manner:

a. The proposed services to be delivered;

b. Any alternative services that might be advantageous for the individual; and

c. Any accompanying risks or benefits of the proposed alternative services.

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2. If no alternative services are available to the individual, it shall be documented within the individual's service record that alternative services were not available as well as any steps taken to identify if alternative services were available.

3. Whenever there is a change to an individual's safety plan or crisis ISP, the changes shall be documented within the safety plan or crisis ISP or within attached documentation that:

a. The individual participated in the development of or revision to the safety plan or crisis ISP;

b. The proposed and alternative services and their respective risks and benefits were explained to the individual or the individual's authorized representative; and

c. The reasons the individual or the individual's authorized representative chose the option included in the safety plan or crisis ISP.

12VAC35-278-90. Safety plan and crisis ISP minimum requirements.

A. All individuals receiving crisis services shall have a safety plan.

1. The safety plan shall be based on the individual's immediate service, health, and safety needs identified in the crisis assessment. The safety plan shall include:

a. Warning signs that a crisis may be developing, such as thoughts, images, moods, situations, behavior or stressors that may trigger the individual;

b. Internal coping strategies or methods performed independently, such as relaxation techniques or physical activities;

c. People and social settings that the individual may turn to for distraction or support;

d. People the individual may ask for help;

e. Professionals or agencies the individual can contact during a crisis; and

f. Specific steps the individual can take to make the individual's environment safe.

2. The safety plan may include:

a. A description of how to support the individual when pre-crisis behaviors are observed;

b. Specific instructions for the systems supporting the individual when pre-crisis behaviors are observed;

c. A description of how to support the individual when crisis behaviors are observed; and

d. Specific instructions for the systems supporting the individual during crisis.

B. Providers of community-based crisis stabilization and crisis stabilization unit shall also develop a crisis ISP for each individual. A crisis ISP shall be based on the individual's immediate service, health, and safety needs identified in the crisis assessment. The crisis ISP shall include:

1. Relevant and attainable goals, measurable objectives to inform current and future treatment, and specific strategies for addressing each need documented within the individual's crisis assessment;

2. Services, and supports, and frequency of services required to accomplish the goals, including relevant psychological, mental health, substance use, behavioral, medical, rehabilitation, training, and nursing needs and supports;

3. Any use of seclusion if allowed in the service per 12VAC35-115;

4. The role of the individual and others, including the individual's family, if appropriate, in implementing the crisis ISP;

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457 5. Identification of employees or contractors responsible for coordination and integration
458 of services, including employees of other agencies;

459 6. A behavioral support or treatment plan, if applicable; and

460 7. Projected discharge plan and estimated length of stay within the service.

461 C. The crisis ISP shall be implemented as soon as possible after admission but no later than
462 48 hours after admission. The crisis ISP shall continue in effect until the individual is discharged
463 from the provider's crisis service.

464 D. In order to document agreement, both the safety plan and the crisis ISP shall be signed
465 and dated, at a minimum, by (i) the person responsible for implementing the safety plan or crisis
466 ISP and (ii) the individual receiving services or the individual's authorized representative, if
467 appropriate.

468 1. If the signature of the individual receiving services or the individual's authorized
469 representative cannot be obtained, the provider shall document attempts to obtain the
470 necessary signature and the reason it was unobtainable. The provider shall attempt to
471 obtain the necessary signature while the safety plan or crisis ISP is in effect, on a periodic
472 basis and at a minimum each time the provider reviews the safety plan or crisis ISP as
473 required by 12VAC35-278-100.

474 2. The provider shall document distribution of the safety plan and crisis ISP to the
475 individual and others authorized to receive it within the individual's service record. If the
476 safety plan or and crisis ISP cannot be distributed, the provider shall document the reason
477 distribution attempts were unsuccessful. The provider shall attempt to distribute the safety
478 plan and the crisis ISP for the length of time the safety plan or crisis ISP is in effect, on a
479 periodic basis and at a minimum each time the provider reviews the safety plan or crisis
480 ISP as required by 12VAC35-278-100.

481 E. The provider shall have a crisis ISP policy that designates an employee or contractor
482 responsible for developing, implementing, reviewing, and revising each individual's safety plan
483 and crisis ISP, in collaboration with the individual or the individual's authorized representative, as
484 appropriate.

485 F. The designated employees or contractors shall (i) have access to the individual's safety
486 plan or crisis ISP, including detailed health and safety protocols, and (ii) be competent to
487 implement the plans as written.

488 G. Whenever possible, the identified goals in the safety plan or crisis ISP shall be written in
489 the words of the individual receiving services.

490 H. The provider shall use signed and dated progress notes to document the provider's efforts
491 towards the implementation of the goals and objectives contained within the safety plan or crisis
492 ISP.

493 **12VAC35-278-100. Reassessments and review of safety plans and crisis ISPs.**

494 A. Reassessments shall be completed any time the individual is within the provider's service
495 and there is a need based on changes in the medical, psychiatric, behavioral, or other status of
496 the individual.

497 B. The provider shall actively involve the individual and the individual's authorized
498 representative, if applicable, in reassessments. The provider shall consider the individual's needs,
499 strengths, goals, preferences, and abilities within the individual's cultural context.

500 C. Providers shall complete changes to the safety plan or crisis ISP, if necessary or if desired
501 by the individual, as a result of the reassessment.

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D. If necessary as a result of a reassessment, providers shall complete changes to medical protocols or collaborate with other providers to ensure changes are made to medical, medical equipment, behavioral, or other corresponding protocol.

E. After each reassessment the provider shall ensure that the individual's most current crisis ISP is easily accessible to the employee or contractor responsible for implementing the safety plan or crisis ISP.

12VAC35-278-110. Progress notes.

A. The records management policy required by 12VAC35-270-580 shall ensure that progress notes are maintained pursuant to this section.

B. The provider shall use signed and dated progress notes or other documentation to document the services provided. Progress notes shall at a minimum:

1. Be consistent across the provider's service;

2. Be legible and readable;

3. Record the individual's response to the intervention by staff who are responsible for implementing the treatment plan, including care provided and events relevant to diagnosis and treatment or care of the individual;

4. Have a narrative component, which notes relevant events that occurred during the provision of services;

5. Describe needed follow-up care; and

6. Be signed and dated by the staff who provided the service.

C. Progress notes shall be entered into the individual's record each time the individual receives services.

D. Communication logs and supervision notes shall not be considered progress notes.

12VAC35-278-120. Arrangements for follow-up care.

A. Community-based crisis stabilization providers of mobile crisis response and crisis receiving center providers shall make arrangements and referrals to all follow-up service providers. The provider shall document in the individual's safety plan (i) the discharge arrangements or referrals or (ii) reasons why follow-up care was not indicated.

B. Community-based crisis stabilization providers, when providing mobile crisis response services, and crisis receiving center providers are not required to provide the discharge planning described within 12VAC35-278-130 to individuals receiving services.

12VAC35-278-130. Discharge planning.

A. Crisis providers are not subject to the provisions of 12VAC35-270-430.

B. Community-based crisis stabilization providers and crisis stabilization units shall have written policies and procedures regarding the discharge or termination of individuals from the service. These policies and procedures shall include medical and clinical criteria for discharge.

C. Discharge instructions shall be provided in writing to the individual, the individual's authorized representative, and any successor provider, as applicable. Discharge instructions shall include, at a minimum, medications and dosages; names, telephone numbers, and addresses of any providers to whom the individual is referred; current medical issues or conditions; and the identity of the treating health care providers. The provider shall make appropriate referrals to all service providers identified within the individual's discharge instructions prior to the individual's scheduled discharge date.

D. The provider shall document in the individual's service record whether the individual, the individual's authorized representative, and the individual's family members, as appropriate, were involved in the discharge planning process.

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E. The content of the discharge plan and the determination to discharge the individual shall be consistent with the crisis ISP and the criteria for discharge.

12VAC35-278-140. Written policies and procedures for crisis or emergency response; required elements.

A. For the purposes of this section, a crisis or a behavioral, medical, or psychiatric emergency is a situation that poses an imminent risk to the individual or others that cannot be addressed within the scope of the provider's services. This does not include events that require the use of restrictive behavior intervention and supports as discussed within 12VAC35-270-500.

B. The provider shall implement written policies and procedures, as approved by the department, for prompt intervention in the event of a crisis or a behavioral, medical, or psychiatric emergency that may occur during screening and referral, at admission, or during the period of service provision.

C. The policies and procedures shall include:

1. Procedures for immediately accessing appropriate internal and external resources. This shall include a provision for obtaining physician and mental health clinical services if the provider's or service's on-call or back-up physician or mental health clinical services are not available at the time of the emergency;

2. Employee or contractor responsibilities; and

3. Location of the face sheets with emergency medical information as required by 12VAC35-270-460.

12VAC35-278-150. Nursing assessment.

A. Crisis receiving centers and crisis stabilization units shall administer a nursing assessment within 24 hours of admission of an individual.

B. Prior to admission to crisis receiving centers or crisis stabilization units, each individual shall have a screening for communicable diseases, including tuberculosis, as evidenced by the completion of a screening form containing, at a minimum, the elements found on the Report of Tuberculosis Screening form published by the Virginia Department of Health. The screening may be no older than 30 days. No screening shall be required for an individual separated from a service with another licensed provider with a break in service of six months or less.

C. A staff member who is a medical professional shall conduct a nursing assessment. The nursing assessment shall collect information about the individual's nonpsychiatric medical or surgical condition to determine whether a more thorough medical assessment is needed before a decision is made regarding continuation of treatment within the provider's service or transfer to a more intensive level of care. The nursing assessment shall evaluate if there is a current medical crisis or underlying medical condition for the individual's psychological crisis, such as any medical condition that affects the individual's psychological state, presenting behavior, or ability to receive the provider's service. The nursing assessment shall note the date of examination and include the signature of a qualified practitioner.

D. Locations designated for nursing assessments shall ensure individual privacy.

E. The provider shall (i) review the results of the nursing assessment, including any follow-up diagnostic tests, treatments, or examinations, and (ii) document the arrangements for follow-up care in the individual's record.

F. Each individual's health record shall include notations of any health or dental complaints mentioned by the individual or any injuries and shall summarize symptoms and treatment given.

G. Each individual's health record shall include or document the facility's efforts to obtain treatment summaries of ongoing psychiatric or other mental health treatment and reports.

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H. The provider shall develop and implement written policies and procedures that include use of standard health precautions and address communicable and contagious medical conditions.

I. Community-based crisis stabilization providers are not required to administer nursing assessments. The provider may administer a nursing assessment if the provider has the resources to do so or may obtain a medical history or relevant information that would be a part of a medical history if the individual receiving services provides it.

12VAC35-278-160. Health care policy.

A. Providers shall ensure the provision of emergency medical services for each individual.

B. Crisis stabilization units shall implement a policy that addresses provision of adequate and appropriate medical and dental care. This policy shall describe to what extent and how:

1. Medical and dental care needs will be assessed including and the circumstances that will prompt the decision to obtain a medical assessment.

2. Crisis ISPs will address any medical and dental care needs appropriate to the scope and level of service.

3. The provider will provide or arrange for the provision of medical and dental care needs identified at admission.

4. During the provision of the provider's services, the provider will provide or arrange for the provision of routine ongoing and follow-up medical and dental care services.

5. The provider will communicate the results of physical examinations, medical assessments, diagnostic laboratory results, treatments, or examinations to the individual and the individual's authorized representative, as appropriate.

6. The provider will keep accessible to staff and contractors on duty the names, addresses, and phone numbers of the individual's medical and dental providers.

7. The provider will ensure a means for facilitating and arranging, as appropriate, transportation to medical and dental appointments and medical tests, when services cannot be provided on site.

C. Providers shall provide or arrange for the provision of appropriate medical care.

D. The provider shall implement written infection control measures including the use of universal precautions.

E. The provider shall report outbreaks of infectious diseases to the Department of Health pursuant to § 32.1-37 of the Code of Virginia.

F. Employees, contractors, students, or volunteers of CSUs shall complete tuberculosis education as part of initial orientation and thereafter on an annual basis. The education shall focus on self-presentation in the event of exposure to active tuberculosis or the development of symptoms of active tuberculosis disease.

12VAC35-278-170. Medication errors and drug reactions.

In the event of a medication error or adverse drug reaction:

1. First aid shall be administered if indicated.

2. Employees or contractors shall promptly contact a poison control center, pharmacist, nurse, or physician and shall take actions as directed.

3. The individual's physician shall be notified as soon as possible unless the situation is addressed in standing orders.

4. All actions taken by employees or contractors shall be documented, such as in incident reports or progress notes.

5. The provider shall review medication errors at least quarterly as part of the quality assurance in 12VAC35-270-570.

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6. Medication errors and adverse drug reactions shall be recorded in the individual's medication log.

12VAC35-278-180. (Reserved).

12VAC35-278-190. Vital signs.

A. This section applies to all crisis receiving centers and crisis stabilization units.

B. Unless the individual refuses, the provider shall take vital signs upon admission, during the provision of services as per the medical provider's orders, and at discharge.

C. The provider shall implement written procedures regarding the collection of vital signs, including documentation of vital signs, all refusals, and follow-up actions taken.

12VAC35-278-200. Emergency preparedness and response plan.

A. The scope of emergency preparedness in relation to this section applies to disasters and emergencies as defined by § 44-146.16 of the Code of Virginia.

B. The provider shall develop a written emergency preparedness and response plan for all of its services and locations. This plan shall include specifics for each location and shall include the following:

1. An analysis and prioritization of vulnerability of all services and locations to various hazards that may impact the provider. Vulnerability is a combination of the likelihood and severity of hazard occurrence.

2. A base-level response plan that is applicable to all hazards and includes:

a. Documentation of preparedness activities such as emergency planning team meetings, incident reviews, plan revisions, etc.

b. Maintenance of a 24-hour phone line which can be used for communication during emergencies.

c. Documented procedure for activation of the emergency plan including a description of various triggers for activation, who may activate, and overall situation assessment, response escalation, situation stabilization, and life and property preservation as first priority during any response.

d. Documented procedure to notify the department of activation of the emergency plan as soon as possible, but no later than 24 hours after incident occurrence.

e. Documented policies, outlining specific responsibilities for incident command and the necessary incident management team including operations, logistics, planning and finance.

f. Documented policies and procedures to ensure, to the extent possible, the life safety of employees, contractors, volunteers, visitors, and individuals served.

g. Policy and procedures for building access and security to include both provision of a secure building under adverse circumstances and appropriate access to the building by emergency responders.

h. Documented policies and procedures for the resumption of normal activities following service disruption by and emergency including any necessary site inspections required before repatriation can take place.

i. Documented identification, consideration and mitigation activities related to high-priority vulnerabilities as identified by a vulnerability analysis.

3. An evacuation plan that includes:

a. Documented, current consideration of local or regional sites that could function as evacuation locations or stop-over points, including documentation of any arrangements the provider has made with such local or regional sites.

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b. Policy and procedures for executing an evacuation or relocation of individuals receiving services to include individual and staff location tracking and preservation of all critical services (pharmacy, feeding, etc.).

c. Policy and procedures for handling PHI during an evacuation or relocation to ensure the PHI is both properly secured and accessible at the new location or by new service providers to allow for proper continuity of care.

C. The provider shall develop a written communication plan detailing:

1. The process for notifying local and state authorities of an emergency, including the department.

2. The process for notifying and communicating with staff, employees, contractors, volunteers, and community responders during emergencies.

3. The process for warning, notifying, and communicating with individuals receiving services.

4. The process for notifying and communicating with family members or authorized representatives during emergencies.

D. The provider shall develop a written Continuity of Operations Plan detailing:

1. Delegation of authority under emergency conditions.

2. Succession planning for emergency conditions, including in the event of the license holder's death or incapacitation as required by subsection B 1 of 12VAC35-270-40. Community service boards are not required to have a succession plan.

3. Indication of which services are critical to the health and well-being of the individuals being served and therefore must be continued; services less critical that may be delayed; ancillary services that may be discontinued during emergency circumstances; and triggers with regard to the continuity of these services.

4. Documented plans for continuity of activities related to the provision of care, treatment, and services, including scheduling, modifying, or discontinuing services; PII and PHI access and security; providing medication; and transportation services.

5. Contingency planning for supply chain disruptions of critical supplies such as pharmaceuticals, food, water, toiletries, linens, and any other supplies required for subsistence.

E. The provider shall maintain documentation of outreach to local emergency officials to include local emergency managers at least annually.

F. The provider shall implement annual emergency preparedness and response training for all employees, contractors, students, and volunteers pursuant to 12VAC35-270-290. This training shall also be provided during the onboarding of new employees. This training shall include:

1. Activation and notification for the emergency plan.

2. Evacuation procedures that include consideration of individuals with medical, functional, and access needs.

3. Use, maintenance, and operations of any emergency equipment.

4. Medical record stewardship during emergencies.

5. Utilization of community support services in emergencies.

G. The provider shall document review of the emergency preparedness plan and continuity of operations annually and make necessary revisions. Such revisions shall be (i) communicated to employees, contractors, students, volunteers, and individuals receiving services and (ii) incorporated into training for employees, contractors, students, and volunteers and into the orientation of individuals to services.

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H. Crisis stabilization units shall ensure a three-day supply of emergency food and water for all individuals and staff. Emergency food caches should include food that is easily prepared and does not need to be cooked. One gallon of potable water per person, per day is required.

1. The emergency food cache shall not include expired food.

2. The emergency food cache shall be appropriate for meeting the dietary needs of the population served.

3. The provider shall ensure any tools needed to prepare the emergency food supply (such as can openers or portable blenders) are stored with the emergency food cache.

4. The emergency food cache shall be separate from the provider's day-to-day food supply.

5. The emergency food cache shall be packed and ready for transport in case of emergency.

12VAC35-278-210. Clinical and safety coordination.

A. In the event the provider employs or contracts with security employees this section shall apply.

B. The provider shall develop and implement written methods of resolving procedural and programmatic issues regarding individual care arising between the clinical and security employees or contractors.

C. The provider shall engage in and document ongoing communication between clinical and security employees to ensure care of individuals receiving services.

D. The provider shall provide cross-training for the clinical and security employees or contractors that includes:

1. Mental health, developmental disability, and substance abuse education;

2. Use of restraints; and

3. Channels of communication.

E. Employees or contractors shall receive periodic in-service training, and have knowledge of and be able to demonstrate the appropriate use of restraints.

F. Security and behavioral assessments shall be completed, as applicable, at the time of admission to determine service eligibility and at least weekly for the safety of individuals, other persons, employees, and visitors.

G. Personal grooming and care services for individuals shall be a cooperative effort between the clinical and security employees or contractors, as required by individual need if the individual has been deemed a safety risk.

H. Clinical needs and safety risk shall be considered when arrangements are made regarding privacy for individual contact with family and visitors.

I. Living quarters shall be assigned on the basis of the individual's safety risk and clinical needs.

J. A documented review of the individual's clinical condition and needs shall be made when restrictions or actions are required for safety measures.

K. Clinical services consistent with the individual's condition and plan of treatment shall be provided when safety measures or seclusion are utilized.

12VAC35-278-220. Seclusion.

Seclusion is only allowed as permitted by 12VAC35-115 and other applicable state regulations.

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12VAC35-278-230. Nutrition.

A. Crisis receiving center providers shall offer light snacks and fluids to individuals who are not in danger of aspirating.

B. Crisis stabilization units shall:

1. Implement a service protocol for the provision of food services that ensures access to nourishing, well-balanced, varied, and healthy meals that shall, at a minimum:

a. Ensure that each individual's dietary needs, as reflected within each individual's crisis ISP or dietary orders, are fulfilled;

b. Ensure the provider learns through reasonable efforts the cultural background, personal preferences, religious requirements and food habits; and ensure meals are prepared in a manner that considers these preferences; and

c. List steps staff shall take to assist individuals who require assistance feeding themselves in a manner that effectively addresses any deficits while maintaining the dignity of individuals.

2. The provider shall have menus. Menus shall:

a. Meet the nutritional needs of each individual as indicated within the individual's crisis ISP;

b. Be prepared in advance;

c. Be followed;

d. Reflect the religious, cultural, and ethnic needs of individuals served, based on the provider's reasonable efforts; and

e. Be updated periodically and at least quarterly.

3. The provider shall implement protocols to monitor each individual's food consumption and nutrition for:

a. Warning signs of changes in physical or mental status related to nutrition; and

b. Compliance with any needs determined by the crisis ISP or prescribed by a physician, nutritionist, or health care professional.

4. Each individual shall be provided a daily diet that consists of:

a. At least three nutritionally balanced meals;

b. An adequate variety and quantity of food for the age of the individual.

c. Meets minimum nutritional requirements and the U.S. Department of Health and Human Services and U.S. Department of Agriculture Dietary Guidelines for Americans.

5. Providers of crisis stabilization services to children and adolescents shall also provide each individual with an evening snack.

C. Nothing in this section should be construed to limit the individual's right to make personal dietary choices.

Part II

CRC and CSU Physical Environment Standards

12VAC35-278-240. Beds or recliners.

A. For the purposes of this section, "clean" means freshly laundered, sanitized, and not soiled or stained.

B. Crisis receiving centers shall arrange for each individual to have a recliner. Crisis stabilization units shall arrange for each individual to have a bed.

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820 C. Upon admission, the provider shall offer to launder the individual's clothes.

821 D. The provider shall not operate more recliners or beds at each service location than the
822 number for which its service location is licensed.

823 E. Providers shall ensure recliners are at a minimum three feet apart at the head, foot, and
824 sides upright as well as in a reclined position. Providers shall ensure each recliner is positioned
825 in such a way that the chair can recline.

826 F. Recliners, beds, and linens shall be clean, comfortable, and well-maintained.

827 G. Recliners shall be equipped with clean cushions and blankets. Beds shall be equipped with
828 a clean mattress, a clean pillow, clean blankets, and clean bed linens. When a bed or recliner is
829 soiled, providers shall assist individuals with bathing, as needed, and provide clean clothing and
830 clean linens, including a clean waterproof mattress cover for a bed.

831 H. Providers shall change used linens at least every seven days and with each new admission.

832 I. Providers shall provide mattresses that are fire retardant as evidenced by documentation
833 from the manufacturer, except in buildings equipped throughout with an automatic sprinkler
834 system in accordance with the Virginia Statewide Building Code (13VAC5-63).

835 J. Providers shall inspect each individual's recliner or bed upon discharge to (i) ensure the
836 individual has all personal belongings and (ii) prepare the bed or recliner for cleaning.

837 **12VAC35-278-250. Laundry requirements.**

838 A. This section applies to crisis receiving centers and crisis stabilization unit providers.

839 B. Providers shall have the ability to launder clothes and linens 24 hours a day.

840 C. A clean quantity of linens shall be available at all times to provide for proper care and
841 comfort of individuals receiving services.

842 D. Linens and other laundry must be handled, stored, and processed to control the spread of
843 infection.

844 E. Clean linens shall be stored in a clean and dry area, separate from soiled laundry,
845 accessible to staff.

846 F. Soiled linens and laundry shall be stored in covered containers in separate, well-ventilated
847 areas and shall not accumulate.

848 G. Soiled linens and laundry shall not be sorted, laundered, rinsed, or stored in bathrooms,
849 bedrooms, kitchens, or food storage areas.

850 H. If the provider has multiple licensed services, the laundry facilities may be in a shared
851 program area if access is restricted to staff only.

852 **12VAC35-278-260. Bathrooms.**

853 A. Bathrooms intended for use by more than one individual at the same time shall provide
854 privacy for showers and toilets.

855 B. The right of privacy within bathrooms includes the right to be free of cameras or audio
856 monitors within the bathroom or angled toward a bathroom.

857 C. Bathrooms shall be free of all protrusions, sharp corners, hardware, fixtures, ligature risks,
858 or other devices that may cause injury to the individual. Windows in the bathrooms shall be
859 constructed so as to minimize breakage and otherwise reduce the risk of the individual self-
860 harming.

861 D. Bathroom equipment and fixtures shall be interior permanent structures plumbed according
862 to state and local building regulations.

863 E. Crisis receiving center services shall make available on-site at least one shower for every
864 sixteen individuals.

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F. Crisis stabilization unit services shall make available on-site at least one shower or bath, one toilet, and one hand basin for every four individuals.

G. Providers of multiple licensed services shall provide separate bathrooms for each service. Bathrooms shall not be shared with unlicensed services.

12VAC35-278-270. Bedrooms.

A. This section only applies to crisis stabilization unit providers.

B. Bedrooms shall meet the following square footage requirements:

1. Single occupancy bedrooms shall have no less than 80 square feet of floor space.

2. Multiple occupancy bedrooms shall have no less than 60 square feet of floor space per individual.

C. No more than four individuals shall share a bedroom.

D. Bedrooms shall be free of all protrusions, sharp corners, hardware, fixtures, ligature risks, or other devices that may cause injury to the individual.

E. Windows in the bedrooms shall be constructed so as to minimize breakage and otherwise reduce the risk of the individual self-harming.

F. No required path of travel to the bathroom shall be through another bedroom. Each individual's room shall have direct access to a corridor, living area, dining area, or other common area.

G. Each individual shall have adequate private storage space accessible to the bedroom for clothing and personal belongings.

H. Each sleeping area shall have a door that can be (i) closed for privacy or quiet and (ii) readily opened in case of fire or other emergency.

I. The environment of sleeping areas shall be conducive to sleep and rest.

J. Providers shall ensure beds are at least three feet apart at the head, foot, and sides.

K. Providers of crisis services to children shall provide separate sleeping areas for boys and girls four years of age or older.

12VAC35-278-280. Seclusion room requirements.

The room used for seclusion of persons shall meet the following design requirements:

1. The seclusion room shall be at least six feet wide and six feet long with a minimum ceiling height of eight feet.

2. The seclusion room shall be free of all protrusions, sharp corners, hardware, fixtures, or other devices that may cause injury to the occupant.

3. Windows in the seclusion room shall be constructed to minimize breakage and otherwise prevent the occupant from self-harming.

4. Light fixtures and other electrical receptacles in the seclusion room shall be recessed or so constructed as to prevent the occupant from self-harming. Light controls shall be located outside the seclusion room.

5. Doors to the seclusion room shall be at least 32 inches wide, open outward, and shall contain observation view panels of transparent wire glass or its approved equivalent, not exceeding 120 square inches but of sufficient size for someone outside the door to see into all corners of the room.

6. The seclusion room shall contain only a mattress with a washable mattress covering designed to avoid damage by tearing.

7. The seclusion room shall maintain temperatures appropriate for the season.

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8. All space in the seclusion room shall be visible through the locked door, either directly or by mirrors.

12VAC35-278-290. Physical Environment.

A. The physical environment, design, structure, furnishings, and lighting shall be appropriate to the individuals receiving services and the services provided.

B. The physical environment shall be accessible to individuals with physical or sensory disabilities.

C. The exterior and interior physical environment shall be kept clean and in good repair to (i) protect against dust, dirt, mold, or transmission of disease, and (ii) prevent the entrance or harboring of insects, rodents, vermin, and other pests. Exterior and interior furnishings shall be dry, free of foul odors, safe, and well-maintained.

D. Floor surfaces and floor coverings shall promote mobility in areas used by individuals and shall promote maintenance of sanitary conditions. There shall be clear pathways through the setting, free of tripping hazards, to ensure that all individuals can move about the setting safely. Any electrical cords, extension cords, or power strips utilized by the provider shall be properly secured and shall not be placed anywhere that the cord or strip can cause trips or falls.

E. Unless otherwise mandated by state or federal authorities, heat shall be evenly distributed in all rooms occupied by individuals such that a temperature no less than 68°F is maintained. Natural or mechanical ventilation to the outside shall be provided in all rooms used by individuals receiving services. Individual or mechanical ventilating systems shall be provided in all rooms occupied by individuals receiving services when the temperature in those rooms exceeds 80°F.

F. Plumbing shall be maintained in good operational condition. Adequate hot and cold running water of a safe and appropriate temperature shall be available. Hot water accessible to individuals receiving services shall be maintained within a range of 100° to 120°F. Precautions shall be taken to prevent scalding from running water.

G. Adequate provision shall be made for the collection and legal disposal of garbage and waste materials.

H. If smoking is permitted, the provider shall make provisions for alternate smoking areas that are separate from the service environment.

I. Bedroom, bathroom, and dressing area windows and doors shall provide privacy.

J. If a provider monitors or records individuals receiving services using audio-visual or other technology, the provider shall develop written policies and procedures for submission to the Office of Licensing and the Office of Human Rights for approval. The policies and procedures shall:

1. Describe how all staff, individuals, guardians, and authorized representatives, if applicable, will be notified of monitoring, including wearable and portable monitoring devices.

2. Outline the process for obtaining signed written acknowledgements from staff, individuals, guardians, and authorized representatives, if applicable, attesting to their understanding of the monitoring;

3. Require prominent postings informing individuals receiving services and others that recording or monitoring is taking place; and

4. Ensure all recordings are used in a manner that respects the dignity and confidentiality of individuals receiving services.

Q. Providers shall develop written policies and procedures approved by Office of Licensing governing searches. The policies and procedures shall:

1. Limit searches to instances where they are necessary to prohibit contraband;

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2. Identify the specific personnel who are authorized to conduct contraband searches;

3. Ensure searches are conducted in such a way to protect the individual's dignity and in the presence of one or more witnesses; and

4. Document the actions to be taken by a provider if contraband is found by as a result of a search, including methods to manage or dispose of contraband.

R. Providers that serve temporary detention orders or emergency custody orders shall ensure the service is provided in a secure facility or a secure service space.

S. Providers shall ensure individuals' privacy from routine sight supervision by staff members while bathing, dressing, or conducting toileting activities. This subsection does not apply to medical personnel performing medical procedures or staff assisting individuals whose physical, mental, or safety needs dictate the need for assistance with these activities as justified in the individual's record.

T. Providers of both children's and adult services shall ensure that children receiving services and adults receiving services are not mixed in shared spaces.

12VAC35-278-300. Lighting.

A. Artificial lighting shall be by electricity.

B. All areas within buildings shall be lighted for safety and the lighting shall be sufficient for the activities being performed.

C. Lighting in halls shall be adequate at night for safe egress.

D. Operable flashlights or battery-powered lanterns shall be available for each staff member on the premises between dusk and dawn to use in emergencies.

E. Outside entrances and parking areas shall be lighted as appropriate for protection against injuries and intruders. The provider shall abide by local ordinances regarding lighting and light pollution.

12VAC35-278-310. Building inspection and classification.

All locations shall be inspected and approved as required by the appropriate building regulatory entity. Documentation of approval shall be a Certificate of Use and Occupancy indicating the building is classified for its proposed licensed purpose. The provider shall submit a copy of the Certificate of Use and Occupancy to the department for new locations.

12VAC35-278-320. Fire inspection.

The provider shall document at the time of its original application and annually thereafter that buildings and equipment are maintained in accordance with the Virginia Statewide Fire Prevention Code (13VAC5-52).

12VAC35-278-330. Building and grounds.

A. The interior and exterior of all buildings shall be safe, properly maintained, clean, and in good working order. This includes, required locks, mechanical devices, indoor and outdoor equipment, recreational spaces, and furnishings.

B. The provider shall implement policies for infrastructure concerns including building and site maps to shut off utilities when necessary.

12VAC35-278-340. Floor plan and building modifications.

A. All services shall submit floor plans with room dimensions to the department for new locations. New locations require a modification application to be submitted to the

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department in accordance with 12VAC35-270-80 at least 30 days prior to opening the new location.

B. With the modification application submitted to the department pursuant to 12VAC35-270-80, the provider shall submit building plans and specifications for (i) any planned construction at a new location, (ii) changes in the use of existing locations, and (iii) any renovations, structural modifications, or additions to existing locations where services are provided.

C. The provider shall submit an interim plan to the department addressing the health and safety of individuals receiving services and continued service delivery if new construction or renovations to existing buildings is approved. The interim plan shall be submitted with the modification application required by 12VAC35-270-80.

12VAC35-278-350. Sewer and water inspections.

A. Service locations shall be on a public water and sewage system or on a nonpublic water and sewage system. Prior to a location being licensed, the provider shall obtain the report from the building inspector pertaining to the sewage disposal system and its capacity. Nonpublic water and sewer systems shall be maintained in good working order and in compliance with local and state laws.

B. Service locations that are not on a public water system shall have a water sample tested by an accredited, independent laboratory for the absence of coliform (i) prior to being licensed and (ii) on an annual basis thereafter. The water sample shall also be tested for lead or nitrates if recommended by the local health department. Documentation of the three most recent test samples shall be kept on file.

Project 8174 - NOIRA

Department of Behavioral Health And Developmental Services

Regulatory Restructuring - Case Management Services (Part 6 of 7)

Chapter 280

Regulations for Case Management Services

12VAC35-280-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed in 12VAC35-270-20:

"Abuse"

"Admission"

"Authorized representative"

"Case management service" or "support coordination service"

"Commissioner"

"Contractor"

"Crisis"

"Department"

"Developmental disability"

"Discharge"

"Discharge plan"

"Individual" or "individual receiving services"

"Informed choice"

"Initial assessment"

"Legal guardian"

"Location"

"Medication"

"Mental illness"

"Neglect"

"Person-centered"

"Provider"

"Referral"

"Restriction"

"Screening"

"Service"

"Substance abuse (substance use disorders)"

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

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

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40 "Comprehensive assessment" means a comprehensive and written assessment that
41 updates and finalizes the initial assessment. The comprehensive assessment shall consider the
42 individual's needs, strengths, goals, preferences, and abilities within the individual's cultural
43 context and shall be completed in a time period appropriate to the nature and scope of the
44 service provided. The comprehensive assessment includes all relevant social, psychological,
45 medical, and level of care information as the basis for the development of the person-centered
46 comprehensive ISP. The comprehensive assessment may be completed at the time of initial
47 assessment if it includes all elements of the comprehensive assessment. In the event a
48 comprehensive assessment is completed at the time of an initial assessment the provider is not
49 required to update the assessment.

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

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

59 "Face-to-face" means encounters that occur in person, unless explicitly indicated by a
60 specific provision of this chapter.

61 "Family" means an individual's biological family or the family in which an individual is raised.
62 For the purposes of this chapter, it also means family of choice or the group of people in an
63 individual's life that satisfies the typical role of family as a support system.

64 "Individualized services plan" or "ISP" shall have the meaning ascribed in 12VAC35-270-20.
65 For the purposes of this chapter, it also means an individualized supports plan for individuals
66 with a primary diagnosis of developmental disability. An individualized supports plan includes
67 the plan for supports, or "Part 5," that incorporates the activities and instructions that are tailored
68 specifically to the preferences of the individual with a developmental disability to support the
69 accomplishment of the individual's desired outcomes.

70 "Planning team" means the team that is consulted to plan the individual's plan for supports.
71 The planning team shall, at a minimum, consist of the individual receiving services, the case
72 manager, and any legally required authorized representative, including legal guardians. The
73 planning team may include the individual's family or family of choice or other identified persons
74 as desired by the individual.

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

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

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12VAC35-280-20. License required.

Providers shall be licensed to provide specific services as defined in 12VAC35-270, in this chapter, or as determined by the commissioner. The case management service, as defined in 12VAC35-270-20, shall require a case management license.

12VAC35-280-30. Service description.

Case management includes assisting the individual and the individual's family, family of choice, and other identified persons as desired by the individual, in accessing medical, psychological, psychiatric, social, educational, vocational, residential, or other services that are responsive to the individual's needs and preferences. This service is offered to provide the individual with essential support for living in the community and developing his desired lifestyle. Activities include identifying and contacting potential service users; conducting needs assessments and community integration enhancement; service planning, coordination, and monitoring; and discharge planning and advocating for individuals in response to changing needs. The 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. The terms "support coordination" and "care coordination" are used in certain communities to identify providers of targeted case management services.

12VAC35-280-40. Service requirements.

Providers shall document that the following services are performed consistent with the individual's assessment and ISP.

1. Enhancing community integration through increased opportunities for community access and involvement, and creating opportunities to enhance community living skills to promote community adjustment, including, to the maximum extent possible, the use of local community resources available to the general public;
2. Making collateral contacts with family members, family of choice, and other persons as desired by the individual with properly authorized releases to promote implementation of the individual's ISP;
3. Assessing needs and planning services, to include developing an ISP;
4. Linking the individual to those community supports that are most likely to promote the personal habilitative or rehabilitative and life goals of the individual as identified in the ISP;
5. Assisting the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;
6. Ensuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments;
7. Monitoring service delivery through contacts with the individual receiving services; family members, family of choice, or other persons as desired by the individual; service providers; and periodic site and home visits, as appropriate, to assess the quality of care and satisfaction of the individual;
8. Providing follow up instruction, education, and guidance to support the individual and develop relationships that promote the goals in the ISP;
9. Advocating for the individual with others, such as other providers and human service agencies and systems, in response to changing needs and preferences, which shall be reflected in the ISP;
10. Planning for transitions in the individual's life;

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11. Monitoring the individual's health status, including any medical conditions, and the individual's medications and potential side effects, and assisting the individual in accessing primary care and other medical and dental services, as needed; and

12. Understanding the capabilities of services to meet the individual's identified needs and preferences without placing the individual, other participants, or staff at risk of serious harm.

12VAC35-280-50. Screening.

A. Providers shall implement screening policies and procedures that include:

1. Identification, qualification, training, and duties of employees responsible for screening;

2. The following minimum required elements of screening for case management services:

a. Date of contact;

b. Legal name, preferred name, date of birth, sex, and gender of the individual;

c. Contact information, including address, telephone number, and email address of the individual, if applicable;

d. Reasons why the individual is requesting services;

e. Current reported diagnoses and medical conditions;

f. Medical symptoms;

g. Psychoactive or other medications currently being used, including recent increases, decreases, discontinuation, misuse, or overdose of prescription medication;

h. Recent or current substance use or dependence, including risk for intoxication or substance withdrawal; and

i. Status of the individual, including referral to other services for further assessment, placement on a waiting list for services, or admission to the service; and

3. Methods to identify other appropriate services for referral to assist individuals who are not admitted to the service after screening.

B. The provider shall retain documentation of the individual's screening for six months. For individuals who are admitted to the service, documentation shall be included in the individual's record in accordance with 12VAC35-270-580.

C. The provider shall review all elements of the screening at the time of initial assessment and update as necessary.

12VAC35-280-60. Assessment.

A. The provider shall implement a written assessment policy. The policy shall define how assessments will be conducted and documented.

B. The provider shall actively involve the individual and the individual's authorized representative, if applicable, and any family, family of choice, or other identified persons as desired by the individual, in the preparation of initial and comprehensive assessments. In these assessments, the provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

C. The assessment policy shall designate appropriately qualified employees or contractors who are responsible for conducting, obtaining, or updating assessments and coordinating medical screenings. These employees or contractors shall have experience in working with the needs of individuals who are being assessed, the assessment tools being utilized, and knowledge of the array of services that the individuals may require.

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D. Assessment is an ongoing activity. The provider shall make reasonable attempts to obtain previous assessments or relevant history in order to complete an individual's initial or comprehensive assessment. The provider shall use previous assessments or relevant history within the course of treatment, if applicable.

E. Providers shall utilize an assessment tool that meets the requirements in subsection F of this section for initial assessments and subsection G of this section for comprehensive assessments. Providers may utilize a standardized state-sanctioned or federally sanctioned assessment tool that does not meet the criteria in these regulations if the tool is approved by the department prior to use.

F. Providers shall conduct an individual's initial assessment prior to or at admission to the service. The provider shall complete or obtain information from other qualified providers in order to complete an initial assessment detailed enough to determine whether the individual qualifies for admission and to initiate an ISP for those individuals who are admitted to the service.

1. The initial assessment shall assess immediate service, health, and safety needs and be conducted using an assessment tool that evaluates, at a minimum, the following criteria concerning the individual:

a. Diagnosis;

b. Presenting needs, including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of needs;

c. Current medical issues;

d. Current medications;

e. Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders;

f. At-risk behavior to self and others; and

g. Risk factors that may impact the individual's ability to seek treatment or continue to participate in services.

2. For individuals presenting with substance use disorder, at the time of the initial assessment, the provider shall:

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

b. Assess substances used and time of last use.

3. The comprehensive assessment may be completed at the time of initial assessment if it includes all elements noted within subsection G of this section. In the event a comprehensive assessment is completed at the time of an initial assessment, the provider is not required to update the assessment unless a reassessment is medically or clinically indicated.

G. Providers shall conduct a comprehensive assessment for each individual who is admitted to the service. A comprehensive assessment shall update and finalize the initial assessment, unless the comprehensive assessment is completed at the time of initial assessment as provided in subdivision F 3 of this section.

1. Completion of the comprehensive assessment shall be based upon the nature and scope of the service, but shall occur no later than (i) 30 days after admission for providers of mental health and substance abuse services and (ii) 60 days after admission for providers of developmental services.

2. The comprehensive assessment may be completed at the time of initial assessment only if the assessment includes all elements enumerated in subdivision 3 of this subsection. In the event a comprehensive assessment is completed at the time of an

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individual's initial assessment, the provider is not required to update the assessment unless a reassessment is medically or clinically indicated.

3. The comprehensive assessment shall be conducted using an assessment tool that evaluates, at a minimum, the following criteria:

a. Onset and duration of needs;

b. Social, behavioral, developmental, and family history and supports;

c. Cognitive functioning, including strengths and weaknesses;

d. Employment, vocational, and educational background;

e. Prior interventions and outcomes, including interventions and outcomes that were unsuccessful, with the provider utilizing previous assessments and relevant history to note prior interventions as required by subsection D of this section;

f. Overall financial situation, including resources, support, and benefits, and whether the individual has the means to meet the individual's financial needs;

g. Health history and current medical care needs, to include:

(1) Allergies, including allergies to food and medications;

(2) Recent physical complaints and medical conditions;

(3) Nutritional needs;

(4) Chronic conditions;

(5) Communicable diseases;

(6) Restrictions on physical activities, if any;

(7) Restrictive protocols or special supervision requirements;

(8) Past serious illnesses, serious injuries, and hospitalizations;

(9) Serious illnesses and chronic conditions of the individual's parents, siblings, and significant others in the same household; and

(10) Current and past substance use, including alcohol, prescription and nonprescription medications, and illicit drugs.

h. Psychiatric and substance use issues, including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or dependence, and circumstances that increase the individual's risk for mental illness or substance use issues;

i. History of abuse, neglect, sexual or domestic violence, or other trauma, including psychological trauma;

j. Legal competency, including authorized representative, commitment, and representative payee status;

k. Relevant criminal charges or convictions and probation or parole status;

l. Daily living skills;

m. Housing arrangements;

n. Ability to access services, including transportation needs;

o. As applicable, fall risk, communication needs, and mobility and adaptive equipment needs;

p. Leisure and recreation information; and

q. Individual empowerment, self-advocacy, and volunteerism information.

H. Case managers shall meet with each individual face-to-face as dictated by the individual's needs. At face-to-face meetings, the case manager shall (i) observe and assess for

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any previously unidentified risks, injuries, needs, or other changes in status; (ii) assess the status of previously identified risks, injuries, needs, or other changes in status; (iii) assess whether the individual's service plan is being implemented appropriately and remains appropriate for the individual; and (iv) assess whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.

I. The provider shall retain documentation of the individual's assessments in accordance with its written records management policy and 12VAC35-270-580.

12VAC35-280-70. Individualized services plan (ISP); service planning.

A. The provider shall actively involve, through face-to-face contacts, the individual and the individual's authorized representative, as appropriate, in the development, review, and revision of a person-centered ISP. For substance use and mental health case management services, face-to-face contacts may be fulfilled through telemedicine if clinically appropriate and utilized for the convenience of the individual. The individualized services planning process shall be consistent with laws protecting confidentiality, privacy, human rights of individuals receiving services, and the rights of minors.

1. Providers of developmental services shall collaborate with the individual's planning team to develop and implement the initial plan for supports, which is a component of the comprehensive ISP, no later than 24 hours after admission. The initial plan for supports shall address the individual's immediate health and safety needs for the first 60 days, may include assessment activities, and shall continue in effect until the ongoing comprehensive plan for supports is developed or the individual is discharged, whichever occurs first. An ongoing comprehensive plan for supports shall be completed within 60 days of admission.

2. Providers of mental health or substance abuse services shall develop and implement an initial person-centered ISP no later than 24 hours after admission. The initial ISP shall address the individual's immediate service, health, and safety needs for the first 30 days and shall continue in effect until the comprehensive ISP is developed or the individual is discharged, whichever occurs first. An ongoing comprehensive ISP based upon the nature and scope of services shall be completed as soon as possible, but no later than (i) 48 hours after admission by providers of short-term intensive services typically provided for less than 30 days or (ii) 30 days after admission.

B. The initial ISP and the comprehensive ISP shall be developed based on the respective assessment with the participation and informed choice of the individual receiving services.

1. To ensure the individual's participation and informed choice, the following shall be explained to the individual or the individual's authorized representative, as applicable, in a reasonable and comprehensible manner:

a. The proposed services to be delivered;

b. Any alternative services that might be advantageous for the individual; and

c. Any accompanying risks or benefits of the proposed alternative services.

2. If no alternative services are available to the individual, it shall be clearly documented within the ISP or within documentation attached to the ISP, that alternative services were not available as well as the steps taken to identify alternative services.

3. Whenever there is a change to an individual's ISP, it shall be clearly documented within the ISP or within documentation attached to the ISP that:

a. The individual participated in the development of or revision to the ISP;

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b. The proposed and alternative services and the respective risks and benefits were explained to the individual or the individual's authorized representative; and

c. The reasons the individual or the individual's authorized representative chose the option included in the ISP.

12VAC35-280-80. ISP minimum requirements.

A. The case manager shall collaborate with the individual, the individual's authorized representative, the individual's other service providers, where applicable, and other persons as desired by the individual, to complete the individualized, person-centered initial ISP and comprehensive ISP.

B. The initial ISP shall be based on the individual's immediate service, health, and safety needs identified in the initial assessment. The initial ISP shall include:

1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing needs and preferences documented within the individual's initial assessment;

2. Services, supports, and frequency of services planned to accomplish the individual's goals, including relevant psychological, mental health, substance abuse, behavioral, developmental, medical, rehabilitation, training, and nursing needs and supports;

3. The role of the individual and others, including the individual's family, if appropriate, in implementing the service plan;

4. Target dates for accomplishment of goals and objectives;

5. Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies; and

6. The activities, services, and supports of each provider, including the case manager.

C. The comprehensive ISP shall be based on the individual's needs, strengths, abilities, personal preferences, goals, and natural supports identified in the comprehensive assessment. The comprehensive ISP shall include the following minimum provisions:

1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing each need documented within the individual's comprehensive assessment;

2. Services and supports required to accomplish the goals, including relevant psychological, mental health, substance abuse, behavioral, developmental, medical, rehabilitation, training, and nursing needs and supports;

3. The frequency at which services and supports must be provided to accomplish the individual's goals;

4. The role of the individual and others, including the individual's family, if appropriate, in implementing the comprehensive ISP;

5. A communication plan for individuals with communication barriers, including language barriers;

6. A behavioral support or treatment plan, if applicable;

7. A physical safety plan that addresses identified risks to the individual or to others, including a fall risk plan if indicated by the individual's assessment;

8. A crisis or recovery plan, if applicable;

9. Target dates for accomplishment of goals and objectives;

10. Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies;

11. A transportation plan, if applicable;

12. Services the individual elects to self-direct, if applicable;

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13. Projected discharge plan and estimated length of stay within the service; and

14. The activities, services, and supports of each provider, including the case manager.

D. Both the initial ISP and the comprehensive ISP shall be signed and dated, at a minimum, by (i) the person responsible for implementing the plan and (ii) the individual receiving services or the individual's authorized representative, if applicable, in order to document agreement.

1. If the signature of the individual receiving services or the individual's authorized representative cannot be obtained, the provider shall document attempts to obtain the necessary signature and the reason the signature was unobtainable. The provider shall attempt to obtain the necessary signature on a periodic basis while each ISP is in effect. An attempt to obtain the necessary signature shall occur, at a minimum, each time the provider reviews the ISP as required by 12VAC35-280-90 E.

2. Prior to implementation, each ISP shall be distributed to the individual and others authorized to receive the ISP. The provider shall document dates of the distribution within the individual's record.

E. The case manager shall be responsible for developing, implementing, reviewing, and revising each individual's comprehensive ISP in collaboration with the individual or the individual's authorized representative, as appropriate, and other persons as desired by the individual. The case manager shall also monitor implementation of the individual's ISP by other service providers, if applicable.

F. The case manager shall maintain a working knowledge of the objectives and strategies contained in the individual's current ISP, including an individual's detailed health and safety protocols.

1. The case manager shall initiate revisions of the ISP as appropriate based on the changing needs and preferences of the individual.

2. When changes occur to an individual's ISP, the case manager shall notify affected providers and other persons as appropriate.

G. When a case management agency provides more than one service to an individual, the agency may maintain a single case management ISP document that contains individualized objectives and strategies for each service provided.

H. Whenever possible, the identified goals in the ISP shall be written in the words of the individual receiving services.

I. The provider shall use signed and dated progress notes to document the implementation of the goals and objectives contained within the ISP.

J. A copy of the individual's most current ISP shall be readily accessible to the case manager during the provision of case management services.

12VAC35-280-90. Reassessments and quarterly ISP reviews.

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

B. The provider shall actively involve the individual, the individual's authorized representative, and other service providers, as applicable, in reassessments. The provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

C. Providers shall revise the ISP if the reassessment supports changes or if desired by the individual. If a reassessment does not support changes to the ISP, the provider shall document that no revisions are necessary and the reasoning.

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D. If necessary as a result of a reassessment, case managers shall collaborate with other providers to ensure changes are made to medical, medical equipment, behavioral, or other corresponding protocols.

E. The provider shall complete quarterly reviews of the ISP in writing every three months from (i) the date of the implementation of the most recent comprehensive ISP or (ii) the most recent reassessment, whichever occurs later. For case management services, the quarterly ISP review shall be added to the individual's record no later than 30 calendar days from the date the review was due to be completed.

F. The quarterly ISP review shall be conducted in a person-centered manner to determine if services are being delivered as described within the ISP. The individual receiving services and the individual's authorized representative, if applicable, shall be included in the ISP review to determine if the individual's treatment needs and preferences are being met and whether the individual is satisfied with the services provided.

1. A quarterly review of the ISP shall evaluate the individual's progress toward meeting the ISP goals, outcomes, objectives, and support activities; assess the continued relevance of the ISP objectives, strategies, and support instructions; and update the goals, outcomes, objectives, support activities, support instructions, and strategies contained in the ISP, if indicated, and implement any updates made.

2. A quarterly review of the ISP shall document evidence of progress toward or achievement of a specific targeted outcome for each goal and objective.

3. For goals and objectives that were not accomplished by the identified target date, or for which the individual did not demonstrate sufficient progress, the provider shall meet and collaborate with other service providers and support team members to review the reasons for lack of progress and provide the individual an opportunity to make an informed choice of how to proceed. The provider shall retain documentation of this meeting and the individual's informed choice within the individual's record.

4. A quarterly review of the ISP shall note:

a. The involvement of the individual's family or other persons desired by the individual in the individual's treatment;

b. Whether the individual no longer needs the intensity of care provided by case management services;

c. The individual's progress towards discharge; and

d. The status of the individual's discharge planning.

G. The provider shall ensure after each reassessment that the individual's most current ISP is easily accessible to the case manager and direct care staff at the location where the individual receives services.

12VAC35-280-100. Progress notes.

A. The documentation system implemented by the provider pursuant to subdivision E of 12VAC35-270-580 shall ensure that progress notes are (i) maintained in a consistent format that satisfies the minimum provisions of subsection B of this section and (ii) entered into the individual's record in accordance with the provider's record management policy.

B. The provider shall use signed and dated progress notes or other documentation to document the services provided to the individual. Progress notes shall, at a minimum:

1. Be legible and readable;

2. Record the individual's interaction with the staff writing the progress note, including care provided and events relevant to diagnosis and treatment or care of the individual;

3. Provide a narrative or descriptive component;

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4. Describe needed follow-up care or note which objective within the ISP will receive focus the next time the individual receives services; and

5. Be signed and dated by the staff member who rendered the service.

C. Communication logs, information notes, and supervision notes shall not be considered progress notes.

12VAC35-280-110. Enhanced case management.

A. Enhanced case management contacts shall be provided to individuals receiving developmental services who:

1. Receive services from providers holding conditional or provisional licenses;

2. Have more intensive behavioral or medical needs as defined by the supports for intensity scale (SIS) category representing the highest level of risk to individuals;

3. Experience an interruption of service greater than 30 days;

4. Encounter the crisis system for a serious crisis or for multiple less serious crises within a consecutive three-month period;

5. Have transitioned from a training center within the previous 12 months; or

6. Reside in congregate settings of five or more individuals.

B. An individual eligible for enhanced case management contacts shall meet with the individual's case manager face-to-face at least once every 30 days, with a minimum of every other visit occurring in person in the individual's place of residence.

12VAC35-280-120. Health care policy.

A. The provider shall implement a policy that addresses the facilitation and coordination of adequate and appropriate medical care. This policy shall describe to what extent and how:

1. A case manager will ensure that an individual's medical care needs will be assessed and the circumstances that will prompt the case manager to facilitate a medical assessment.

2. The ISP will address any medical care needs appropriate to the scope and level of service.

3. The provider will arrange for or support the individual with the arrangement of the provision of medical and dental care needs identified at admission.

4. The provider will arrange for or support the individual with the arrangement of routine, ongoing, and follow-up medical and dental care services after admission.

5. The case manager will facilitate communicating the results of physical examinations, medical assessments, diagnostic tests, treatments, or examinations conducted by the individual's providers to the individual and the individual's authorized representative, as appropriate.

6. The case manager will ensure the provider keeps on file and up to date the names, addresses, and telephone numbers of the individual's medical and dental providers.

7. The provider will ensure a means for facilitating and arranging, as appropriate, transportation to medical and dental appointments and medical tests.

8. The provider will ensure the provision of emergency medical services for each individual.

B. The case management agency shall implement written policies to identify any individuals who are at risk for falls. If an individual is identified as at risk for falls by a department-licensed provider or health care professional, the case manager shall obtain the at-risk individual's assessment and ensure that a fall prevention and management plan and program for the individual is implemented across providers appropriately.

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C. The provider shall report outbreaks of infectious diseases to the Department of Health pursuant to § 32.1-37 of the Code of Virginia.

12VAC35-280-130. Qualifications of employees or contractors.

A. Employees or contractors providing case management services shall provide documentation of education, training, supervision, or verified work experience that demonstrates knowledge of:

1. Services and systems available in the community, including primary health care, support services, eligibility criteria and intake processes, and generic community resources;

2. The nature of serious mental illness, developmental disability, substance use disorders, or co-occurring disorders depending on individuals receiving services, including clinical and developmental issues;

3. Different types of assessments, including functional assessment, and use of those assessments in service planning;

4. Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;

5. Types of mental health, developmental, and substance use disorder programs available in the locality;

6. The service planning process and major components of a service plan;

7. The use of medications in the care or treatment of the population served; and

8. All applicable federal and state laws and regulations.

B. Employees or contractors providing case management services shall provide documentation of supervision or experience that demonstrates the following skills and abilities:

1. Identifying and documenting an individual's need for resources, services, and other supports;

2. Using information from assessments, evaluations, observation, and interviews to develop service plans or supports plans;

3. Identifying and documenting how resources, services, and natural supports, such as family or other persons as desired by the individual, can be utilized to promote achievement of an individual's personal habilitative or rehabilitative and life goals;

4. Coordinating the provision of services by diverse public and private providers;

5. Working as team members to maintain effective interagency and intraagency relationships;

6. Working independently and performing position duties under general supervision; and

7. Engaging in and sustaining ongoing relationships with individuals receiving services.

C. Case managers serving individuals with developmental disability shall complete the department's core competency-based curriculum within 30 days of hire.

12VAC35-280-140. Choice of case manager.

The provider shall implement a written policy explaining how case managers are assigned and outlining the process by which an individual or the individual's representative, as appropriate, may request a change of an assigned case manager.

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1	CATEGORY	RESTRUCTURED CHAPTER	SECTION	CURRENT REGULATORY SOURCE(S)	NOTES
2	General Provisions	12VAC35-270	10	12VAC35-105-10	
3	General Provisions	12VAC35-270	20	12VAC35-105-20	
4	General Provisions	12VAC35-270	30	12VAC35-105-30	
5	General Provisions	12VAC35-270	40	12VAC35-105-40	
6	General Provisions	12VAC35-270	50	12-VAC35-105-50	
7	General Provisions	12VAC35-270	60	12VAC35-105-70; 12VAC35-105-160	
8	General Provisions	12VAC35-270	70	12VAC35-105-40; 12VAC35-105-50	
9	General Provisions	12VAC35-270	80	12VAC35-105-50; 12VAC35-105-60; 12VAC35-105-180	
10	General Provisions	12VAC35-270	90	12VAC35-105-120	
11	General Provisions	12VAC35-270	100	12VAC35-105-80	
12	General Provisions	12VAC35-270	110	12VAC35-105-90; 12VAC35-105-150	
13	General Provisions	12VAC35-270	120	12VAC35-105-170	
14	General Provisions	12VAC35-270	130	12VAC35-105-100	
15	General Provisions	12VAC35-270	140	12VAC35-105-110	
16	General Provisions	12VAC35-270	150	12VAC35-105-115	
17	General Provisions	12VAC35-270	160	n/a	
18	General Provisions	12VAC35-270	170	n/a	
19	General Provisions	12VAC35-270	180	12VAC35-105-200	
20	General Provisions	12VAC35-270	190	12VAC35-105-190	
21	General Provisions	12VAC35-270	200	n/a	
22	General Provisions	12VAC35-270	210	12VAC35-105-210; 12VAC35-105-240	
23	General Provisions	12VAC35-270	220	12VAC35-105-220	
24	General Provisions	12VAC35-270	230	12VAC35-105-390	
25	General Provisions	12VAC35-270	240	12VAC35-105-400	
26	General Provisions	12VAC35-270	250	12VAC35-105-430	
27	General Provisions	12VAC35-270	260	12VAC35-105-510	
28	General Provisions	12VAC35-270	270	12VAC35-105-410	
29	General Provisions	12VAC35-270	280	12VAC35-105-420	
30	General Provisions	12VAC35-270	290	12VAC35-105-440; 12VAC35-105-450; 12VAC35-105-460	
31	General Provisions	12VAC35-270	300	12VAC35-105-590	
32	General Provisions	12VAC35-270	310	12VAC35-105-470	
33	General Provisions	12VAC35-270	320	12VAC35-105-480	
34	General Provisions	12VAC35-270	330	n/a	
35	General Provisions	12VAC35-270	340	12VAC35-105-140	
36	General Provisions	12VAC35-270	350	n/a	

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1	CATEGORY	RESTRUCTURED CHAPTER	SECTION	CURRENT REGULATORY SOURCE(S)	NOTES
37	General Provisions	12VAC35-270	360	n/a	
38	General Provisions	12VAC35-270	370	n/a	
39	General Provisions	12VAC35-270	380	12VAC35-105-230	
40	General Provisions	12VAC35-270	390	12VAC35-105-250	
41	General Provisions	12VAC35-270	400	12VAC35-105-180	
42	General Provisions	12VAC35-270	410	12VAC35-105-691	
43	General Provisions	12VAC35-270	420	n/a	
44	General Provisions	12VAC35-270	430	12VAC35-105-693	
45	General Provisions	12VAC35-270	440	12VAC35-105-940	
				12VAC35-105-240; 12VAC35-105-210; 12VAC35-105-700; 12VAC35-105-760; 12VAC35-105-800; 12VAC35-105-400; 12VAC35-105-40; 12VAC35-105-450; 12VAC35-105-480; 12VAC35-105-500; 12VAC35-105-490; 12VAC35-105-870; 12VAC35-105-690; 12VAC35-105-620; 12VAC35-105-160; 12VAC35-105-440; 12VAC35-105-520; 12VAC35-105-691; 12VAC35-105-940; 12VAC35-105-310	
46	General Provisions	12VAC35-270	450		
47	General Provisions	12VAC35-270	460	12VAC35-105-750	
48	General Provisions	12VAC35-270	470	12VAC35-105-710	
49	General Provisions	12VAC35-270	480	12VAC35-105-580	
50	General Provisions	12VAC35-270	490	12VAC35-105-770	
51	General Provisions	12VAC35-270	500	12VAC35-105-800	
52	General Provisions	12VAC35-270	510	12VAC35-105-810	
53	General Provisions	12VAC35-270	520	12VAC35-46-210	
54	General Provisions	12VAC35-270	530	12VAC35-46-510	
55	General Provisions	12VAC35-270	540	12VAC35-46-1060	
56	General Provisions	12VAC35-270	550	12VAC35-105-160	
57	General Provisions	12VAC35-270	560	12VAC35-105-520	
58	General Provisions	12VAC35-270	570	12VAC35-105-620	

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1	CATEGORY	RESTRUCTURED CHAPTER	SECTION	CURRENT REGULATORY SOURCE(S)	NOTES
59	General Provisions	12VAC35-270	580	12VAC35-105-870; 12VAC35-105-880; 12VAC35-105-890; 12VAC35-105-920; 12VAC35-105-1100; 12VAC35-105-390	
60	General Provisions	12VAC35-270	590	12VAC35-105-690	
61	General Provisions	12VAC35-270	600	12VAC35-105-150	
62	General Provisions	12VAC35-270	610	12VAC35-105-820	
63	General Provisions	12VAC35-270	620	12VAC35-115-70	
64	General Provisions	12VAC35-270	630	12VAC35-115-100	
65	General Provisions	12VAC35-270	640	12VAC35-46-470	
66	General Provisions	12VAC35-270	650	12VAC35-46-620	
67	General Provisions	12VAC35-270	660	12VAC35-105-310	
68	General Provisions	12VAC35-270	670	n/a	
69	General Provisions	12VAC35-270	680	12VAC35-105-540	
70	General Provisions	12VAC35-270	690	12VAC35-105-550	
71	General Provisions	12VAC35-270	700	12VAC35-105-560	
72	Residential	12VAC35-272	10	12VAC35-46-10; 12VAC35-105-20	
73	Residential	12VAC35-272	20	12VAC35-105-30	
74	Residential	12VAC35-272	30	12VAC35-105-20	
75	Residential	12VAC35-272	40	12VAC35-105-155; 12VAC35-105-645; 12VAC35-105-650	
76	Residential	12VAC35-272	50	12VAC35-105-650	
77	Residential	12VAC35-272	60	12VAC35-105-660	
78	Residential	12VAC35-272	70	12VAC35-105-665	
79	Residential	12VAC35-272	80	12VAC35-105-675	
80	Residential	12VAC35-272	90	12VAC35-105-680	
81	Residential	12VAC35-272	100	12VAC35-105-155	
82	Residential	12VAC35-272	110	12VAC35-105-530; 12VAC35-46-480	
83	Residential	12VAC35-272	120	12VAC35-105-720	
84	Residential	12VAC35-272	130	12VAC35-105-700	

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1	CATEGORY	RESTRUCTURED CHAPTER	SECTION	CURRENT REGULATORY SOURCE(S)	NOTES
85	Residential	12VAC35-272	140	12VAC35-105-10; 12VAC35-105-1530; 12VAC35-105-1630; 12VAC35-105-1580; 12VAC35-105-1430; 12VAC35-105-1480; 12VAC35-46-380; 12VAC35-46-390; 12VAC35-460-380; 12VAC35-46-350	
86	Residential	12VAC35-272	150	12VAC35-105-590; 12VAC35-46-870	
87	Residential	12VAC35-272	160	12VAC35-105-600; 12VAC35-46-860	
88	Residential	12VAC35-272	170	12VAC35-105-290; 12VAC35-105-600	
89	Residential	12VAC35-272	180	12VAC35-105-610; 12VAC35-46-980; 12VAC35-46-1000	
90	Residential	12VAC35-272	190	12VAC35-105-780	
91	Residential	12VAC35-272	200	(reserved)	
92	Residential	12VAC35-272	210	12VAC35-105-740; 12VAC35-46-840	
93	Residential	12VAC35-272	220	12VAC35-105-830	
94	Residential	12VAC35-272	230	12VAC35-105-840; 12VAC35-46-960	
95	Residential	12VAC35-272	240	n/a	
96	Residential	12VAC35-272	250	12VAC35-105-1050	
97	Residential	12VAC35-272	260	12VAC35-105-330; 12VAC35-105-350; 12VAC35-46-480	
98	Residential	12VAC35-272	270	12VAC35-105-340; 12VAC35-46-480; 12VAC35-46-500	
99	Residential	12VAC35-272	280	12VAC35-46-550	
100	Residential	12VAC35-272	290	n/a	

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1	CATEGORY	RESTRUCTURED CHAPTER	SECTION	CURRENT REGULATORY SOURCE(S)	NOTES
101	Residential	12VAC35-272	300	12VAC35-105-280; 12VAC35-105-360; 12VAC35-105-370; 12VAC35-46-530; 12VAC35-46-420; 12VAC35-46-430; 12VAC35-46-450; 12VAC35-46-460; 12VAC35-46-500; 12VAC35-46-610	
102	Residential	12VAC35-272	310	12VAC35-105-260	
103	Residential	12VAC35-272	320	12VAC35-105-320; 12VAC35-46-420	
104	Residential	12VAC35-272	330	12VAC35-46-590	
105	Residential	12VAC35-272	340	12VAC35-105-265; 12VAC35-105-270; 12VAC35-46-420	
106	Residential	12VAC35-272	350	(reserved)	
107	Residential	12VAC35-272	360	12VAC35-105-300	
108	Residential	12VAC35-272	370	12VAC35-46-680	
109	Residential	12VAC35-272	380	12VAC35-46-640	
110	Residential	12VAC35-272	390	12VAC35-46-630; 12VAC35-46-700	
111	Residential	12VAC35-272	400	12VAC35-46-710	
112	Residential	12VAC35-272	410	12VAC35-46-720	
113	Residential	12VAC35-272	420	12VAC35-46-760	
114	Residential	12VAC35-272	430	12VAC35-46-240	
115	Residential	12VAC35-272	440	12VAC35-46-395	
116	Residential	12VAC35-272	450	(reserved)	
117	Residential	12VAC35-272	460	(reserved)	
118	Residential	12VAC35-272	470	(reserved)	
119	Residential	12VAC35-272	480	12VAC35-46-625	
120	Residential	12VAC35-272	490	12VAC35-46-800	
121	Residential	12VAC35-272	500	(reserved)	
122	Residential	12VAC35-272	510	12VAC35-46-260	
123	Residential	12VAC35-272	520	12VAC35-46-1080	
124	Residential	12VAC35-272	530	12VAC35-46-570	
125	Residential	12VAC35-272	540	12VAC35-46-890	
126	Residential	12VAC35-272	550	12VAC35-46-900	
127	Residential	12VAC35-272	560	12VAC35-46-910	
128	Residential	12VAC35-272	570	12VAC35-46-780	
129	Residential	12VAC35-272	580	12VAC35-46-970	
130	Residential	12VAC35-272	590	12VAC35-46-990	

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1	CATEGORY	RESTRUCTURED CHAPTER	SECTION	CURRENT REGULATORY SOURCE(S)	NOTES
131	Residential	12VAC35-272	600	12VAC35-46-1010	
132	Residential	12VAC35-272	610	12VAC35-46-1020	
133	Residential	12VAC35-272	620	12VAC35-46-1030	
134	Residential	12VAC35-272	630	(reserved)	
135	Residential	12VAC35-272	640	12VAC35-46-920	
136	Residential	12VAC35-272	650	12VAC35-46-765	
137	Residential	12VAC35-272	660	12VAC35-46-770	
138	Residential	12VAC35-272	670	12VAC35-46-490; 12VAC35-46-520; 12VAC35-46-530; 12VAC35-46-540; 12VAC35-46-560; 12VAC35-46-580; 12VAC35-46-590	
139	Residential	12VAC35-272	680	12VAC35-105-1140	
140	Residential	12VAC35-272	690	12VAC35-105-1150	
141	Residential	12VAC35-272	700	12VAC35-105-1160	
142	Residential	12VAC35-272	710	12VAC35-105-1170	
143	Residential	12VAC35-272	720	12VAC35-105-1180	
144	Residential	12VAC35-272	730	12VAC35-105-1200	
145	Residential	12VAC35-272	740	12VAC35-105-1210	
146	Residential	12VAC35-272	750	12VAC35-105-1220	
147	Residential	12VAC35-272	760	12VAC35-105-1190	
148	Residential	12VAC35-272	770	12VAC35-105-1230	
149	Residential	12VAC35-272	780	12VAC35-105-1235	
150	Residential	12VAC35-272	790	12VAC35-105-1440	
151	Residential	12VAC35-272	800	12VAC35-105-1450	
152	Residential	12VAC35-272	810	12VAC35-105-1460	
153	Residential	12VAC35-272	820	12VAC35-105-1470	
154	Residential	12VAC35-272	830	12VAC35-105-1490	
155	Residential	12VAC35-272	840	12VAC35-105-1500	
156	Residential	12VAC35-272	850	12VAC35-105-1510	
157	Residential	12VAC35-272	860	12VAC35-105-1520	
158	Residential	12VAC35-272	870	12VAC35-105-1540	
159	Residential	12VAC35-272	880	12VAC35-105-1550	
160	Residential	12VAC35-272	890	12VAC35-105-1560	
161	Residential	12VAC35-272	900	12VAC35-105-1570	
162	Residential	12VAC35-272	910	12VAC35-105-1590	
163	Residential	12VAC35-272	920	12VAC35-105-1600	
164	Residential	12VAC35-272	930	12VAC35-105-1610	
165	Residential	12VAC35-272	940	12VAC35-105-1620	
166	Residential	12VAC35-272	950	12VAC35-105-1640	
167	Residential	12VAC35-272	960	12VAC35-105-1650	

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1	CATEGORY	RESTRUCTURED CHAPTER	SECTION	CURRENT REGULATORY SOURCE(S)	NOTES
168	Residential	12VAC35-272	970	12VAC35-105-1660	
169	Residential	12VAC35-272	980	12VAC35-105-1670	
170	NonCenter	12VAC35-274	10	12VAC35-105-20	
171	NonCenter	12VAC35-274	20	12VAC35-105-30	
172	NonCenter	12VAC35-274	30	12VAC35-105-20	
173	NonCenter	12VAC35-274	40	12VAC35-105-155; 12VAC35-105-645; 12VAC35-105-650	
174	NonCenter	12VAC35-274	50	12VAC35-105-650	
175	NonCenter	12VAC35-274	60	12VAC35-105-660	
176	NonCenter	12VAC35-274	70	12VAC35-105-665	
177	NonCenter	12VAC35-274	80	12VAC35-105-675	
178	NonCenter	12VAC35-274	90	12VAC35-105-680	
179	NonCenter	12VAC35-274	100	12VAC35-105-720	
180	NonCenter	12VAC35-274	110	12VAC35-105-590	
181	NonCenter	12VAC35-274	120	12VAC35-105-1370	
182	NonCenter	12VAC35-274	130	12VAC35-105-780	
183	NonCenter	12VAC35-274	140	12VAC35-105-700	
184	NonCenter	12VAC35-274	150	(reserved)	
185	NonCenter	12VAC35-274	160	12VAC35-105-530	
186	NonCenter	12VAC35-274	170	(reserved)	
187	NonCenter	12VAC35-274	180	12VAC35-105-1360	
188	NonCenter	12VAC35-274	190	12VAC35-105-1380	
189	NonCenter	12VAC35-274	200	12VAC35-105-1390	
190	NonCenter	12VAC35-274	210	12VAC35-105-1400	
191	NonCenter	12VAC35-274	220	12VAC35-105-1410	
192	NonCenter	12VAC35-274	230	Emergency Action	New CPST service
193	NonCenter	12VAC35-274	240	Emergency Action	New CPST service
194	NonCenter	12VAC35-274	250	Emergency Action	New CPST service
195	NonCenter	12VAC35-274	260	Emergency Action	New CPST service
196	NonCenter	12VAC35-274	270	Emergency Action	New CPST service
197	Center-Based	12VAC35-276	10	12VAC35-105-20	
198	Center-Based	12VAC35-276	20	12VAC35-105-30	
199	Center-Based	12VAC35-276	30	12VAC35-105-20	
200	Center-Based	12VAC35-276	40	12VAC35-105-155; 12VAC35-105-645; 12VAC35-105-650	
201	Center-Based	12VAC35-276	50	12VAC35-105-650	
202	Center-Based	12VAC35-276	60	12VAC35-105-660	
203	Center-Based	12VAC35-276	70	12VAC35-105-665	
204	Center-Based	12VAC35-276	80	12VAC35-105-675	
205	Center-Based	12VAC35-276	90	12VAC35-105-680	
206	Center-Based	12VAC35-276	100	n/a	

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1	CATEGORY	RESTRUCTURED CHAPTER	SECTION	CURRENT REGULATORY SOURCE(S)	NOTES
207	Center-Based	12VAC35-276	110	12VAC35-105-720	
208	Center-Based	12VAC35-276	120	12VAC35-105-530	
209	Center-Based	12VAC35-276	130	12VAC35-105-290; 12VAC35-105-600	
210	Center-Based	12VAC35-276	140	12VAC35-46-550	
211	Center-Based	12VAC35-276	150	12VAC35-105-260	
212	Center-Based	12VAC35-276	160	12VAC35-105-280; 12VAC35-46-430	
213	Center-Based	12VAC35-276	170	12VAC35-46-590	
214	Center-Based	12VAC35-276	180	12VAC35-105-265; 12VAC35-105-270; 12VAC35-46-420	
215	Center-Based	12VAC35-276	190	12VAC35-105-300	
216	Center-Based	12VAC35-276	200	(reserved)	
217	Center-Based	12VAC35-276	210	12VAC35-105-925	
218	Center-Based	12VAC35-276	220	12VAC35-105-930	
219	Center-Based	12VAC35-276	230	12VAC35-105-935	
220	Center-Based	12VAC35-276	240	12VAC35-105-940	
221	Center-Based	12VAC35-276	250	12VAC35-105-945	
222	Center-Based	12VAC35-276	260	12VAC35-105-950	
223	Center-Based	12VAC35-276	270	12VAC35-105-960	
224	Center-Based	12VAC35-276	280	12VAC35-105-965	
225	Center-Based	12VAC35-276	290	12VAC35-105-970	
226	Center-Based	12VAC35-276	300	12VAC35-105-980	
227	Center-Based	12VAC35-276	310	12VAC35-105-990	
228	Center-Based	12VAC35-276	320	12VAC35-105-1000	
229	Center-Based	12VAC35-276	330	12VAC35-105-1010	
230	Center-Based	12VAC35-276	340	12VAC35-105-1020	
231	Center-Based	12VAC35-276	350	12VAC35-105-1030	
232	Center-Based	12VAC35-276	360	12VAC35-105-1050	
233	Center-Based	12VAC35-276	370	12VAC35-105-1821	
234	Center-Based	12VAC35-276	380	12VAC35-105-1822	
235	Center-Based	12VAC35-276	390	12VAC35-105-1824	
236	Center-Based	12VAC35-276	400	12VAC35-105-1826	
237	Center-Based	12VAC35-276	410	12VAC35-105-1828	
238	Center-Based	12VAC35-276	420	12VAC35-105-1690	
239	Center-Based	12VAC35-276	430	12VAC35-105-1700	
240	Center-Based	12VAC35-276	440	12VAC35-105-1710	
241	Center-Based	12VAC35-276	450	12VAC35-105-1720	
242	Center-Based	12VAC35-276	460	12VAC35-105-1740	
243	Center-Based	12VAC35-276	470	12VAC35-105-1750	
244	Center-Based	12VAC35-276	480	12VAC35-105-1760	
245	Center-Based	12VAC35-276	490	12VAC35-105-1770	

	A	B	C	D	E
1	CATEGORY	RESTRUCTURED CHAPTER	SECTION	CURRENT REGULATORY SOURCE(S)	NOTES
246	Center-Based	12VAC35-276	500	12VAC35-105-1790	
247	Center-Based	12VAC35-276	510	12VAC35-105-1800	
248	Center-Based	12VAC35-276	520	12VAC35-105-1810	
249	Center-Based	12VAC35-276	530	12VAC35-105-1820	
250	Center-Based	12VAC35-276	540	n/a	
251	Center-Based	12VAC35-276	550	n/a	
252	Center-Based	12VAC35-276	560	n/a	
253	Crisis	12VAC35-278	10	12VAC35-105-20	
254	Crisis	12VAC35-278	20	12VAC35-105-30	
255	Crisis	12VAC35-278	30	n/a	
256	Crisis	12VAC35-278	40	12VAC35-105-20	
257	Crisis	12VAC35-278	50	12VAC35-105-1840	
258	Crisis	12VAC35-278	60	12VAC35-105-155; 12VAC35-105-645	
259	Crisis	12VAC35-278	70	12VAC35-105-1850	
260	Crisis	12VAC35-278	80	12VAC35-105-1860	
261	Crisis	12VAC35-278	90	12VAC35-105-1870	
262	Crisis	12VAC35-278	100	12VAC35-105-675	
263	Crisis	12VAC35-278	110	12VAC35-105-680	
264	Crisis	12VAC35-278	120	12VAC35-105-1880	
265	Crisis	12VAC35-278	130	12VAC35-105-1880	
266	Crisis	12VAC35-278	140	12VAC35-105-700	
267	Crisis	12VAC35-278	150	12VAC35-105-1890	
268	Crisis	12VAC35-278	160	12VAC35-105-720	
269	Crisis	12VAC35-278	170	12VAC35-105-780	
270	Crisis	12VAC35-278	180	(reserved)	
271	Crisis	12VAC35-278	190	12VAC35-105-1900	
272	Crisis	12VAC35-278	200	12VAC35-105-530; 12VAC35-46-480	
273	Crisis	12VAC35-278	210	12VAC35-105-1140	
274	Crisis	12VAC35-278	220	12VAC35-105-1940	
275	Crisis	12VAC35-278	230	12VAC35-105-600; 12VAC35-105-1130; 12VAC35-46-860	
276	Crisis	12VAC35-278	240	12VAC35-105-1910	
277	Crisis	12VAC35-278	250	Fast-Track Action	
278	Crisis	12VAC35-278	260	Fast-Track Action	
279	Crisis	12VAC35-278	270	12VAC35-105-1920	
280	Crisis	12VAC35-278	280	12VAC35-105-1950	
281	Crisis	12VAC35-278	290	12VAC35-105-1930	
282	Crisis	12VAC35-278	300	12VAC35-46-440	
283	Crisis	12VAC35-278	310	12VAC35-105-260; 12VAC35-46-420	

	A	B	C	D	E
1	CATEGORY	RESTRUCTURED CHAPTER	SECTION	CURRENT REGULATORY SOURCE(S)	NOTES
284	Crisis	12VAC35-278	320	12VAC35-105-320; 12VAC35-46-420	
285	Crisis	12VAC35-278	330	12VAC35-105-280; 12VAC35-46-590	
286	Crisis	12VAC35-278	340	12VAC35-105-265; 12VAC35-105-270; 12VAC35-46-420	
287	Crisis	12VAC35-278	350	12VAC35-105-300	
288	Case Management	12VAC35-280	10	12VAC35-105-20	
289	Case Management	12VAC35-280	20	12VAC35-105-30	
290	Case Management	12VAC35-280	30	12VAC35-105-20	
291	Case Management	12VAC35-280	40	12VAC35-105-1240	
292	Case Management	12VAC35-280	50	12VAC35-105-155; 12VAC35-105-645; 12VAC35-105-650	
293	Case Management	12VAC35-280	60	12VAC35-105-650; 12VAC35-105-1245	
294	Case Management	12VAC35-280	70	12VAC35-105-660	
295	Case Management	12VAC35-280	80	12VAC35-105-665	
296	Case Management	12VAC35-280	90	12VAC35-105-675	
297	Case Management	12VAC35-280	100	12VAC35-105-680	
298	Case Management	12VAC35-280	110	n/a	
299	Case Management	12VAC35-280	120	12VAC35-105-720	
300	Case Management	12VAC35-280	130	12VAC35-105-1250	
301	Case Management	12VAC35-280	140	12VAC35-105-1255	

REGULATORY BUSINESS

Petition for Rulemaking | Amend Licensing Regulations to allow crisis stabilization units to base nursing coverage on an ISP-driven, two-tier nursing model.

Included in Agenda Packet:

- Petitioner's Request and Public Comments Received
- 12VAC35-105-1840. Crisis Services; Staffing.
- Excerpt from [DMAS Mental Health Services Provider Manual, Appendix G: Comprehensive Crisis Services](#)

Background:

A petition for rulemaking is a request for a board to develop a new regulation, or to amend or repeal an existing regulation. The board must respond in writing with its rationale for granting or denying the petitioner's request.

→ Refer to this flowchart for more information about the rulemaking petition process:
<https://www.townhall.virginia.gov/um/chartpetitionpublic.pdf>

Staff Analysis:

Petitioner's request appears based on an erroneous belief that DBHDS Regulations are more stringent than DMAS policy regarding nursing staff ratios for crisis stabilization units. Petitioner states, in relevant part (***emphasis added***):

This amendment will align DBHDS regulations with ***DMAS standards, which base nursing coverage on the initial nursing assessment and ISP***, [...].

Under the DMAS Comprehensive Crisis Services Manual (Appendix G), crisis stabilization units must provide in-person nursing services 24 hours a day, seven days a week ***when required by the initial nursing assessment and individualized service plan (ISP)***.

Petitioner misinterprets DMAS policy in asserting that staffing ratios are tied to nursing assessments or ISPs. Rather, DMAS standards require 24/7 in-person, onsite nursing coverage, as reflected in the Appendix G excerpt.

DBHDS coordinated with DMAS when developing the regulatory text and staff confirmed the current requirement in 12VAC35-105-1840 is in alignment.

Recommendation:

Take no action. As currently written, 12VAC35-105-1840 is aligned with Medicaid standards for nursing services staffing in crisis stabilization units. According to DMAS, its Behavioral Health Division does not anticipate lessening the standards for crisis services nursing coverage. Therefore, granting the petitioner's request would place DBHDS Licensing Regulations out of alignment and reduce consistency for providers.

Action Needed:

- Take no action on the petition, clearly stating the board's rationale; or
- Accept the petition and initiate a regulatory change.



Secretariat Health and Human Resources

Agency Department of Behavioral Health and Developmental Services

Board State Board of Behavioral Health and Developmental Services

Petition 443

Petition Information

Petition Title	Amend 12VAC35-105-1840(C)(3)
Date Filed	9/26/2025 [Transmittal Sheet]
Petitioner	R.C. Carter
Petitioner's Request	The petitioner requests that the Board amend 12VAC35-105-1840(C)(3) to allow crisis stabilization units to base nursing coverage on an individualized services plan (ISP)-driven, two-tier nursing model. According to petitioner: This amendment will align DBHDS regulations with DMAS standards, which base nursing coverage on the initial nursing assessment and ISP, and will help ensure that crisis stabilization services remain both safe and financially sustainable across the Commonwealth. <i>Nursing Requirement & Financial Impact Analysis</i> Under the DMAS Comprehensive Crisis Services Manual (Appendix G), crisis stabilization units must provide in-person nursing services 24 hours a day, seven days a week when required by the initial nursing assessment and individualized service plan (ISP). However, a detailed financial review demonstrates that meeting this standard for every client—regardless of actual clinical need—creates unavoidable deficits when all required professionals are considered. A registered nurse (RN) or licensed practical nurse (LPN) paid between \$35 and \$40 per hour costs about \$840 to \$960 per day, or \$4,200 to \$4,800 over a five-day stay. In addition, a Qualified Mental Health Professional (QMHP) at roughly \$20 per hour adds about \$160 per day (\$800 per five days); a Certified Substance Abuse Counselor (CSAC) at \$25 per hour adds \$200 per day (\$1,000 per five days); and a Licensed Mental Health Professional (LMHP) at \$30 per hour adds \$240 per day (\$1,200 per five days). Together, these staff drive a combined direct cost of roughly \$1,440 per day—or \$7,200 over five days—before any employer burden such as payroll taxes, overtime differentials, benefits, workers' compensation, or professional liability insurance is applied. When compared with the fixed DMAS reimbursement of \$847.04 per day (about \$4,235 for five days), even the most conservative scenario falls short. For example, an RN at \$30 per hour yields a

	narrow daily surplus of about \$127 before fringe costs. But at more realistic market wages—around \$40 per hour, in line with Bureau of Labor Statistics data—the nursing expense alone creates a daily loss of more than \$112, or about \$41,230 annually per client. Once the required QMHP, CSAC, and LMHP staffing is included, the gap widens dramatically. With modest employer overhead (~30 % for taxes, benefits, and insurance), the daily cost climbs toward \$1,875, producing a loss of over \$1,000 per day, or \$5,000 for each five-day admission. This analysis confirms three critical points. First, the true breakeven wage for 24/7 nursing is approximately \$35.29 per hour, and even at that rate, sustainability disappears when employer costs and additional staff are added. Second, the DMAS reimbursement structure cannot absorb market-based wages and required professional coverage. Third, aligning staffing with the results of the initial nursing assessment and each client's ISP, as DMAS already permits, is the only way to preserve both safety and financial viability. In summary, when all required professionals—RN/LPN, QMHP, CSAC, and LMHP—are included, the actual cost of a single five-day crisis stabilization stay far exceeds DMAS reimbursement. Without regulatory flexibility to implement an ISP-driven, two-tier nursing model, providers face unavoidable and continuing losses, placing essential crisis services and timely access to care at risk throughout the Commonwealth.
Agency's Plan	The petition for rulemaking will be published in the Virginia Register of Regulations on October 20, 2025. The petition will also be posted on the Virginia Regulatory Town Hall at www.townhall.virginia.gov to receive public comment. The public comment period will open on October 20, 2025, and close on November 10, 2025. The Board will consider the petition and all comments at its next regular meeting, currently scheduled for December 10, 2025. The petitioner will be notified of the Board's decision no later than 14 days after that meeting.
Comment Period	Began 10/20/2025 Ended 11/10/2025 <u>2 comments</u>
Virginia Register Announcement	Submitted on 9/26/2025 <u>The Virginia Register of Regulations</u> Published on: 10/20/2025 Volume: 42 Issue: 5
Agency Decision	Pending

Contact Information	
Name / Title:	Susan Puglisi / <i>Regulatory Research Specialist</i>
Address:	Jefferson Building 1220 Bank St., 4th Floor Richmond, 23219

Public Petition for Rulemaking: 443

Commenter	Title	Comment	Date/ID
Olabisi Yusuf	Support the Petition	I support amending 12VAC35-105-1840(C)(3) to allow crisis stabilization units to base nursing coverage on an individualized services plan (ISP)-driven, two-tier nursing model. Since current regulations requiring in-person nursing services 24 hours a day, 7 days a week for all clients result in significant financial losses for providers, as the combined staffing costs of registered nurses, licensed practical nurses, and other behavioral health professionals exceed the DMAS daily reimbursement rate. The unsustainable gap risks reducing access to vital crisis stabilization services for individuals and families in need across Virginia. Adopting an ISP-driven, two-tier nursing model would align the Board's regulations with established DMAS standards and ensure both safety and fiscal sustainability. It matches nursing coverage to the actual clinical needs of each client, rather than imposing a uniform standard on all admissions, making better use of limited resources without compromising quality of care. I would urge the Board to consider this amendment to preserve essential crisis stabilization programs and maintain timely, effective access to care throughout the Commonwealth.	11/7/25 8:58 pm CommentID:237582

Commenter	Title	Comment	Date/ID																				
Dr. Michael Moates	Statement in Support of Petition to Amend 12VAC35-105-1840(C)(3)	I write in strong support of the petition requesting amendment of 12VAC35-105-1840(C)(3) to permit crisis stabilization units to base nursing coverage on an individualized services plan (ISP)-driven, two-tier nursing model. This proposed change is both reasonable and necessary. It would align DBHDS regulations with existing DMAS Comprehensive Crisis Services Manual (Appendix G) standards, which already base nursing requirements on the initial nursing assessment and individualized service plan (ISP) rather than a rigid, one-size-fits-all 24-hour mandate. Adopting this model will help ensure crisis stabilization programs remain clinically safe, person-centered, and financially sustainable throughout the Commonwealth. Rationale and Financial Considerations Current DBHDS regulations require continuous 24/7 nursing coverage, regardless of a client's assessed needs. This approach imposes costs that far exceed DMAS reimbursement rates, even for well-managed programs. The petitioner's financial analysis highlights the following realities faced by crisis stabilization providers: <table> <tr> <th>Position</th><th>Hourly Rate</th><th>Daily Cost</th><th>Five-Day Cost</th></tr> <tr> <td>Registered Nurse (RN) / Licensed Practical Nurse (LPN)</td><td>\$35–\$40</td><td>\$840–\$960</td><td>\$4,200–\$4,800</td></tr> <tr> <td>Qualified Mental Health Professional (QMHP)</td><td>\$20</td><td>\$160</td><td>\$800</td></tr> <tr> <td>Certified Substance Abuse Counselor (CSAC)</td><td>\$25</td><td>\$200</td><td>\$1,000</td></tr> <tr> <td>Licensed Mental Health Professional (LMHP)</td><td>\$30</td><td>\$240</td><td>\$1,200</td></tr> </table> Even before adding employer costs (benefits, insurance, taxes), the total daily expense exceeds \$1,400, while DMAS reimbursement is capped at \$847.04 per day. After factoring in realistic market wages and overhead (roughly 30%), providers incur a loss of more than \$1,000 per day per client, or \$5,000 per typical five-day stay. This structure is simply unsustainable. Maintaining mandatory 24/7 RN or LPN presence regardless of acuity places essential crisis stabilization services, and the patients who rely on them, at risk of reduction or closure. Why the Amendment Is Needed Alignment with DMAS Standards: The Department of Medical Assistance Services already allows flexibility based on individual clinical need. DBHDS should harmonize its regulations to eliminate conflicting expectations.	Position	Hourly Rate	Daily Cost	Five-Day Cost	Registered Nurse (RN) / Licensed Practical Nurse (LPN)	\$35–\$40	\$840–\$960	\$4,200–\$4,800	Qualified Mental Health Professional (QMHP)	\$20	\$160	\$800	Certified Substance Abuse Counselor (CSAC)	\$25	\$200	\$1,000	Licensed Mental Health Professional (LMHP)	\$30	\$240	\$1,200	11/10/25 6:38 pm CommentID:237599
Position	Hourly Rate	Daily Cost	Five-Day Cost																				
Registered Nurse (RN) / Licensed Practical Nurse (LPN)	\$35–\$40	\$840–\$960	\$4,200–\$4,800																				
Qualified Mental Health Professional (QMHP)	\$20	\$160	\$800																				
Certified Substance Abuse Counselor (CSAC)	\$25	\$200	\$1,000																				
Licensed Mental Health Professional (LMHP)	\$30	\$240	\$1,200																				

Safety and Clinical Integrity:

The proposed two-tier model continues to ensure that individuals who clinically require 24-hour nursing receive it. It simply allows others, whose needs do not warrant constant presence, to be served safely under ISP-guided supervision.

Financial Sustainability:

Without regulatory flexibility, the financial model for crisis stabilization programs is unworkable, especially in regions where recruitment of licensed nurses is already difficult and costly.

Access to Care:

Continued regulatory misalignment risks program closures and reduced capacity limiting access to timely crisis services in communities already facing psychiatric workforce shortages.

This amendment represents a practical and evidence-based improvement to Virginia's behavioral health system. It supports both fiscal responsibility and person-centered care, ensuring resources are deployed according to each individual's assessed clinical need.

I respectfully urge the Board to approve the petitioner's request to amend 12VAC35-105-1840(C)(3) and permit an ISP-driven, two-tier nursing model for crisis stabilization units. Doing so will sustain critical services, uphold safety, and bring DBHDS policy into alignment with DMAS and contemporary best practices in crisis care delivery.

Michael Moates, Ed.D.

Part VIII. Crisis Services

12VAC35-105-1840. Staffing.

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

1. A licensed psychiatrist or nurse practitioner shall be available to the program, either in person or via telemedicine, 24 hours per day, seven days per week;
2. An LMHP, LMHP-R, LMHP-RP, or LMHP-S shall be available for conducting assessments;
3. Nursing services shall be provided by a registered nurse (RN) or a licensed practical nurse (LPN). Nursing staff shall be available 24 hours per day, in person. LPNs shall work directly under the supervision of a physician, nurse practitioner, or RN; and
4. Medical, psychological, psychiatric, laboratory, and toxicology services shall be available by consult or referral.

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

1. An LMHP, LMHP-R, LMHP-RP, or LMHP-S shall conduct assessments and, for any CEPP not authored by an LMHP, review, and if the LMHP, LMHP-R, LMHP-RP, or LMHP-S agrees, sign the CEPP;
2. All staff are required to utilize a working global positioning system (GPS) enabled smart phone or GPS-enabled tablet;
3. Any time staff are dispatched for the provision of mobile crisis response, the provider shall dispatch a team that meets at least one of the following staffing composition requirements:
 - a. If a single person is dispatched for mobile crisis response:
 - (1) One licensed staff member; or
 - (2) One certified pre-screener.
 - b. If the provider dispatches a team for mobile crisis, the team shall include:
 - (1) One licensed staff member and one peer recovery specialist (PRS);
 - (2) One licensed staff member and one certified substance abuse counselor (CSAC), CSAC-supervisee, or certified substance abuse counselor assistant (CSAC-A);
 - (3) One licensed staff member and one QMHP or QMHP-T;
 - (4) One PRS and either one QMHP or one CSAC or CSAC-supervisee. A licensed staff

member shall be required to be available via telemedicine for the assessment;

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

(6) Two QMHPs or one QMHP and one QMHP-T. A licensed staff member shall be required to be available via telemedicine for the assessment;

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

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

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

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

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

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

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

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

Statutory Authority

§§37.2-203 and 37.2-400 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 40, Issue 22, eff. July 17, 2024; amended, Virginia Register Volume 41, Issue 20, eff. June 18, 2025.

				assessment when an assessment is completed but the individual does not enter the service.	

Residential Crisis Stabilization Unit (RCSU)

Residential Crisis Stabilization Unit (RCSU) Level of Care Guidelines	
Service Definition	RCSUs provide short-term, 24/7, residential psychiatric and substance related assessment and brief intervention services. The service supports the following individuals: • Individuals experiencing changes in behavior noted by impairment or decompensation in functioning that may result in the need of a higher level of care. • Individuals stepping down from a higher level of care that need continued monitoring, stabilization and mobilization of resources. • Individuals who need a safe environment for assessment, stabilization, and prevention of further escalation or decompensation. RCSUs may also provide medically monitored residential services for the purpose of providing psychiatric stabilization and substance withdrawal management services on a short-term basis; see provider qualifications and billing guidance for further details. The goals of RCSU services are as follows but are not limited to 1) stabilize the individual in a community-based setting and support the individual and natural support system; 2) Reduction of acute symptoms; and 3) Identification and mobilization of available resources including support networks. This service occurs in a non-hospital, community-based crisis stabilization residential unit with no more than 16 beds. RCSUs may co-locate with 23- Hour Crisis Stabilization. Critical Features/Covered Service Components of RCSUs include: • Assessment (medical, psychiatric evaluation, nursing assessment, etc.) • Care Coordination • Crisis Intervention • Health Literacy Counseling
Critical Features & Service Components	

	• Individual, Group and/or Family Therapy • Peer Recovery Support Services • Skills Restoration • Treatment Planning
Required Activities	In addition to the “Requirements for All Services” section of Chapter IV, the following required activities apply to RCSUs: Assessment: • At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S must conduct an assessment for determining medical necessity criteria and the individual's appropriateness for the service. The assessment should be completed as soon as possible after admission but no later than 24 hours after admission. See the Assessment Requirements section for details. • A psychiatric evaluation by a psychiatrist, nurse practitioner or physician assistant or nurse practitioner working under the psychiatrist is required. • At a minimum, a brief psychiatric intake assessment completed by a psychiatrist, nurse practitioner or physician assistant or nurse practitioner working under the psychiatrist must be completed within four hours of admission to ensure that there are no medical or psychiatric needs that warrant immediate referral to a higher level of care. This brief psychiatric intake assessment can be completed in person, via telehealth or RCSU staff telephonic consultation with the psychiatrist, nurse practitioner or physician assistant, to identify and address any potential immediate medical or psychiatric needs. • A comprehensive psychiatric evaluation must be completed within 24 hours of admission. • The RCSU provider may use a psychiatric evaluation completed within 24 hours prior to admission by a psychiatrist or nurse practitioner to meet this requirement. Documentation that the RCSU psychiatrist, nurse practitioner or physician assistant has reviewed and updated (as clinically necessary) the evaluation within four hours of admission, must be in the clinical record.

	Nursing: RCSU providers must have 24 hour in-person nursing. <i>(RCSU providers have until 11/30/2024 to fully meet this requirement)</i> A nursing assessment meeting the requirements of 12VAC35-105-1890 must be completed at the time of admission. Nursing can be shared among co-located programs. Care Coordination: • Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV). • Appropriate transition to the next level of care shall be required. Documentation must include a demonstration of active transitioning from RCSU to an appropriate level of care which includes care coordination and communication with the individual's MCO or FFS service authorization contractor, service providers and other collateral contacts. • The provider shall collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers. • Coordination of withdrawal management services with a medical provider is required as necessary including medication and clinical supports. • The provider shall establish and maintain referral relationships with step-down programs appropriate to the population served; Crisis Intervention: A safety plan is required. See the Safety Plan and Crisis ISP section for additional information. Treatment Planning: A crisis ISP is required. See the Safety Plan and Crisis ISP section for additional information. The following components must be available to individuals in the treatment program and provided in accordance with the individual's ISP. • Individualized treatment planning; • Individual, group and family therapies; • Nursing in-person 24/7; • Skills restoration and health literacy counseling;

	• Assessment and evaluation as well as additional clinically indicated psychiatric and medical consultation services must be available; • Medical, psychological, psychiatric, laboratory, and toxicology services available by consult or referral; • Crisis intervention and safety planning support available 24/7; • Peer recovery support services, offered as an optional supplement for individuals; • Care coordination through referrals to higher and lower levels of care, as well as community and social supports, to ensure continuity of care. Additional Service Requirements: • To bill the per diem on days other than the day of admission, providers must provide daily individual, group or family therapy unless the LMHP, LMHP-R, LMHP-RP or LMHP-S documents the reason why therapy is not clinically appropriate. In addition, providers must, at a minimum, provide at least two of the following daily: - o Crisis Intervention - o Health Literacy Counseling - o Peer Recovery Support Services - o Psychiatric Evaluation - o Skills Restoration • Services must be individualized and provided in-person with the exceptions of the psychiatric evaluation, individual, group and family therapy and care coordination.
Residential Crisis Stabilization Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	Individuals must meet all of the following criteria (1-5)*: 1. One of the following must be present: a. The individual must be experiencing a behavioral health crisis or b. The individual is stepping down from a higher level of care after a recent behavioral health crisis and needs continued stabilization prior to returning to the community and 2. Documentation indicates evidence that the individual currently meets criteria for a primary diagnosis consistent with the most recent version of the International Statistical Classification of Diseases and Related Health Problems (ICD) diagnosis that correlates with the Diagnostic and Statistical Manual; and 3. One of the following must be present:

	a. Substantial changes in behavior noted by significant impairment or decompensation in functioning related to a behavioral health crisis; or b. Actual or potential danger to self or others as evidenced by: 1. Suicidal thoughts or behaviors and/or recent self-injurious behavior with suicidal intent; or 2. Hopelessness and helplessness likely to lead to self-injury or 3. Threatening harm to others or homicidal ideation; or 4. Command hallucinations or delusions; or 5. Acted in unpredictable, disruptive or bizarre ways that require further immediate observation and evaluation; or c. Significant loss of impulse control that threatens the safety of the individual and/or others; or d. Significant inability to maintain basic care for oneself and to keep oneself safe in the community in an age appropriate manner that is not associated with Dementia; or e. Intoxication that causes significant emotional, behavioral, medical, or thought process disturbance that interfere with judgment so as to seriously endanger the individual if not monitored and evaluated; or f. Acute stress reaction that threatens to lead to significant emotional and/or behavioral deterioration without rapid intervention, evaluation, and treatment; or g. Individual does not have the ability and/or the resources to support maintenance of safety and/or stability in the community until longer term services are available/accessible or mobilized; and 4. The presenting clinical problem requires a safe, contained environment wherein assessment, evaluation and treatment can be conducted to determine next steps in the individual's care; and 5. Without urgent intervention, the individual will likely decompensate which will further interfere with their ability to function in at least one of the following life domains: family, living situation, school, social, work, or community. <i>*The medical necessity for individuals admitted under a TDO issued pursuant to section §37.2-800 et. seq. and §16.1-335 et seq. of the Code of Virginia is established and DMAS or its contractor cannot limit or deny services specified in a TDO (see the Temporary Detention Order Supplement to the Psychiatric Services Manual for additional details).</i>

Continued Stay Criteria	All of the following criteria must be met (1-8): 1. The individual continues to meet admission criteria 2. Another less restrictive level of care would not be adequate to meet the individual's safety needs 3. Treatment is still necessary to reduce symptoms and improve functioning so that the individual may participate in a less restrictive level of care 4. There is evidence of progress towards resolution of the symptoms that are preventing treatment from continuing in a less restrictive level of care 5. The individual's progress is monitored regularly and the treatment plan is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals 6. Psychiatric medication monitoring is occurring as clinically indicated. 7. Individual/family/guardian/caregiver/natural support is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway 8. Coordination of care and active discharge planning are ongoing, with goal of transitioning the individual to a less intensive level of care
Diagnosis, Symptoms, and Functional Impairment	
Discharge Criteria	Any one of the following criteria must be met: 1. The individual no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive, and that level of care is available; or 2. The individual is not making progress toward goals, nor is there expectation of any progress and a different level of care is being recommended by the supervising LMHP; or 3. Functional status is restored as indicated by one or both of the following: a. no essential function is significantly impaired; and/or b. an essential function is impaired, but impairment is manageable at an available lower level of care
Exclusion Criteria and Service Limitations	The individual is not appropriate for this service if there is a presence of any condition of sufficient severity to require acute psychiatric inpatient, medical, or surgical care. In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:

	1. RCSUs may not be billed concurrently with any other behavioral health service except when a service overlap with other community behavioral health services is needed as part of a safe discharge plan. Documented justification of the time needed for discharge planning and care coordination to other services is required. Overlap durations will vary depending on the documented needs of the individual and the intensity of the services but may not exceed 48 hours unless approved by the MCO or FFS service authorization contractor. 2. Services may not be provided in facilities that meet the definition of an Institutions of Mental Disease (IMDs) as defined in 42 CFR 435.1010.
Residential Crisis Stabilization Unit Provider Participation Requirements	
Provider Qualifications	RCSU service providers must be licensed by DBHDS as a provider of MH Residential Crisis Stabilization for Adults (01-019) or Children and Adolescents (01-020), REACH Group Home Service Adult (01-004) or Children and Adolescents (01-041) and be enrolled with DMAS (see Chapter II). If RCSUs choose to provide ASAM 3.7 (medically monitored intensive inpatient) services, they must also be licensed by DBHDS for ASAM 3.7 services. If RCSUs provide services to an individual under a TDO, the provider must have a stipulation on their DBHDS license authorizing the provider to serve individuals who are under a TDO in accordance with 12VAC35-105-580. This service must be provided in a DBHDS licensed location that meets the crisis services physical site requirements within DBHDS Licensing Regulations. The licensed location must be identified on the provider's DBHDS license. Services may not be provided in other locations outside of the licensed site. RCSU providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.
Staff Requirements	A LMHP (who is acting within the scope of their professional license and applicable State law) must supervise this program. A licensed psychiatrist or nurse practitioner (who is acting within the scope of their professional license and applicable State law) must be available to the program 24/7 either in-person or via telemedicine to provide assessment, treatment recommendations and consultation

	meeting the licensing standards for residential crisis stabilization and medically monitored withdrawal services at ASAM level 3.7. A nurse practitioner or physician assistant working under the licensed psychiatrist may provide this coverage for the psychiatrist. Service components must be provided by the following: • Assessments must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP. • Care Coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CATP, QMHP-A, QMHP-C, QMHP-T, CSAC*, CSAC Supervisee*, or CSAC-A*. • Crisis Intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-T, CSAC*, CSAC Supervisee* or CSAC-A*. • Health Literacy Counseling must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, CSAC*, CSAC Supervisee* or a RN or LPN with at least one year of clinical experience involving medication management. • Individual, Group, and Family Therapy must be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. • Nursing services must be provided by either a RN or a LPN who is present on the unit. The LPN must work directly under the supervision of an RN or licensed medical practitioner in accordance with 18VAC90-19-70. • Peer Recovery Support Services must be provided by a Registered Peer Recovery Specialist. • Skills Restoration must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-T or a residential aide under the supervision of at least a QMHP-A or QMHP-C. • Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-T, CSAC* or CSAC Supervisee* <i>*CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2</i> Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. RNs and LPNs shall hold an active license issued by the Virginia Board of Nursing or hold a multistate licensure

	privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. Physicians and Physician Assistants shall hold an active license issued by the Virginia Board of Medicine. Supervisors of Registered Peer Recovery Specialists must complete the DBHDS Peer Recovery Specialist Supervisor Training available through the DBHDS Office of Recovery Services.
Residential Crisis Stabilization Service Authorization and Utilization Review	
Service Authorization	Providers must submit a registration to the individual's MCO or FFS service authorization contractor within one business day of admission. The registration permits five calendar days/five units of service. Units billed must reflect the treatment needs of the individual and be based on the individual meeting medical necessity criteria. If additional activities beyond five calendar days/five units are clinically required, the provider shall submit an authorization request to the FFS service authorization contractor or MCO through a continued stay service authorization request submitted no earlier than 48 hours before the requested start date of the continued stay and no later than the requested start date accompanied by the following items: 1. An initial assessment that meets the Assessment Requirements section. 2. A current addendum to the initial assessment, (can be in a progress note) that describes any new information impacting care, progress and interventions to date, a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria; and 3. Nursing Assessment; and 4. Psychiatric Evaluation; and 5. Crisis ISP; and 6. Safety plan; and 7. Documentation of care coordination. Service authorization requests may require the submission of documentation of referrals to post-discharge services at the appropriate level of care based on the assessed needs of the individual. If a provider is licensed for both RCSU and for the provision of ASAM 3.7-WM, and an individual is admitted to the RCSU for withdrawal management services, the provider should bill for the Addiction and Recovery Treatment Services until withdrawal

	management is no longer needed. At that time, they may submit a registration for RCSU services. Consecutive registrations from the same or different provider are not allowed. A service authorization is required if additional service is required beyond the five calendar days/five units. Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes is located at www.dmas.virginia.gov/providers/behavioral-health/training-and-resources/. Information on the FFS service authorization contractor's processes is located at Acentra Health/DMAS Reference Info MES (virginia.gov).
Documentation and Utilization Review	Refer to Chapter IV and VI of this manual for documentation and utilization review requirements that apply to all providers of Mental Health Services.

Residential Crisis Stabilization Billing Requirements

1. One unit of service equals one calendar day and is reimbursed as a per diem. The day of admission is billable regardless of the time of admission.
2. Day of discharge is billable if the minimum required activities to bill the RCSU per diem are met.
3. Individuals who meet criteria for RCSU may transition from ASAM Level 3.7 to RCSU services.
4. The individual should be directly admitted to a level of care that is appropriate to meet their treatment needs ie. Individuals likely to need greater than 23 hours of stabilization should be directly admitted to RCSU versus admitting to 23 hour Crisis Stabilization.
5. Psychiatric evaluations and individual, group and family therapy may be provided through telemedicine. Providers must follow the requirements for the provision of telemedicine described in the "Telehealth Services Supplement" including the use telemedicine modifiers. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Billing Code	Modifier	Unit	Description	Notes	Provider Qualifications (see Provider qualification and staff requirements section)
H2018		Per Diem			Service components must be

					provided by a qualified provider
H2018	32	Per Diem	RCSU – Emergency Custody Order	Billing modifiers for dates of service are determined by the status of the individual at the admission, and any subsequent billing is determined by the status of the individual at 12:01am on the day of service.	Service components must be provided by a qualified provider
H2018	HK	Per Diem	RCSU – TDO	Billing modifiers for dates of service are determined by the status of the individual at the admission, and any subsequent billing is determined by the status of the individual at 12:01am on the day of service.	Service components must be provided by a qualified provider
90791, 90792	n/a	n/a	Psychiatric Diagnostic Evaluation	Providers should bill CPT codes appropriate for the activity and professional conducting the assessment when an assessment is completed but the individual does not enter the service.	Qualified provider

TRANSITION SERVICE

Community Stabilization

Community Stabilization Level of Care Guidelines

REGULATORY ACTIVITY STATUS REPORT

VAC CITATION Chapter and Title		SHORT DESCRIPTION	Action Summary	Regulatory Stage	Current Status
RECENT/UPCOMING ACTIONS					
1	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Amendments to align with Medication for Opioid Use Disorder (MOUD) federal rule	Aligns with federal regulatory changes to increase access to lifesaving, evidence-based medication for opioid use disorder (MOUD).	Fast-Track <i>Dec. 2024 Board Vote</i>	Effective 12/1/2025 <i>GOV approved 8/19/2025</i>
2	Chapter 260 (12VAC35-260): Certified Recovery Residences	Conditional certification of recovery residences	Pursuant to SB 838 (2025), incorporates statutory provision for temporary, non-renewable certification for recovery residences working toward full certification.	Final/Exempt <i>July 2025 Board Vote</i>	Effective 1/14/2026 <i>GOV approved 11/19/2025</i>
3	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Alignment with Medicaid behavioral health redesign: CSC	Pursuant to 2024-2026 Appropriation Act, aligns Licensing Regulations with modifications made by DMAS to Medicaid behavioral health services for Coordinated Specialty Care (CSC).	Emergency/ NOIRA	PENDING BOARD ACTION
4	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Alignment with Medicaid behavioral health redesign: REC	Pursuant to 2024-2026 Appropriation Act, aligns Licensing Regulations with modifications made by DMAS to Medicaid behavioral health services for Recovery and Empowerment Center (REC).	Emergency/ NOIRA	PENDING BOARD ACTION
5	Chapter 105 (12VAC35-105): Provider Licensing Regulations + Chapter 46 (12VAC35-46): Regulations for Children's Residential Facilities	Regulatory Restructuring Seven actions: 1. General Chapter 2. Residential 3. NonCenter-Based 4. Center-Based 5. Crisis Services 6. Case Management 7. Repeal and replace	Applicable provisions of existing licensing regulations are reenacted within a new "umbrella" General Chapter and five service-specific chapters, with corrections, streamlining, and strengthening of regulations where appropriate. (Seventh action repeals current chapters when newly restructured chapters become effective.)	Proposed <i>NOIRA ended Sept. 24, 2025; 180 days to file</i>	PENDING BOARD ACTION
UNDER EXECUTIVE BRANCH REVIEW					
1	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Mandatory reporting of previous negative actions by applicants	Pursuant to HB 597 (2020), incorporates statutory requirements for initial provider applicants to report prior disciplinary or other negative actions.	Fast-Track <i>July 2024 Board Vote</i>	Submitted to HHR 5/5/25 <i>DPB approved 5/5/25; OAG certified 3/17/25</i>
2	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Mandatory valid discharge plans by substance abuse treatment facilities	Pursuant to HB 434 (2024), incorporates additional statutory requirement for substance use disorder treatment facilities upon discharging an individual from services or when an individual withdraws from a program.	Fast-Track <i>Sept. 2024 Board Vote</i>	Submitted to HHR 5/2/25 <i>DPB approved 5/2/25; OAG certified 3/17/25</i>

3	Chapter 115 (12VAC35-115): Regulations to Assure the Rights of Individuals	Updates to Human Rights Regulations; conform to Health Care Decisions Act	Amendments to improve the ability of the Office of Human Rights to protect individuals receiving services; also makes necessary updates to align with Code of Virginia where applicable.	NOIRA <i>April 2025 Board Vote</i>	Submitted to HHR 4/23/25 <i>DPB approved 4/23/25; OAG certification N/A</i>
4	Chapter 105 (12VAC35-105): Provider Licensing Regulations + Chapter 46 (12VAC35-46): Regulations for Children's Residential Facilities	Amendments to align with VDH Regulations	Technical and clarifying amendments to reflect current practice and update outdated references.	Fast-Track <i>April 2025 Board Vote</i>	Submitted to OAG 4/23/25
5	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Technical and clarifying revisions for crisis services	Reduces administrative burden, clarifies provisions, and makes technical amendments to newly implemented crisis services regulations.	Fast-Track <i>July 2025 Board Vote</i>	Submitted to OAG 7/10/25
6	Chapter 105 (12VAC35-105): Provider Licensing Regulations + Chapter 250 (12VAC35-250): Peer Recovery Specialists	Mandatory Peer Recovery Specialist-Trainee (PRS-T) designation	Pursuant to 2024-2026 Appropriation Act, creates a trainee designation to allow individuals to bill for services while working on the 500 hours of experience necessary for full Peer Recovery Specialist certification.	Emergency/NOIRA <i>Sept. 2025 Board Vote</i>	Submitted to OAG 9/26/25
7	Chapter 105 (12VAC35-105): Provider Licensing Regulations	Alignment with Medicaid behavioral health redesign: CPST	Pursuant to 2024-2026 Appropriation Act, aligns Licensing Regulations with modifications made by DMAS to Medicaid behavioral health services for Community Psychiatric Support and Treatment (CPST).	Emergency/NOIRA <i>Sept. 2025 Board Vote</i>	Submitted to OAG 9/26/25

MEMORANDUM

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

FROM: Mary Broz Vaughan, Board Liaison

DATE: November 7, 2025

RE: Technical Amendment to Bylaws and Electronic Meetings Policy Revisions

Code of Virginia [§ 2.2-3708.3](#) sets forth the procedures public bodies must follow to conduct business electronically, including provisions for all-virtual meetings and remote participation by board members. The Virginia Freedom of Information Act now requires annual review and readoption of the board's electronic meetings policy.

This memorandum serves as the 30-day special notice mandated by Article IX, Section 2 of the board's bylaws to make the necessary updates to Article V, Section 10. Also enclosed for your review are conforming amendments to the Electronic Meetings Policy (Appendix A).

The agenda packet for the December 10th meeting will be sent the week of Thanksgiving.

State Board of Behavioral Health and Developmental Services

BYLAWS

ARTICLE I. Name

The name of this body shall be the State Board of Behavioral Health and Developmental Services, hereinafter referred to as the Board.

ARTICLE II. Authority

Section 37.2-200 of the Code of Virginia establishes the Board as a policy board, within the meaning of § 2.2-2100 of the Code of Virginia, in the executive branch of government.

ARTICLE III. Members

Section 1. Composition. The composition of the Board and qualifications, appointment, and terms of office of Board members shall be as provided in § 37.2-200 of the Code of Virginia.

Section 2. Orientation. All new members appointed to the Board shall receive an orientation that includes information about Board roles and responsibilities; the committee structure and bylaws of the Board; the Department of Behavioral Health and Developmental Services, hereinafter referred to as the Department; state hospitals and training centers operated by the Department, hereinafter referred to as state facilities; community services boards and behavioral health authorities; Title 37.2 of the Code of Virginia, which governs the operations of the Board and Department and the provision of mental health, developmental, and substance abuse services in Virginia; the Virginia Freedom of Information Act; and the State and Local Government Conflict of Interests Act.

ARTICLE IV. Officers and Staff Support

Section 1. Officers. The officers of the Board shall be the Chair and the Vice Chair. Officers shall perform the duties prescribed by these bylaws and by the parliamentary authority adopted by the Board.

Section 2. Nominating and Election Procedure. The Board Chair shall appoint a Nominating Committee of three members at the spring regular meeting each year. Each year the Committee shall offer its slate of candidates at the first regular meeting following the beginning of the state fiscal year. Before the election, additional nominations from the floor shall be permitted. Officers shall be elected by the Board from among its membership at its first regular meeting following the beginning of the state fiscal year and shall serve for a period of one year. Officers shall be eligible for re-election.

Section 3. Chair. The Chair shall be the presiding officer at all Board meetings, shall appoint the members of all standing and special committees, and shall be an ex officio member of all

standing committees. In any votes of the Board, the Chair shall vote last. Upon request of the Board, the Chair shall act as its representative.

- 3.1. The Chair shall perform any additional duties imposed on the office by an act of the General Assembly or direction of the Board. The Chair shall work with the Commissioner of the Department or his designee to determine the types of Board meetings, agendas, reports, communications, and involvement that will enable Board members to carry out their powers, duties, and responsibilities.
- 3.2. The Chair may appoint members to serve on various task forces, committees, and other bodies on which representation of the Board is required or would be beneficial; direct the Policy Development and Evaluation Committee to develop drafts of proposed policies and circulate those drafts for field review on behalf of the Board; and assign other duties or responsibilities to standing committees. The Chair shall notify the Board and the Department of these actions, which the Board shall review and, where appropriate, approve at its next regular meeting.
- 3.3. The Chair, pursuant to § 37.2-200 of the Code of Virginia, shall submit to the Governor and the General Assembly an annual executive summary of the activity and work of the Board no later than the first day of each regular session of the General Assembly.

Section 4. Vice Chair. In the absence of the Chair at any meeting or in the event of the Chair's disability or of a vacancy in that office, all of the powers and duties of the Chair shall be vested in the Vice Chair. The Vice Chair also shall perform other duties imposed on him by the Board or the Chair.

Section 5. Secretary. Section 37.2-200 of the Code of Virginia authorizes the Board to employ a secretary to assist in its administrative duties, including maintenance of minutes and records. The Secretary shall be selected by the full Board in consultation with the Commissioner or his designee, but the Secretary shall not be a member of the Board.

- 5.1. The compensation of the Secretary shall be fixed by the Board within the specific limits of the appropriation made therefore by the General Assembly, and the compensation shall be subject to the provisions of the Virginia Personnel Act (§ 2.2-2900 et seq. of the Code of Virginia). The Secretary shall perform the duties required by the Board and the Commissioner or his designee.
- 5.2. The Secretary shall be a member of the Department's staff and shall report to the Commissioner or his designee; however, the Secretary shall be responsible to the Board. The Secretary shall be supervised in his daily responsibilities by the Commissioner or his designee. The Board and the Commissioner or his designee shall evaluate the performance of the Secretary annually.

Section 6. Department Liaison. The Commissioner shall designate a staff member to serve as the Department's liaison to the Board. The liaison shall coordinate the activities of the Board; provide primary administrative, policy, and technical support to the Board; and orient new Board members.

ARTICLE V. Meetings

Section 1. Regular Meetings. In accordance with § 37.2-200 of the Code of Virginia, the Board shall meet quarterly and at such other times as it deems proper. The Board at its first regular meeting following the beginning of the state fiscal year shall adopt an annual meeting schedule. Other regular meetings of the Board shall be held at the call of the Chair or whenever a majority of the members so request; however, when possible, no meetings will be scheduled during January or February.

Section 2. Special Meetings. The Chair, the Vice Chair in the event of the Chair's disability or of a vacancy in that office, or any three members of the Board may call special or emergency meetings of the Board at the dates, times, and places specified in the call for these meetings.

Section 3. Biennial Planning Meeting. The Board shall hold a biennial planning meeting in the summer of the year in which the biennial budget is developed.

Section 4. Notices. Notice of the date, time, location, and remote location, if required, of all regular Board meetings and all committee meetings shall be announced in advance by posting the notice electronically on the Commonwealth Calendar, as required by § 2.2-3707 of the Code of Virginia, and by written notice to Board members at least three days in advance of the date of the meeting.

- 4.1. All notices of Board meetings shall state that public comments will be received at the beginning of the meeting.
- 4.2. A notice of the date, time, location, and remote location, if required, of all special or emergency meetings shall be posted electronically on the Commonwealth Calendar, as required by § 2.2-3707 of the Code of Virginia.
- 4.3. When the Board determines that a public hearing on a proposed regulatory action is appropriate, the notice of the hearing shall be posted in accordance with the requirements of the Board's Public Participation Guidelines [12 VAC-35-12-100].

Section 5. Quorum. Five members shall constitute a quorum, as specified in § 37.2-200 of the Code of Virginia. The Board shall not conduct business without a quorum.

Section 6. Attendance. Each member shall be responsible for attending all Board meetings. Members shall notify the Chair or his designee of any anticipated absence, and if seeking remote participation, do so in accordance with the policy in Appendix A. If a member fails to notify the Chair or his designee more than twice during a fiscal year that he is unable to attend a meeting, the Chair shall notify the member of his non-compliance with this provision of the bylaws. With the approval of the Board, the Chair may notify the Governor and request that the Governor remove that member and appoint a new member to fill the vacancy, as authorized by § 37.2-200 of the Code of Virginia.

Section 7. Parliamentary Authority. All meetings shall be conducted in accordance with the rules contained in the current edition of Robert's Rules of Order Newly Revised, except as otherwise stated in these bylaws.

Section 8. Public Comment. The agenda for each meeting of the Board shall indicate that public comment will be received at the beginning of the meeting. Each person giving public comment shall be limited to three minutes unless an exception is deemed appropriate by the Chair.

Section 9. Minutes. Minutes shall be recorded at all regular and special or emergency Board meetings, as required by § 2.2-3707 of the Code of Virginia. The draft minutes shall be posted electronically on the Commonwealth Calendar as soon as possible but no later than 10 working days after the conclusion of the meeting. Final approved meeting minutes shall be posted within three working days of final approval of the minutes.

Section 10. Meetings Held Using Electronic Communication. In accordance with § 2.2-3708.3 D of the Code of Virginia, the Board shall review the electronic meetings policy in Appendix A annually and amend its provisions on remote participation and all-virtual meetings as necessary. The policy shall not prohibit or restrict any Board member who is using remote participation or who is attending an all-virtual meeting from voting on matters before the Board.

10.1. Remote Participation. An individual Board member may participate in a public meeting of the Board, or any committee or subcommittee established by the Board, through electronic communication from a remote location as permitted by § 2.2-3708.3 of the Code of Virginia by following the policy in Appendix A.

10.2. All-Virtual Meetings. The Board may hold all-virtual public meetings by following the policy in Appendix A and by complying with subsections C and D of § 2.2-3708.3 and all other provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia).

10.3. Electronic Meetings During State of Emergency. In accordance with § 2.2-3708.2 of the Code of Virginia and Item 4-0.01.g-h of the 2023 Special Session 1 Appropriation Act (Chapter 1), certain requirements shall not apply if a meeting is called when the Governor has declared a state of emergency.

ARTICLE VI. Powers and Duties

Section 1. Statutory Powers and Duties. The Board shall exercise the powers and duties authorized by § 37.2-203 of the Code of Virginia.

Section 2. Appointments by the Board. Pursuant to § 37.2-204 of the Code of Virginia, the Board shall appoint members of the State Human Rights Committee. The Board may appoint other committees as it deems necessary or appropriate.

ARTICLE VII. Committees

Section 1. Standing Committees. The committee structure of the Board reflects its statutory duties enumerated in § 37.2-203 of the Code of Virginia.

Standing committees shall report at each regular meeting of the Board, unless there has been no meeting or no action to report. The Board Chair shall appoint standing committee chairs, unless they are designated otherwise in these bylaws.

1.1. Policy Development and Evaluation Committee. Consisting of the Board Vice Chair, who shall chair the Committee, and at least two other Board members appointed by the Board Chair.

1.1.1. The Committee shall draft and coordinate field reviews of newly proposed or revised policies; compile and present summaries of comments received during field reviews; and report its recommendations and revised or newly proposed policies to the Board, which shall take action thereon as deemed appropriate.

1.1.2. The Committee shall maintain a Review Schedule of all existing policies on behalf of the Board and, at the scheduled review time, circulate to Board members, community services boards (CSBs), Department facilities and central office, advocacy groups, and stakeholders for comment.

1.1.3. The Committee shall report its findings to the Board regarding its assessment of the effectiveness of Board policies in fostering the intended outcomes within the Department, state facilities, CSBs and behavioral health authorities in carrying out those policies. The Board shall take action thereon as deemed appropriate, which may include making recommendations to the Department or the Secretary of Health and Human Resources.

1.1.4. The Department shall designate and provide staff to support the activities of the Policy Development and Evaluation Committee. Final policies will be maintained in a publicly accessible compilation on the Department's web site in the standard format for Board policies.

1.2. Planning and Budget Committee. Consisting of the Board Chair, who shall chair the Committee, and at least two other Board members appointed by the Board Chair.

1.2.1. The Committee shall participate in the 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. The committee shall provide updates on its planning activities to the full Board.

1.2.2. The Committee also shall work with the Department to assure that the agency's budget priorities and submission packages reflect Board policies and shall, through the Board's biennial planning meeting, 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, Policy Development and Evaluation.

1.2.3. The Department shall designate and provide staff to support the activities of the Planning and Budget Committee.

1.3. Grant Review Committee. Consisting of two Board members appointed by the Board Chair on an as-needed basis.

1.3.1. The Committee, acting on behalf of the full Board to fulfill its duty to review and comment on all applications for federal funds and to enable the Department to respond to federal grant solicitations expeditiously, shall review all requests for federal funds before they are submitted to the soliciting federal agency.

1.3.2. The Department shall designate and provide staff to support the activities of the Grant Review Committee.

Section 2. Special Committees. Special committees may be established at any time by action of the full Board or the Chair, acting on behalf of the Board. The Board Chair shall appoint a chair and members to any special committees and may appoint individuals who are not Board members to serve on these committees including individuals receiving services, family members, and other individuals as appropriate. When a special committee is established, its mission and the time within which it shall complete the task or accomplish the purpose for which it was created shall be specified.

ARTICLE VIII. Liaison Assignments

Pursuant to § 37.2-203 of the Code of Virginia, the Board shall ensure that programs to educate Virginians about and elicit public support for the activities of the Department, state facilities, community services boards, and behavioral health authorities are initiated by the Department.

The Board seeks to further the integration and coordination of services to individuals receiving services and to support, encourage, and build close working partnerships among community services boards and behavioral health authorities, state facilities, and the Department. The Board also seeks to enhance its knowledge and understanding of the wide diversity of community and state facility services across the Commonwealth and to develop and maintain connections with entities in the public behavioral health and developmental services system.

The Chair, in consultation with Department staff, may develop a list for each Board member of agencies and organizations with which the Board wishes to liaise, including state facilities, the Virginia Association of Community Services Boards, community services boards and behavioral health authorities, and the State Human Rights Committee.

The Chair shall appoint members of the Board to serve as liaisons with these agencies and organizations, recognizing the time constraints of members and that each member may fulfill Board member liaison responsibilities in different ways. Board member liaisons shall report successes, issues, and concerns to the Board at its regular meetings and to appropriate Department staff. Board member liaisons shall confer or meet regularly with groups to which they are assigned and report to the full Board as necessary.

ARTICLE IX. Evaluation, Amendment, and Review

Section 1. Evaluation. The Board shall conduct an evaluation of its performance during the Board's biennial planning meeting with the process and outcomes included as part of the Board's Annual Executive Summary for that year.

Section 2. Amendments. These bylaws may be amended at any regular or special meeting of the Board by an affirmative vote of at least five members of the Board, provided members were given the amendments in a special notice at least 30 days prior to the action. While the bylaws and any attached policy strictly conform to the minimum requirements set out in the Code of Virginia, the Board has the liberty within its discretion to make changes to the bylaws as long as those changes do not exceed the limits set out in the Code of Virginia.

Section 3. Bylaws Review. The Board shall review its bylaws every four years in the fall of the first year of the new Governor's term and amend them as necessary. Bylaws shall be signed and dated to indicate the last amendment date.

Section 4. Procedural Irregularities. Failure to observe procedural provisions of these bylaws does not affect the validity of Board actions.

ARTICLE X. Conflicts

These bylaws shall not diminish or circumscribe the Board's statutory authority, duties, or powers, and any conflict between provisions in these bylaws and the Code of Virginia shall be resolved in favor of the statute.

ARTICLE XI. Effective Date

These bylaws are effective on the 10th day of December 2025, and until subsequently revised.

ADOPTED BY THE BOARD

Board Chair

Department Liaison

State Board of Behavioral Health and Developmental Services

ELECTRONIC MEETINGS POLICY

I. Authority and Scope

This policy of the State Board of Behavioral Health and Developmental Services (“Board”) is adopted to comply with the requirements of § 2.2-3708.3 D of the Code of Virginia.

This policy shall not govern an electronic meeting conducted to address a state of emergency declared by the Governor. Any meeting conducted by electronic communication means during a state of emergency declared by the Governor shall be governed by the provisions of § 2.2-3708.2 of the Code of Virginia.

This policy shall apply to the entire membership and without regard to the identity of the Board member requesting remote participation or the matters that will be considered or voted on at the meeting.

This policy shall not restrict any individual Board member who is using remote participation or who is participating in an all-virtual meeting from voting on matters before the Board.

This policy applies to all committees and subcommittees of the Board.

II. Remote Participation by Individual Board Members

- A. Pursuant to § 2.2-3708.3 B of the Code of Virginia, it is the policy of the Board that individual Board members may use remote participation instead of attending a public meeting in person for the following reasons:
1. A temporary or permanent disability or other medical condition that prevents the Board member's physical attendance; or
 2. A family member's medical condition that requires the Board member to provide care for such family member, thereby preventing the Board member's physical attendance; or
 3. The member is a caregiver who must provide care for a person with a disability at the time the meeting is being held, thereby preventing the member's physical attendance; or
 4. The Board member's principal residence is more than 60 miles from the meeting location identified in the required notice for such meeting; or
 5. A personal matter, which must be identified with specificity. When remote participation is due to a personal matter, such participation is limited by law to two meetings each calendar year or 25 percent of the meetings held per calendar year rounded up to the next whole number, whichever is greater.

- B.** Whenever an individual Board member wishes to participate from a remote location, a quorum of the Board must be physically assembled at the primary or central meeting location. In addition, there must be arrangements for the voice of the remotely participating Board member to be heard by all persons at the primary or central meeting location. The remote location does not need to be open to the public.

C. Process for Making, Approving, and Recording Requests

1. Requests for remote participation by a Board member shall be conveyed to the Board Chair (or the Vice Chair, if the requesting member is the Chair) through the staff liaison using the Member Request Form. Failure to use the form or notify the staff liaison shall not affect the member's ability to participate remotely if the Chair was notified directly.
2. The requesting Board member is not obligated to provide independent verification regarding the reason for remote participation, including the disability or other medical condition of the member, family member, or person for whom the member is a caregiver that prevents attending in person.
3. Individual participation from a remote location shall be approved unless such participation would violate this policy or provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia). If a Board member's remote participation is challenged, then the Board shall vote on whether to allow such participation. The Chair shall promptly notify the requesting Board member whether the request is approved or disapproved based on conformance with this policy.
4. The request for remote participation, the reason the member is unable to attend in person, and a general description of the remote location from which the member participates shall be recorded in the minutes. If the Board votes to disapprove of the member's remote participation because it would violate this policy, such disapproval shall be recorded in the minutes with specificity.

III. All-Virtual Public Meetings

- A.** Pursuant to § 2.2- 3708.3 C of the Code of Virginia, it is the policy of the Board that it may hold all-virtual public meetings. Such all-virtual public meetings are limited by law to two meetings per calendar year or 50 percent of the meetings held per calendar year rounded up to the next whole number, whichever is greater. Additionally, an all-virtual public meeting shall not be held consecutively with another all-virtual public meeting.
- B.** Subject to the limitations set forth in this policy, a public meeting of any committee or subcommittee of the Board may be all-virtual whenever the applicable chair deems an all-virtual meeting necessary or convenient.

C. Meeting Requirements

1. The meeting notice shall include a statement notifying the public that the all-virtual meeting method will not be changed unless the Board provides a new notice in accordance with the provisions of § 2.2-3707 of the Code of Virginia.

2. Public access to the all-virtual public meeting must be provided via electronic communication means, and such means must allow the public to hear all participating Board members. Additionally, when audio-visual technology is available, it must allow the public to see the Board members as well.
3. A phone number or other live contact information monitored by staff during the meeting must be provided to alert the Board if the electronic transmission of the meeting fails, and the Board must recess until access is restored if the transmission fails for the public.
4. The public is afforded the opportunity to comment through electronic means, including by way of written comments, at those public meetings when public comment is customarily received.
5. No more than two members of the Board are together in any one remote location unless that remote location is open to the public to physically access it.
6. If a closed session is held during an all-virtual public meeting, transmission of the meeting to the public must resume before the Board votes to certify the closed meeting as required by subsection D of § 2.2-3712 of the Code of Virginia.
7. Minutes shall be taken as required by § 2.2-3707 of the Code of Virginia and include the fact that the meeting was held by electronic communication means and the type of electronic communication means by which the meeting was held.

REVIEW AND APPROVAL

This Board policy was originally reviewed and approved on December 6, 2023. A revised version was adopted by the Board on December 10, 2025, to reflect changes in the law.

Board Chair

Department Liaison



Virginia Department of Behavioral Health
and Developmental Services

State Board of Behavioral Health and Developmental Services

DRIVING DIRECTIONS

DBHDS Central Office, Jefferson Building
1220 Bank Street, Richmond, VA 23219

! The Jefferson Building is located on the southeast corner of Capitol Square, at the intersection of 13th/Governor Street and Bank Street.

! View maps of [Capitol Square](#) or [public parking](#) lots.

FROM I-64 EAST OR WEST OF RICHMOND:

- Following I-64, get onto I-95 South and continue toward downtown
- Take **Exit 74B**, Franklin Street
- Turn right onto Franklin Street
- Go through the next intersection at 14th Street (Franklin Street becomes Bank Street)
 - o Look for on-street meter parking on 14th or Main Street
 - o If you do not find street parking, [other parking options](#) are available

FROM I-95 NORTH OF RICHMOND:

- Follow I-95 South toward downtown Richmond
- Take **Exit 74B**, Franklin Street
- Turn right onto Franklin Street
- Go through the next intersection at 14th Street (Franklin Street becomes Bank Street)
 - o Look for on-street meter parking on 14th or Main Street
 - o If you do not find street parking, [other parking options](#) are available

FROM I-95 SOUTH OF RICHMOND:

- Follow I-95 North toward downtown Richmond
- Cross the bridge over the James River
- Take **Exit 74C** on your right (17th Street is one-way) and continue to Broad Street
- Turn right onto Broad Street
- Turn left onto 14th Street at the first light after crossing over I-95
- Turn right onto Franklin Street
- Go through the next intersection at 14th Street (Franklin Street becomes Bank Street)
 - o Look for on-street meter parking on 14th or Main Street
 - o If you do not find street parking, [other parking options](#) are available

If you have questions about the information in this meeting packet,
contact Mary Broz Vaughan at mary.broz-vaughan@dbhds.virginia.gov or 804-903-1390.