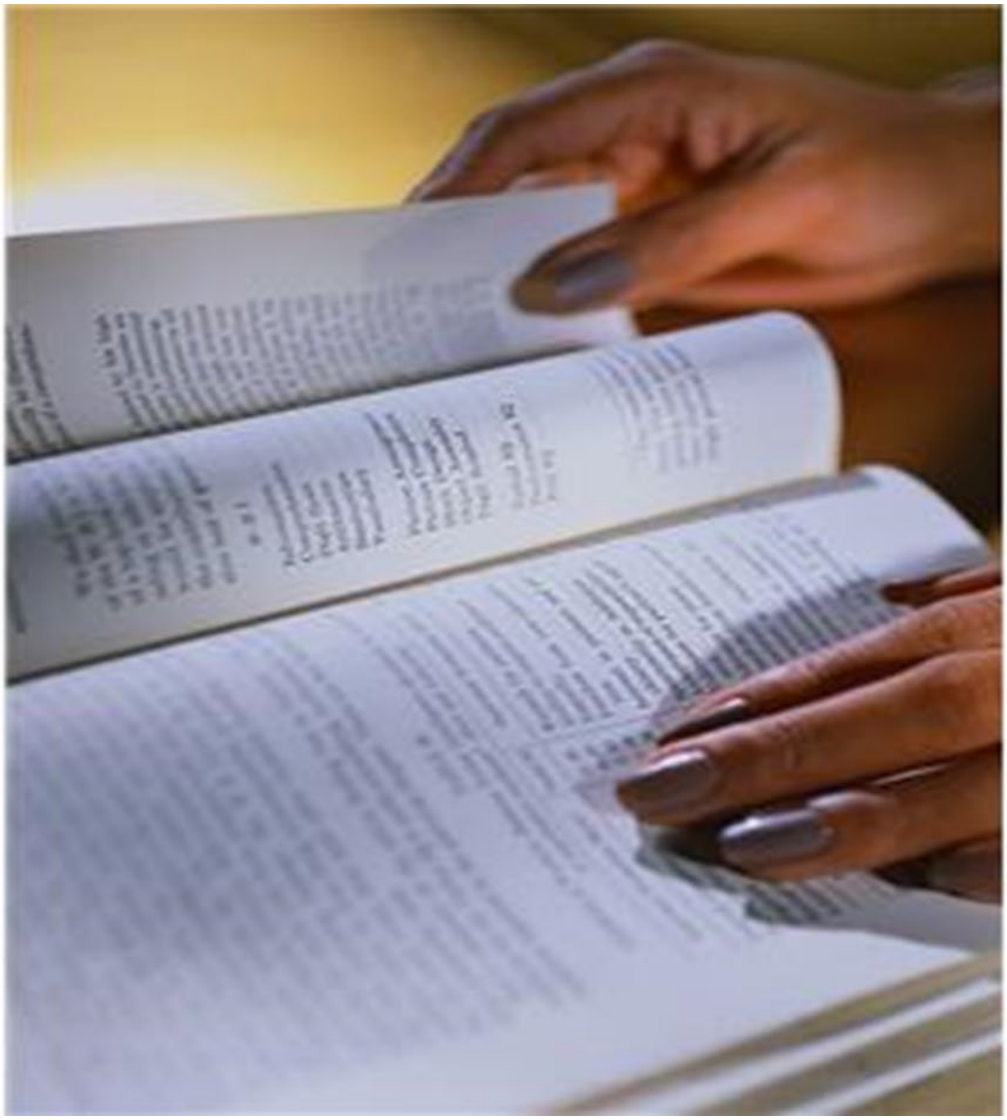
DBHDS - Office of Licensing

2022 New Applicant Licensing Resources



Department of Behavioral Health and Developmental Services
Office of Licensing
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Contents

**This packet includes tools and resources for initial applicants for a DBHDS provider license. Please note all initial applications will be submitted through CONNECT, the new online based licensing system.

For additional resources on how to use the CONNECT system, including how to submit an initial application, please visit the Office of Licensing Website.**

Licensing Process Overview

When applying for a license from the Department of Behavioral Health and Developmental Services (DBHDS), it is important for all applicants to understand the DBHDS licensing process. Due to the high volume of applications received by DBHDS, the entire licensing process could take up to twelve months or longer to complete. Please be mindful that incomplete applications, applications that fail to adequately address all Licensing Regulations, and applicant delays in providing requested information can further extend the licensing process. Applicants should expect to wait up to nine months on the application waiting list prior to assignment to a Policy Review Specialist, unless DBHDS determines that the application should be expedited.

1. Until you are confident that you are near the end of the licensing process, please **delay**:
    - Buying a home for a service;
    - Renting office space (please note this does not apply to applicants for MAT Services who will need to submit an identified location with their application for zoning purposes);
    - Buying insurance; &
    - Hiring staff.

2. However, you should be collecting and submitting resumes for prospective staff, identifying potential property locations and getting insurance quotes because these items will be required during the on-site inspection. Please note that the Office of Licensing will not expedite the review of an application due to expenditures on the abovementioned items.

3. Review your business plan including how you expect to get referrals for your program. A license does not guarantee sufficient referrals to sustain a business. This is especially true for services where a large number of providers may already exist.

4. Be sure to submit all of the required documentation and information for the service you wish to be licensed for.

The Six-Phase Licensing Process is as follows:

PHASE ONE:

1. New applicants will submit the following information for review through the DBHDS CONNECT Provider Portal:

    - A completed **Licensing Application** with the required attachments **AND**
    - The **Licensing Policies and Procedures (P & Ps)** including all required forms.

2. The completed application is then placed on the waiting list. The waiting list can be viewed on the DBHDS website and from the CONNECT Provider Portal Dashboard at any time.

PHASE TWO:

1. A Policy Review Specialist will review the application, attachments, policies and procedures to determine compliance with the Licensing Regulations.

2. If the submitted documentation requires revisions, the Policy Review Specialist will send a letter to the applicant citing the necessary revisions.

3. Receiving a letter from the Policy Review Specialist will signify to the applicant that their application has been removed from the waiting list and reviewed for the first time.

4. The applicant makes all required corrections and submits the updated policies and procedures to the Policy Review Specialist through the DBHDS CONNECT Provider Portal.

5. Revisions must be received within **six months** from the date on the last revision letter.
   Please note: Applicants that do not provide revisions within **six months** of a request for revisions will be closed for review.

6. This process will continue until the Policy Review Specialist determines that the reviewed policies, procedures, and attachments are in compliance with the Licensing Regulations.

    i. To expedite the licensing process, the focus of the review by the Policy Review Specialist will be on specific, identified policies. However, the applicant still is required to complete and submit ALL policies in order for their application to be deemed complete. The Licensing Specialist will determine the final approval of the policies and procedures as part of their on-site inspection.

PHASE THREE:

1. The Policy Review Specialist will confirm preliminary approval of the licensing application and will send the applicant the on-site inspection preparation checklist though the DBHDS CONNECT Provider Portal.

2. During this time, the applicant will contact the DBHDS Background Investigation Unit and register with Fieldprint to initiate the **Criminal Background Check** process.

3. The applicant will also contact the Virginia Department of Social Services to complete the **Central Registry Check** process.

4. The applicant must develop policies that are in compliance with *The Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Department of Behavioral Health and Developmental Services.* Then the applicant must submit the "human rights compliance verification checklist" with their complaint resolution policy to Human Rights at OHRpolicy@dbhds.virginia.gov.

5. The applicant is required to complete all items in the Additional Application Requirements section for the application and submit the completed on-site inspection preparation checklist to the Policy Review Specialist through the DBHDS CONNECT Provider Portal within six months from the date the on-site inspection preparation checklist was sent to the applicant.

6. Once the applicant has completed all items on the DBHDS CONNECT Provider Portal and the on-site inspection preparation checklist, they will need to submit the completed checklist to the Policy Review Specialist through the DBHDS CONNECT Provider Portal.

PHASE FOUR:

1. Once the Policy Review Specialist reviews and approves the applicant's completed on-site inspection preparation checklist, the Policy Review Specialist will assign the applicant to a Licensing Specialist.

2. The applicant is required to contact the Licensing Specialist for an on-site inspection within six months of being assigned to a Licensing Specialist. If the applicant fails to contact the Licensing Specialist, within six months of the date on the letter assigning the applicant to the Licensing Specialist, the applicant's application will be closed.

3. During the on-site inspection**,** the Licensing Specialist will review the physical facility or administrative office and conduct knowledge based interviews with the Service Director, CEO, licensed staff, etc. to determine if the staff has a working knowledge of the service.

4. The Licensing Specialist will give the final approval for the policies and procedures as part of the on-site inspection.

5. Once the on-site inspection is completed, the Licensing Specialist will make a licensing recommendation to the Office of Licensing management staff for review, who then, will forward the recommendation to the DBHDS Commissioner for the final approval.

PHASE FIVE:

1. While the applicant is waiting for licensure approval from the DBHDS Commissioner, the applicant may request a Pending Letter from the specialist. The Licensing Specialist will initiate the Pending Letter and will submit it to the applicant. The Pending Letter will serve as the authority to conduct business until the finalized license is received. Medicaid can be notified via the Pending Letter, so the new provider may begin providing services, if the provider is providing Medicaid reimbursable services.

PHASE SIX:

1. The finalized license is available to the new provider via CONNECT.

APPLICANTS: Please review this document carefully as it thoroughly explains the DBHDS licensing process.

To be licensed by DBHDS the applicant must:

1. Submit and receive preliminary approval of the initial application, required attachments, policies, procedures and forms by a Policy Review Specialist.

2. Set up the appropriate accounts and request both criminal history background checks and central registry searches for identified staff as required by Code of Virginia § 37.2-416.

3. Have an on-site inspection, which will include the following: an interview with the applicant; an inspection of the physical plant; a discussion with the applicant related to the content of their service description, policies and procedures; and a review of personnel records and sample client records.

INITIAL APPLICATION

1. The applicant submits the completed application, along with all required policies, procedures and attachments to the Office of Licensing through the DBHDS CONNECT Provider Portal.

2. When the Office of Licensing has a waiting list, the application is placed on the waiting list.

3. The waiting list can be viewed on the DBHDS website. An up to date waitlist can be viewed from the CONNECT Provider Portal Dashboard at any time. Please note: The Office of Licensing will prioritize processing initial applications for priority services needed throughout the Commonwealth.

4. When the application is up for review it is then assigned to a Policy Review Specialist.

5. The Policy Review Specialist will determine subjectivity of the application by reviewing the applicant's service description to determine what service will be provided. Code of Virginia **§37.2-405**, defines "service" as "individually planned interventions intended to reduce or ameliorate mental illness, developmental disability or substance addiction or abuse through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, developmental disability or substance addiction or abuse…"

6. If the Policy Review Specialist determines that the service to be provided by the applicant is NOT SUBJECT to licensing by DBHDS, the applicant will be sent formal correspondence through the DBHDS CONNECT Provider Portal explaining that determination.
7. If the application is complete and determined to be subject to licensing by the DBHDS, but there are questions about the application, the Policy Review Specialist will contact the applicant directly through the DBHDS CONNECT Provider Portal.

POLICIES AND PROCEDURES

The Policy Review Specialist will be the first to review the applicant's policies and procedures. **All copies of service descriptions, policies, procedures and forms should have a footer or header noting the date they were developed (or revised) and page numbers.**

WHAT ARE ACCEPTABLE POLICIES AND PROCEDURES?

Applicants should carefully read the regulations to determine when a written policy or procedure is required. A written policy is required when the regulation calls for a "policy" and a written procedure is required when the regulation calls for a "procedure."

"Policy" defines what the plan or guiding principle of the organization is, as related to the required regulation.

"Procedures" are the process (or steps) the applicant takes to ensure the policy is carried out. Procedures should answer the questions of who, where and how a policy will be implemented.

Policies and procedures are not the re-statement of a regulation. When submitted policies are a re-statement of DBHDS or DMAS regulations, they will not be accepted.

Applicants may also need to develop other policies to guide the delivery of services even when not required by the regulations.

REVIEW LETTERS

The Policy Review Specialist will inform the applicant, through a review letter, of needed revisions to their application materials citing the specific regulation that is not yet in compliance, with a brief narrative explaining why the regulation has not been met. The applicant makes all required corrections and submits the updated policies and procedures to the Policy Review Specialist through the DBHDS CONNECT Provider Portal. This process will continue until the Policy Review Specialist determines that the reviewed application materials are in compliance with the Licensing Regulations. Once, the Policy Review Specialist determines the reviewed application materials are in compliance with the Licensing Regulations, they will send the applicant an on-site inspection preparation checklist though the DBHDS CONNECT Provider Portal to be completed and submitted to the Policy Review Specialist prior to assignment to a Licensing Specialist.

Please Note: If the applicant does not provide revisions **within six months** from the date the review letter was sent, the application will be closed.

CRIMINAL HISTORY AND CENTRAL REGISTRY BACKGROUND CHECKS

Code of Virginia § 37.2-416 requires that staff are subject to criminal background check and central registry checks to determine their eligibility to work in services licensed by the DBHDS. ***After*** the Policy Review Specialist has provided the applicant with the on-site inspection preparation checklist, the applicant should contact the DBHDS Background Investigations Unit to obtain the information necessary to register with Fieldprint. Ms. Malinda Roberts is the contact in that office and can be reached by phone at (804) 786-6384 or e-mail at malinda.roberts@dbhds.virginia.gov .

The applicant will also need to conduct central registry searches directly through the Virginia Department of Social Services (VDSS). Required forms can be obtained from the VDSS website. The applicant must have received completed background checks and registry searches for all known staff, contractors, and volunteers prior toscheduling their on-site review. Copies of all paperwork submitted and received shallbe maintained in a separate, confidential personnel record for each employee.

HUMAN RIGHTS REGULATIONS

Working with the Office of Human Rights, the applicant must:

1. Develop policies that are in compliance with *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*.

2. Complete and send in the "Human Rights Compliance Verification Checklist" as well as their complaint resolution policy to OHRpolicy@dbhds.virginia.gov.
    - Within 20 working days of receipt of the "Human Rights Verification Checklist," the Office of Human Rights will notify the applicant of the status of their complaint resolution policy. If approved, the applicant will be referred via e-mail to their assigned Human Rights advocate. If the applicant's complaint resolution policy is not approved, the Office of Human Rights will provide guidance for compliance.
    - The Human Rights advocate will schedule a visit to the program within 30 days of the initial license to review the provider's Human Rights policies for compliance.

ON-SITE INSPECTION

ATTENTION: When the final policies, procedures, forms, and on-site inspection checklist have been reviewed by the Policy Review Specialist and deemed to be complete and in compliance with the Licensing Regulations, the applicant will be assigned to a Licensing Specialist. It is then the applicant's responsibility to contact their assigned Licensing Specialist for an on-site inspection. If the applicant fails to contact the Licensing Specialist, within six months of the date on the letter assigning the applicant to the Licensing Specialist, the applicant's application will be closed.

The on-site inspection verifies the applicant's compliance with several Licensing Regulations including, but not limited to, the physical plant requirements, personnel documentation and current financial resources.

FINAL STEPS

1. Achieving compliance with the Licensing and Human Rights Regulations are separate, yet concurrent processes. Each office independently reviews submitted documentation for compliance with its own regulations.
2. When the applicant is deemed to be in compliance with all applicable regulations, the Office of Licensing will make a recommendation to issue a license to the Commissioner. Only the Commissioner can issue a license.
3. Providers may not begin service operation until they have received written notification of their pending licensure via a "**Pending Letter**."
4. All new providers are issued a conditional license for a period not to exceed six (6) months, for one service and one location.

DENIAL OF A LICENSE

According to Licensing Regulation 12VAC35-105-110, an application for a license may be denied by the Commissioner if:

1. The provider or applicant has violated any provisions of Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2-403 of the Code of Virginia or the 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 a 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.

NOTE: Should an application be denied, applicants may have to wait at least six months before they can re-apply pursuant to Virginia Code § 37.2-418.

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Required Initial Application Attachments

A complete application for licensing DBHDS includes **all of** the following.

	REQUIRED ATTACHMENTS FOR ALL APPLICANTS	Regulations Reference
1.	The Completed Application form;	**12 VAC 35-105-40(A)**
2.	A working budget showing projected revenue and expenses for the first year of operation, including a revenue plan;	**12 VAC 35-105-40(A)**
3.	Documentation of working capital to include (i) documentation of funds or a line of credit in the name of the applicant or owner sufficient to cover at least 90 days of operating expenses if the provider is a corporation, an unincorporated organization or association, a sole proprietor, or a partnership or (ii) appropriated revenue if the provider is a state or local government agency, board, or commission;	**12 VAC 35-105-40(A)(2) & 210(A)**
4.	A copy of the organizational structure, showing the relationship of the management and leadership to the service;	**12 VAC 35-105-40 & 190(B)**
5.	A description of the applicant's program that addresses **all** the requirements, including admission, exclusion, continued stay, discharge/termination criteria, and a copy of the proposed program schedule, descriptions of all services or interventions proposed;	**12 VAC 35-105-40(B)(3), 570 & 580(C)**
6.	The applicant's Records Management policies addressing all the requirements of regulation;	**12 VAC 35-105-40, 390 & 870(A)**
7.	A schedule of the proposed staffing plan, relief staffing plan, comprehensive supervision plan;	**12 VAC 35-105-590**
8.	Resumes of all identified staff, particularly, Service Director, QMHP, QDDP, and Licensed Staff required for the service, if applicable;	**12 VAC 35-105-420**

9.	Copies of **all** position (job) descriptions that address all the requirements (Position descriptions for Case management, ICT and PACT services must address additional regulations);	**12 VAC 35-105-410**
10.	Evidence of the applicant's authority to conduct business in the Commonwealth of Virginia. Generally this will be a copy of the applicant's State Corporation Commission Certificate; AND	**12 VAC 35-105-40(A)(3) & 190(A)(2)**
11.	A certificate of occupancy for the building where services are to be provided, except home based services.	**12 VAC 35-105-260**
	ADDITIONAL REQUIRED ATTACHMENTS FOR RESIDENTIAL PROVIDER APPLICANTS	
12.	A copy of the building floor plan, outlining the dimensions of each room;	**12 VAC 35-105-40 (B)(5)**
13.	A current health inspection; AND	**12 VAC 35-105-290**
14.	A current fire inspection for residential services serving over eight (8) residents.	**12 VAC 35-105-320**

***Copies of service descriptions, policies, procedures, and forms should have page numbers and a "header" or "footer" indicating the date it was created or revised.**

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2022 Licensed As Statements

SERV ID	PROG ID	POP	Description	Program Name	License As Statements
01	001	DD	DD Group Home Srv	**DD Group Home**	A developmental disability residential group home service for adults
01	002	DD	DD Group Home Srv	**DD Group Home**	A developmental disability residential group home service for adults
01	003	MH	MH Group Home Srv	**MH Group Home**	A mental health residential group home service for adults
01	004	DD	Group Home Srv-REACH	**REACH Group Home Adult**	A residential group home with crisis stabilization REACH service for adults with co-occurring diagnosis of developmental disability and behavioral health needs
01	005	DD	ICF-IID	**ICF-IID**	An intermediate care facility for individuals with an intellectual disability (ICF-IID) residential service for adults
01	007	BI	Brain Injury Residential Tx Service	**BI Residential Treatment Serv**	A brain injury residential treatment center for adults
01	011	DD	DD Supervised Living Srv	**DD Supervised Living**	A developmental disability supervised living residential service for adults
01	012	MH	MH Supervised Living Srv	**MH Supervised Living**	A mental health supervised living residential service for adults
01	014	MH	MH Supervised Living Srv	**MH Supervised Living**	A mental health supervised living residential service for adults
01	019	MH	MH Crisis Stabilization Srv	**MH Crisis Stabilization**	A mental health residential crisis stabilization service for adults
01	020	MH	MH Crisis Stabilization Srv	**MH Crisis Stabilization C/A**	A mental health residential crisis stabilization service for children and adolescents
01	022	DD	DD Crisis stabilization - Residential	**DD Crisis Stab Residential**	A developmental disability residential crisis stabilization service
01	023	MH	MH Crisis stabilization - Residential	**MH Crisis Stab Residential**	A mental health residential crisis stabilization service
01	036	DD	DD Residential Respite Srv	**DD Residential Respite Adult**	A developmental disability residential respite service for adults
01	037	DD	DD Residential Respite Srv	**DD Residential Respite C/A**	A developmental disability residential respite service for children and adolescents

01	041	DD	DD Group Home Srv - REACH	**REACH Group Home C/A**	A residential group home with crisis stabilization REACH service for children and adolescents with co-occurring diagnosis of developmental disability and behavioral health needs
01	043	SA	SA Clinically Managed High-Intensity Residential Srv	**ASAM Level 3.5 Adult**	ASAM Level 3.5: Clinically managed high-intensity residential care for adults
01	044	SA	SA Specific High-Intensity Residential Srv	**ASAM Level 3.3 Adult**	ASAM Level 3.3: Specific high-intensity residential service for adults
01	045	SA	SA Clinically Managed Low-Intensity Residential Srv	**ASAM Level 3.1 Adult**	ASAM Level 3.1: Clinically managed low-intensity residential care for adults
02	004	DD	DD Center-Based Respite Srv	**DD Center-Based Respite**	A developmental disability center-based respite service (children, adolescent, and/or adults)
02	006	DD	DD Day Support Srv	**Center-Based Day Sup Adult**	A developmental disability center-based day support service for adults
02	007	DD	DD Day Support Srv	**Center-Based Day Sup C/A**	A developmental disability center-based day support service for children and adolescents
02	008	DD	DD Day Support Srv	**Non Center-Based Day Sup Adult**	A developmental disability non center-based day support service for adults
02	009	DD	DD Day Support Srv	**Non Center-Based Day Sup C/A**	A developmental disability non center-based day support service for children and adolescents
02	010	DD	DD Day Support Srv	**DD Day Support**	A developmental disability day support service for (population served)
02	011	MH	MH Psychosocial Rehabilitation	**Psychosocial Rehabilitation**	A mental health psychosocial rehabilitation service for adults
02	012	MH	MH Psychosocial Rehabilitation	**Psychosocial Rehabilitation**	A mental health psychosocial rehabilitation service for adults
02	014	MH	Therapeutic Afterschool MH Srv	**TDT Center Based**	A mental health non school-based therapeutic day treatment service for children with serious emotional disturbance
02	015	MH	Therapeutic Afterschool MH Srv	**TDT Center Based**	A mental health non school-based therapeutic day treatment service for children with serious emotional disturbance
02	019	MH	MH Partial Hospitalization Srv	**MH Partial Hospitalization**	A mental health partial hospitalization service for adults with serious mental illness
02	020	MH	MH Partial Hospitalization Srv	**MH Partial Hospitalization**	A mental health partial hospitalization service for adults with serious mental illness
02	029	MH	Therapeutic Day Treatment Srv for Children and Adolescents	**TDT School Based**	A mental health school-based therapeutic day treatment service for children and adolescents with serious emotional disturbance
02	030	MH	Therapeutic Day Treatment Srv for Children and Adolescents	**TDT School Based**	A mental health school-based therapeutic day treatment service for children and adolescents with serious emotional disturbance

02	032	MH	MH Partial Hospitalization Srv	**MH Partial Hospitalization C/A**	A mental health partial hospitalization for children and adolescents with serious mental illness
02	033	SA	SA Partial Hospitalization Srv	**ASAM Level 2.5 Adult**	ASAM Level 2.5: Substance Abuse Partial Hospitalization service for adults
02	034	SA	SA Partial Hospitalization Srv	**ASAM Level 2.5 C/A**	ASAM Level 2.5: Substance Abuse Partial Hospitalization service for children and adolescents
02	035	SA	SA Intensive Outpatient Srv	**ASAM Level 2.1 Adult**	ASAM Level 2.1: Substance Abuse Intensive Outpatient service for adults
02	036	SA	SA Intensive Outpatient Srv	**ASAM Level 2.1 C/A**	ASAM Level 2.1: Substance Abuse Intensive Outpatient for children and adolescents
02	037	MH	MH Intensive Outpatient Srv	**MH Intensive Outpatient Adult**	A mental health intensive outpatient service for adults with serious mental illness
02	038	MH	MH Intensive Outpatient Srv	**MH Intensive Outpatient C/A**	A mental health intensive outpatient service for children and adolescents with serious mental illness
03	001	MH	Mental Health Community Supports Srv	**Mental Health Skill Building**	A mental health community support service for (population served) with serious mental illness
03	002	MH	Mental Health Community Supports Srv	**Mental Health Skill Building**	A mental health community support service for (population served) with serious mental illness
03	004	MH	Mental Health Supportive In-Home Srv	**MH Supportive In-Home**	A mental health supportive in-home service for children and adolescents
03	011	DD	DD Supportive In-Home Srv	**DD Supportive In-Home**	A developmental disability supportive in-home service for children, adolescents, and adults
04	001	MH	Psychiatric Unit Srv	**Inpatient Psychiatric Adult**	A mental health inpatient psychiatric service for adults
04	005	MH	Psychiatric Unit Srv-Children	**Inpatient Psychiatric C/A**	A mental health and inpatient psychiatric service for children and adolescents
04	013	SA	SA Medically Managed Intensive Inpatient Srv	**ASAM Level 4.0 Adult**	ASAM Level 4.0: Substance Abuse Medically Managed Intensive Inpatient for adults
04	014	SA	SA Medically Managed Intensive Inpatient Srv	**ASAM Level 4.0 C/A**	ASAM Level 4.0: Substance Abuse Medically Managed Intensive Inpatient for children and adolescents
04	015	SA	SA Medically Monitored Intensive Inpatient Srv	**ASAM Level 3.7 Adult**	ASAM Level 3.7: Substance Abuse Medically Monitored Intensive Inpatient for adults
04	016	SA	SA Medically Monitored High-Intensity Inpatient Services	**ASAM Level 3.7 C/A**	ASAM Level 3.7: Substance Abuse Medically Monitored High-Intensity Inpatient Services for children and adolescents
05	001	MH	Intensive In-Home Srv for children and adolescents	**Intensive In-Home**	A mental health intensive in-home service for children and adolescents and their families
05	002	MH	Intensive In-Home Srv for children and adolescents	**Intensive In-Home**	A mental health intensive in-home service for children and adolescents and their families

06	003	SA	Medication Assisted Opioid Treatment Srv	**MAT/Opioid Treatment**	OTS: A substance abuse medication assisted treatment/opioid service
07	003	MH	Outpatient MH Srv	**MH Outpatient**	A mental health outpatient service for (population served)
07	006	MH	Outpatient Srv /Crisis Stabilization	**Crisis Stabilization**	A mental health non-residential crisis stabilization service for adults/children/adolescents
07	007	DD	DD Outpatient Srv/Crisis Stabilization -REACH	**DD Crisis Stabilization-REACH**	A non-residential crisis stabilization REACH service for (children, adolescent, and/or adults) with a co-occurring diagnosis of developmental disability and behavioral health needs
07	009	DD	DD Crisis Stabilization - Non –Residential	**DD Crisis Stabilization**	A developmental disability non-residential crisis stabilization service
07	012	MH	Outpatient Srv /Crisis Stabilization	**Crisis Stabilization**	A mental health non-residential crisis stabilization service for adults/children/adolescents
07	013	SA	Outpatient SA Srv	**ASAM Level 1.0 Adult**	ASAM Level 1.0: Substance abuse outpatient service for adults
07	014	SA	Outpatient SA Srv	**ASAM Level 1.0 C/A**	ASAM Level 1.0: Substance abuse outpatient service for children and adolescents
08	011	DD	DD Sponsored Residential Homes Srv	**DD Sponsored Residential Adult**	A developmental disability sponsored residential home service for adults
08	013	DD	DD Sponsored Residential Homes Srv	**DD Sponsored Residential C/A**	A developmental disability sponsored residential home service for children and adolescents
08	014	MH	MH Sponsored Residential Homes Srv	**MH Sponsored Residential**	A mental health sponsored residential home service for (population served)
10	001	DD	DD In-Home Respite Srv	**DD In-Home Respite**	An in-home respite service for (children, adolescent, and/or adults)
10	003	MH	MH In-Home Respite Srv	**MH In-Home Respite**	A mental health in-home respite service for (children, adolescent, and/or adults)
11	001	MH	MH Correctional Facility RTC Service	**MH Correctional Facility RTC**	A mental health service in a correctional facility
14	001	MH	Psychiatric Residential Treatment Facility for children and adolescents	**Psychiatric RTF for C/A**	A PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	002	MH	Psychiatric Residential Treatment Facility for children and adolescents	**Psychiatric RTF for C/A**	A PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	003	MH	Psychiatric Residential Treatment Facility for children and adolescents	**Psychiatric RTF for C/A**	A PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE

14	008	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	009	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	010	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	011	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	012	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	015	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	016	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	017	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	018	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	019	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	022	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	023	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	026	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE

14	028	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	030	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	031	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	032	MH	MH Therapeutic Group Home for Children and adolescents	**MH Therapeutic GH for C/A**	A MH THERAPEUTIC GROUP HOME FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE
14	035	DD	DD Children Group Home Residential Srv	**DD Group Home for C/A**	A DEVELOPMENTAL DISABILITY GROUP HOME RESIDENTIAL SERVICE FOR CHILDREN AND ADOLESCENTS
14	036	DD	DD Children Group Home Residential Srv	**DD Group Home for C/A**	A DEVELOPMENTAL DISABILITY GROUP HOME RESIDENTIAL SERVICE FOR CHILDREN AND ADOLESCENTS
14	041	DD	DD Children Group Home Residential Srv	**DD Group Home for C/A**	A DEVELOPMENTAL DISABILITY GROUP HOME RESIDENTIAL SERVICE FOR CHILDREN AND ADOLESCENTS
14	042	DD	DD Children Group Home Residential Srv	**DD Group Home for C/A**	A DEVELOPMENTAL DISABILITY GROUP HOME RESIDENTIAL SERVICE FOR CHILDREN AND ADOLESCENTS
14	043	DD	DD Children Group Home Residential Srv	**DD Group Home for C/A**	A DEVELOPMENTAL DISABILITY GROUP HOME RESIDENTIAL SERVICE FOR CHILDREN AND ADOLESCENTS
14	044	DD	DD Children Group Home Residential Srv	**DD Group Home for C/A**	A DEVELOPMENTAL DISABILITY GROUP HOME RESIDENTIAL SERVICE FOR CHILDREN AND ADOLESCENTS
14	045	DD	DD Children Group Home Residential Srv	**DD Group Home for C/A**	A DEVELOPMENTAL DISABILITY GROUP HOME RESIDENTIAL SERVICE FOR CHILDREN AND ADOLESCENTS
14	046	DD	DD Children Group Home Residential Srv	**DD Group Home for C/A**	A DEVELOPMENTAL DISABILITY GROUP HOME RESIDENTIAL SERVICE FOR CHILDREN AND ADOLESCENTS
14	048	DD	DD Children Group Home Residential Srv	**DD Group Home for C/A**	A DEVELOPMENTAL DISABILITY GROUP HOME RESIDENTIAL SERVICE FOR CHILDREN AND ADOLESCENTS
14	049	DD	DD Children Group Home Residential Srv	**DD Group Home for C/A**	A DEVELOPMENTAL DISABILITY GROUP HOME RESIDENTIAL SERVICE FOR CHILDREN AND ADOLESCENTS
14	050	DD	DD Children Group Home Residential Srv	**DD Group Home for C/A**	A DEVELOPMENTAL DISABILITY GROUP HOME RESIDENTIAL SERVICE FOR CHILDREN AND ADOLESCENTS
14	051	DD	DD Children Group Home Residential Srv	**DD Group Home for C/A**	A DEVELOPMENTAL DISABILITY GROUP HOME RESIDENTIAL SERVICE FOR CHILDREN AND ADOLESCENTS
14	054	MH	Psychiatric Residential Treatment Facility for children and adolescents	**Psychiatric RTF for C/A**	A PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

14	055	MH	Psychiatric Residential Treatment Facility for children and adolescents	**Psychiatric RTF for C/A**	A PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE
14	056	MH	Psychiatric Residential Treatment Facility for children and adolescents	**Psychiatric RTF for C/A**	A PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE
14	060	SA	SA Clinically Managed, Medium-Intensity Residential Srv for Children and adolescents	**ASAM Level 3.5 C/A**	ASAM LEVEL 3.5: SUBSTANCE ABUSE CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL CARE FOR CHILDREN AND ADOLESCENTS
14	061	SA	SA Clinically Managed, Medium-Intensity Residential Srv for Children and adolescents	**ASAM Level 3.5 C/A**	ASAM LEVEL 3.5: SUBSTANCE ABUSE CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL CARE FOR CHILDREN AND ADOLESCENTS
14	062	SA	SA Clinically Managed, Medium-Intensity Residential Srv for Children and adolescents	**ASAM Level 3.5 C/A**	ASAM LEVEL 3.5: SUBSTANCE ABUSE CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL CARE FOR CHILDREN AND ADOLESCENTS
14	063	SA	SA Clinically Managed, Low-Intensity Residential Srv for Children and adolescents	**ASAM Level 3.1 C/A**	ASAM LEVEL 3.1: SUBSTANCE ABUSE CLINICALLY MANAGED LOW-INTENSITY RESIDENTIAL CARE FOR CHILDREN AND ADOLESCENTS
14	064	SA	SA Clinically Managed, Low-Intensity Residential Srv for Children and adolescents	**ASAM Level 3.1 C/A**	ASAM LEVEL 3.1: SUBSTANCE ABUSE CLINICALLY MANAGED LOW-INTENSITY RESIDENTIAL CARE FOR CHILDREN AND ADOLESCENTS
14	065	SA	SA Clinically Managed, Low-Intensity Residential Srv for Children and adolescents	**ASAM Level 3.1 C/A**	ASAM LEVEL 3.1: SUBSTANCE ABUSE CLINICALLY MANAGED LOW-INTENSITY RESIDENTIAL CARE FOR CHILDREN AND ADOLESCENTS
14	066	DD	ICF-IID for Children and adolescents	**ICF-IID for C/A**	AN INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY (ICF-IID) SERVICE FOR CHILDREN AND ADOLESCENTS
14	094	DD	DD RESIDENTIAL RESPITE SRV	**DD RESIDENTIAL RESPITE C/A**	A DEVELOPMENTAL DISABILITY RESIDENTIAL RESPITE SERVICE FOR CHILDREN AND ADOLESCENTS **FOR ALL NEW CHILDREN RESPITE SERVICES**
14	097	MH	MH RESIDENTIAL RESPITE SRV	**MH RESIDENTIAL RESPITE C/A**	A MENTAL HEALTH RESIDENTIAL RESPITE SERVICE FOR CHILDREN AND ADOLESCENTS **FOR ALL NEW CHILDREN RESPITE SERVICES**
16	002	DD	DD Case Management Srv	**DD Case Management**	A developmental disability case management service
16	003	SA	SA Case Management Srv	**SA Case Management**	A substance abuse case management service
16	004	MH	Adult MH Case Management Srv	**MH Case Management Adult**	A mental health case management service for adults with serious mental illness

16	005	MH	Children and Adolescents MH Case Management Srv	**MH Case Management C/A**	A mental health case management service for children and adolescents
17	001	MH	ICT Srv	**ICT**	A mental health intensive community treatment (ICT) service for adults with serious mental illness
18	002	MH	ACT Srv (Small Team)	**ACT Small**	A mental health assertive community treatment (ACT) small team for adults with serious mental illness
18	003	MH	ACT Srv (Medium Team)	**ACT Medium**	A mental health assertive community treatment (ACT) medium team for adults with serious mental illness
18	004	MH	ACT Srv (Large Team)	**ACT Large**	A mental health assertive community treatment (ACT) large team for adults with serious mental illness

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SAMPLE Staff Information Sheet

Name of Service: Click or tap here to enter text.

Date: Click or tap to enter a date.

Location: Click or tap here to enter text.

Position (use * to denote position vacancy)	Name	Staff Member Education Level and Credentials	Service Assigned	SCHEDULED HOURS						
				MON	TUES	WED	THURS	FRI	SAT	SUN

Use @ to indicate staff having current certification in First Aid. Use # to indicate staff who have received a certificate in Cardiopulmonary Resuscitation (CPR).

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SAMPLE Annual Operating Budget

Name of Service: Click or tap here to enter text.

Type of Service: Click or tap here to enter text.

Date: Click or tap to enter a date.

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
1. ADMINSTRATION													
Office equipment & supplies													
Accounting													
Licensing fees													
Legal fees													
Insurance(s):													
Professional liability													
General liability													
Property liability													
Commercial Vehicular liability													
Employee Bonding													
Advertising													
2. SALARIES, WAGES & BENEFITS													
Salaries: (List each separately)													
1.													
2.													
3.													
4.													
5.													
6.													
7.													
8.													
9.													
FICA (Social Security)													
Health Insurance													
Life Insurance													
Employee training (special)													
Other benefits													
3. OPERATIONS													
Food													
Rent/Mortgage													
Utilities:													
Electricity													
Gas													

Cable													
Water													
Sewage													
Internet													
Auto Fuel													
Auto Maintenance													
Facility Maintenance													
Equipment/Supplies													
Motor vehicles													
Laundry/Linens													
Cleaning supplies													
Toiletries													
Staff Travel													
Staff Training (routine)													
Client recreation													
Client allowances													
Office equipment													
Contractual Services													
OTHER:													
Employee taxes													
TOTALS													

SAMPLE of Acceptable Policy & Procedures

***Area*: Record Management**	***Policy*: 12 VAC 35-105-870**	***Page* 1 of 4 pages**
***Title*: Paper and Electronic Records Management Policy**	***Issued*: 9/20/17**	***Revised*:**

***Policy*:**

In order to comply with the regulation a written policy has been established for record management and includes confidentiality, accessibility, security and retention of paper and electronic records pertaining to individuals being served. This policy will cover electronic and paper documents.

***Procedures*:**

An individual file will be maintained as a record of services delivered for all persons participating in this program. Records will be paper unless noted as electronic file.

A. Access and limitation of access, duplication, or dissemination of individual information to persons who are authorized to access such information according to federal and state laws.

1. The files cabinets containing the service record for each individual will a locked, flame retardant file cabinet which will be located in the administrative office; this office has a locked door and must be opened by the employees authorized to share the key.

2. Access to the individual's file will be limited to employees having a role in the development of the Individual Support Plan (ISP), and dependent on the level of support being provided.

3. Limited access to the individual's files will be determined by the role of the professional requesting access and having responsibilities for supports such as: assessment and admission determination, medical care, direct care, and clinical interventions etc.

    a. Supervisor and directors or designees will determine level of employees and grant permission to access the individuals file of record.
    b. Limited access the file by the individual is dependent on their capacity as determined by a medical professional such as a psychiatrist, primary physician etc.

4. Duplication of the individual's file may only be completed by the supervisor, director or designee and the purpose of the duplication must be documented on the "Record Retrieval Form" and include the date of the duplication, and employee name and title.

5. Dissemination of the record must be with written approval of the individual when applicable, placing agent, legally authorized representative (LAR), authorized representative (AR) etc. and documented on the "Authorization to Release Information Form."

    a. The written approval to disseminate record must be placed in the file.
    b. No general written approval will be accepted for dissemination of record.
    c. The written notice must have the name of the recipient, business name, business address, relationship to the individual, name of the person given the permission to dissemination the record and the time frame in which the written authorization is valid.
    d. Dissemination to state or federal law enforcement personnel will be completed by following their agency's guidelines and then immediately notify the placing agency, LAR or AR when it is appropriate to do so.
    e. Provider will comply with the state licensing representative and grant access, duplication and dissemination of the individuals file of records when requested and or during required agency business such as investigation, inspections and annual reviews etc.

A.2 Storage, processing, and handling of active and closed records

1. All files will be stored in a locked flame retardant cabinet, in a locked office.

    Storage of the file of records will be individually for each person receiving service. There will be one record with three sections (medical, program service and financial) for easy access to the documents ; For example a program service section of the record would have assessments, initial and annual individual support plan (ISP), monthly data sheet, quarterly progress reports, documentation of special supports or revision of the ISP. The documents in the record will be filed in chronical dates with the most recent item on the top.

2. The stored file of records will be monitored and maintained by the supervisor or designee of the program.

3. Files must be checked out for specific purposes and then returned; documented of usage must be on the file in/out form.

4. Active files will be maintained separately from closed files and reviewed quarterly for quality assurance (QA); compliance with table of content will be the focus of the QA review.

5. Closed files will be stored in a separate flame retardant file cabinet labeled with the month, year (for beginning and ending dates of the content) and the alphabet of names

contained in the file. For example, January 2022-March 2022 (A-C).

6. Closed files documents will be kept in storage for a minimum of ten years or as specified by state and federal requirements.

7. Duplication and dissemination of the stored material from active or closed files will be documented on required agency form.

A.3 Storage, processing and handling of electronic records

1. Electronic record will not be used at this time.

A.4 Security measure that protect records from loss, unauthorized alteration, inadvertent or unauthorized access, disclosure of information and transportation of records between service sites

1. Paper Records

   a. All employee access the file cabinet must lock in after each use to protect the content from unauthorized use.

   b. Loss information must be reported to the supervisor, directors and designee who will inform the individual, family, authorized responsible agent and significant others of the loss of information. Retrieval of the loss information from other sources must be done immediately to ensure continuity of care and service.

   c. Assessment of the incident involving the loss of information must be completed within 24 hours to avoid any future incidents. Outcome of investigation may include , retraining and record security, change in storage procedures, suspension or termination (depends on severity and volume of loss information).

   d. Errors in documents must be identified by sticking through the error and writing the word “error” and the “employees initial” above the inaccurate information.

   e. Employees will be trained on monitoring where they sit /stand when working in the records and to avoid leaving the files unsupervised in public places or in places where someone can look into the record without permission.

   f. All disclosures and exchange of information must be done with permission and only to persons or facilities identified in writing on the approved agency “authorization to release information form” for each individuals.

   g. Authorization forms may not be used after the documented end date.

h. Records must be transported or shared between program and authorized persons or facility by facsimile, encrypted emails, postal services or delivered in person. Records used between services sited must be placed in locked box, briefcase or a similar case and placed in the trunk when the vehicle is unmanned.

i. Records must be returned to the appropriate locked file cabinet when not in use or is undeliverable.

2. Electronic records

   a. Electronic Records will not be used at this time.

A.5 Strategies for service continuity and record recovery from interruptions that result from disasters or emergencies including contingency plans, electronic or manual back-up system and data retrieval system.

1. The employees will be reminded that safety and well-being is the priority; however, services not documented (abridged or full range) means no service rendered.

2. In the event of service interruption the supervisor, director or designee will provide copies of paper documents/forms for the employees to use when documenting services in their temporary location or current location.

3. Records not immediately retrievable from file cabinets will be sought through requesting copies from placing agency, AR, LAR, or other persons who may have records due to exchange of information or service provider to a mutual individual.

4. Records may be recreated from the data where possible in the form reports and identified and a duplicated record due to interruption of services by disaster or emergency. The reason for the duplicated record must be identified.

A.6 Designation of person responsible for records management

1. The supervisor, director or their designee will be tasked with monthly quality assurance review of the files of records.

2. The records will be checked against the table of content and other agency policies and procedures for completing forms, and documents for service delivered.

3. All findings from the monthly QA review that requires further attention or need to be completed will be responded to by the appropriate employee within fourteen days.

A.7 Disposition of records

1. In the event that the service ceases operation the records will be returned to the placing agency. The face sheet, copies of vital records documents, health history, application for admission, discharge information will be shared with AR, LAR, placing agency representative.

2. If the provider opens another business, the face sheet, application for admission, discharge information will be stored in a secured location to be identified prior to placing the files in that location for ten years or until they cease operation of the new business. They will notify the original placing agency of this business and records stored. Records may be destroyed with permission of the placing agency and or their representative when it deemed to be no longer needed.

3. If the records will be transfer to another provider, the provider must have a written agreement with the provider whose business is ceasing. A document containing the name of both providers (sender and receiver parties) will be completed and files in the permanently stored record.

4. The transferred records receipt will be shared with the placing agency, AR, LAR and stored a copy of the transfer agreement with the archived record held by the provider.

B Record management policy will comply with state and federal regulations including:

1. Records will comply with Section 32.1-127.1:03 of the Code of Virginia;

2. 42 USC § 290dd;

3. 42 CFR Part 2; and

4. Records will be maintained and handled according to the Health Insurance Portability and Accountability Act (Public Law 104-191) and implementing regulation (45 CFR Parts 160, 162, and 164).

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SAMPLE of Unacceptable Policy & Procedures

Area:	***Policy***: 12 VAC 35-105-390	***Page*** 1 of 2 pages
Title: Confidentiality and Security of Personnel Records	***Issued***:	***Revised***:

***Policy*:**
Provider will keep all employees records confidential and secure.

***Procedures*:**
New employees, contractors, volunteers and students to this provider will have personnel record.

1. Personnel records will be kept at the office.
2. Staff may access the personnel file only with permission because of confidentiality.
3. Provider will not use electronic record for personnel files.
4. Separate file will be kept for medical, background and registry checks and general personnel records.
5. Personnel record will contain all training documents.

This policy and procedures would be unacceptable because:

- **The policy statement needed additional information;**
- **The heading is incomplete;**
- **The procedures do not give clear steps as to how the provider will protect the confidentiality of the personnel records;**
- **The policy and procedures are not specific as to which office the records will be kept in; and**
- **There is no identification of who, how, when and why- for all staff having access to the employee records.**

Tools for Developing a Quality Improvement Program

Disclaimer – This document is for educational purposes only and is NOT intended as a template.

This document provides suggestions for an organization to consider when developing a quality improvement program in accordance with 12VAC35-105-620. Licensed providers are encouraged to refer to the Licensing Regulations and the Guidance for a Quality Improvement Program for additional information related to quality improvement programs. This document is not a SAMPLE quality improvement plan. Please see the SAMPLE Quality Improvement Plan for suggestions to consider when developing a quality improvement plan for compliance with 12VAC35-105-620.C.

There is no "one size fits all" quality improvement program. Quality improvement programs are based on the population served, the organization's size and services provided. Licensed providers may use this resource to create, review and/or add to their quality improvement program.

The **bold/underlined** section headings are offered as examples providers may wish to consider. The *italicized language* is for purposes of illustration. The inserted boxes highlight the regulatory language.

Policy Title – Quality Improvement Program

Issue Date: _____
Revisions: _____
Responsible Staff: _____

Purpose and Introduction:

This section could outline the purpose of the policy and an introduction regarding the provider's mission or vision.

12VAC35-105-620.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.

Example:

The purpose of this policy is to outline the quality improvement structure, define quality improvement activities and establish criteria for ensuring that quality improvement is an ongoing and continuous process.

References:

A quality improvement program may include many of the provider's policies and procedures. This

section could list such policies and procedures and how they are part of the provider's overall quality improvement program.

Examples:

- *Risk management policy*
- *Serious incident reporting policy*
- *Root cause analysis policy*
- *Employee training policy*
- *Infection control policy*
- *Records management policy*
- *Medication management policy*

Definitions and Acronyms:

This section could define terms used in this policy and specific to this organization.
Examples:

- *12VAC35-105-20 defines a quality improvement plan as 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."*
- *Executive leadership team includes the executive officer, program manager, nursing director, risk manager.*
- *Quality improvement plan means the provider's work plan which is reviewed and updated at least annually (every 365 days).*

Leadership:

The provider may include senior leadership's commitment to a quality improvement culture which sets the tone for the organization and ensures that quality improvement initiatives are consistent with the provider's mission and strategic plan. The organization could also outline here how stakeholder involvement is fundamental to a well-designed and person-centered quality improvement system.

Examples:

- *The provider's leadership holds managers accountable for quality improvement activities and creates an environment that promotes quality improvement efforts.*
- *Leadership values the input of stakeholders including individuals served and their authorized representatives as applicable.*

Guiding Principles:

Best practice for a quality improvement program is to identify guiding principles.

Examples:

- *Customer focused*
- *Data informed*
- *Leadership involvement*
- *Employee empowerment*
- *Continually improve all processes*

Structure:

The provider may have committees, councils, teams, or workgroups responsible for leading quality improvement activities. Depending on its size, the provider may have one committee that is responsible for all quality improvement activities or multiple subcommittees that report to a larger committee or council. Some smaller provider organizations may incorporate these activities in regular staff meetings. No matter the structure, the provider's meeting minutes provide documentation of quality improvement activities.

Examples:

- *The provider's quality improvement committee meets monthly, reviews and analyzes data and receives reports from the safety committee.*
- *The provider's quality improvement council is charged with approving quality improvement initiatives or performance improvement projects.*
- *Staff meetings include progress toward meeting annual goals and objectives as well as corrective action plans.*

Quality Improvement Tools and Models

This section could outline the systematic approach or quality improvement model the provider utilizes as well as the tools the provider incorporates into their quality improvement program. These tools help address systemic problems, prevent future adverse events, improve processes and promote sustained improvement. The provider could include information on how the chosen models/tools are utilized in the quality improvement program.

12VAC35-105-620.B – The quality improvement program shall utilize standard quality improvement tools, including root cause analysis and shall include a quality improvement plan.

Examples:

- *Aim, Measure, Change*
- *Plan, Do, Study Act (PDSA)*
- *Root Cause Analysis (RCA)*
- *Failure Modes and Effect Analysis (FMEA)*
- *Process Mapping*
- *Pareto Chart*

- *Brainstorming*
- *Focus, Analyze, Develop, Execute (FADE)*
- *Run Chart*

Processes:

This section could outline the quality improvement processes the provider follows. This could include data monitoring, record audits, feedback from employees, implementation of corrective action plans, review of serious incidents, recommendations of root cause analyzes or other quality improvement activities.

12VAC35-620.C.1. – The quality improvement plan shall be reviewed and updated at least annually.

Examples:

- *The provider's quality council meets regularly (monthly/quarterly) to analyze data and trends. Ongoing qualitative and quantitative record reviews are analyzed for trends and opportunities for improvement.*
- *A calendar of quality improvement activities outlines when reports and/or data are reviewed.*
- *The provider updates the quality improvement plan at least annually (365 days) but may update more frequently such as when there is a change of services or the addition of corrective action plans.*

12VAC35-105-620.C.4 – The quality improvement plan shall monitor implementation and effectiveness of approved corrective action plans.

Examples:

- *The provider's executive leadership reviews citations and monitors the implementation of pledged corrective action plans (CAPs).*
- *When citations are received, the provider reviews the quality improvement plan to determine whether it is sufficient to address the pledged CAP or to update the plan. The provider documents this decision in meeting minutes.*

12VAC35-105-620.C.5 – The quality improvement plan shall include ongoing monitoring and evaluation of progress toward meeting established goals and objectives.

Examples:

- *Progress in meeting established goals and objectives is a critical part of quality improvement activities. The goals and objectives are monitored (monthly/quarterly) and based on identified trends, the provider initiates quality improvement projects.*
- *An addendum to the quality improvement plan outlines the data and meeting minutes reflect the quality improvement committee's discussion regarding progress toward meeting the goals and objectives.*

- *If progress is not demonstrated, the provider identifies barriers to improvement and/or makes changes to the goals/objectives.*
- *When a goal/objective is met, the committee determines the necessity for continuing to monitor or focuses on other priorities.*

12VAC35-105-780.5 – The provider shall review medication errors at least quarterly as part of the quality assurance in 12VAC35-105-620.

Examples:

- *The provider reviews medication errors at least quarterly to identify systemic issues and makes recommendations for improvement.*
- *Policies and procedures related to medication administration are reviewed and then updated to reflect implemented improvements. .*

12VAC35-105-160.C – The provider shall collect, maintain, and review at least quarterly all serious incidents, including Level I serious incidents, as part of the quality improvement program in accordance with 12VAC35-105-620 to include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents.

Examples:

- *The quality improvement committee reviews all serious incidents, including Level I serious incidents, at least quarterly.*
- *The risk management committee provides a quarterly report of analysis of trends and recommendations to mitigate the potential for future incidents.*

12VAC35-105-620.E – Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning shall be part of the provider's quality improvement plan. The provider shall implement improvements, when indicated.

Examples:

- *A formal survey is administered as well as complaints/comments received from individuals receiving services and their authorized representatives, if applicable.*
- *Input/feedback from stakeholders is reviewed by the quality committee.*
- *The executive leadership conducts meetings and focus groups to obtain input.*

Criteria:

This section could outline the criteria the provider will use in their quality improvement activities related to 12VAC35-105-620.D.1-3.

12VAC35-105-620.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 recurrence of the cited regulatory violation or correct a systemic deficiency pursuant to 12VAC35-105-170.

Examples:

- *When developing goals and objectives for the quality improvement plan, the provider considers one or several criteria for establishing goals and objectives.*
    - *The goal/objective matters to the licensed provider as it has the potential to result in improved outcomes for the population served or improvement in the provider's processes.*
    - *The goal/objective relates to the agency's purpose, mission, and vision.*
    - *The data sources are available for measuring improvement; baseline data is available.*
    - *The goal/objective relates to an area of high volume (affecting a large number of individuals).*
    - *The goal/objective relates to high risk concerns (places individuals at risk for poor outcomes or places the organization at high risk).*
    - *The goal/objective was identified from stakeholder input.*
    - *The goal/objective relates to a concern identified in the annual systemic risk assessment.*
    - *The goal/objective relates to concerns identified through trends identified in review of serious incidents.*
    - *The goal/objective relates to recommendations identified through medication error reviews.*
    - *The goal/objective was the result of employee input.*

- *When updating the provider's quality improvement plan, the provider will consider one or several of the following criteria:*
    - *The provider has discontinued or added services which would affect the quality improvement plan.*
    - *The provider received citations from external reviews for which an approved CAP should be added to the quality improvement plan.*
    - *The provider is not making progress in meeting established goals/objectives so a revision is necessary.*

- *When determining whether to revise the corrective action plans, the provider will consider one or several of the following criteria:*
    - *The provider determines additional corrective measures are necessary to fully correct the deficiency. The provider will continue to implement the CAP, but adopt additional corrective measures and incorporate those additional measures into the quality improvement plan.*

- *The provider will conduct a root cause analysis (RCA) to determine why the CAP is not effective and based on the RCA team's recommendations amend or submit a revised CAP to the department.*

Evaluation:

This section could outline how the licensed provider evaluates the effectiveness of its quality improvement program and whether the provider seeks to change how quality improvement work is accomplished.

Examples:

- *The provider's executive leadership annually evaluates the quality improvement program. Recommendations for enhancements are incorporated into the program.*
- *The provider uses a self-assessment tool to assess performance management strengths and weaknesses in their quality improvement program.*

Resources:
CMS Guide for Developing A QAPI Plan
CMS QAPI 5 Elements

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SAMPLE Quality Improvement Plan

Disclaimer - This document is for educational purposes only and is NOT intended as a template for a quality improvement plan. This sample provides suggestions for an organization to consider when developing a quality improvement plan for compliance with 12VAC35-105-620.C.

Licensed providers should refer to the requirements of a quality improvement plan as outlined in the regulations and in the Guidance for a Quality Improvement Program.

12VAC35-105-20 Definitions – "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."

The regulatory requirements and Guidance are noted below in bold. The "tips" in the highlighted sections are best practices for consideration when developing a quality improvement plan. A quality improvement plan will depend on the provider's size, scope of the services provided and may be a stand-alone document or include the provider's risk management plan. The quality improvement plan may apply to just one of the provider's services or the entire provider organization. If the quality improvement plan applies to the entire provider organization, the plan should clearly identify each of the licensed services the plan applies to and how it applies to each service.

The italicized language is provided as example only.

12VAC35-105-620.C.1 – The quality improvement plan shall be reviewed and updated at least annually. Office of Licensing Guidance for a Quality Improvement Program states "the quality improvement plan should be dated and signed to indicate when it is implemented and when any updates occur."
Tip – Best practice is to include a section for the date and other information at the top or bottom of the document. Revisions could also be noted and dated in this section.

Example:
Date:_____; Signature: _____: Title of Person: _____
Revision Date:_____; Signature: _____; Title of Person: _____

Tip – Best practice is to include a Table of Contents depending upon the length of the quality improvement plan to clearly indicate sections and pages.

Example: Table of Contents

Tip –Best practice is to define terms used throughout the quality improvement plan that are specific to the organization.

Example – Definitions

"Quality Committee" means the committee responsible for monitoring and analyzing data, reviewing and updating the quality improvement plan, establishing and monitoring measurable goals and objectives, approving quality improvement initiatives, and monitoring corrective action plans.

"Quality improvement program" means the policies and procedures the provider has implemented to identify, monitor and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis.

Tip – Best practice is to include the organization's mission, vision and values related to quality improvement. Consider including guiding principles related to quality (See Reference Section below for resources). The quality improvement plan may be a stand-alone document or include the provider's risk management plan.

Example – Standards of Quality

The provider's quality program is committed to developing a culture of quality which encourages the reporting of errors and uses data to inform quality improvement efforts.

The provider's quality improvement plan is tied to the organization's mission statement: to provide the highest quality, compassionate health care to our clients through an array of services.

Tip – Best practice is to outline how the organization's governing body or leadership is involved in quality improvement. Consider the roles and responsibilities related to quality improvement and who is responsible for monitoring quality improvement efforts. If the information regarding the provider's quality improvement committee is included in a separate policy, a reference to that policy could be included here.

Example – Leadership

The administration is committed to a culture of quality and will provide opportunities for employees throughout the organization to participate in safety and quality initiatives.

The administration ensures adequate resources are dedicated to quality improvement and risk management efforts.

12VAC35-105-620.C.2 –The quality improvement plan shall define measurable goals and objectives.
Office of Licensing Guidance for a Quality Improvement Program states "a provider's quality improvement plan should include goals and objectives that are operationally defined and measurable, and a schedule for monitoring progress towards achieving the planned goals and objectives."
The regulation does not require the provider to set a specific number of goals and objectives. Goals are considered to be endpoints or targets toward which the quality program is directing its efforts (consider what is most important to the organization). Objectives are specific. SMART – Specific, Measurable, Attainable, Relevant and Time-bound.
Tip – Best practice is to include the data source, the frequency of data collection, and the staff person responsible for collecting the data.

Example – Data Monitoring: Performance Goals and Objectives

Goal: Individuals shall receive timely opioid treatment services

Objective: 86% of individuals admitted for service during the calendar year shall receive face-to-face counseling sessions (either individual or group) every two weeks for the first year of receiving services.

Goal: Individuals' dietary needs are met.

Objective: By (date), 86% of monthly menus at each of the provider's group homes will include meals that consider the cultural background, personal preferences, and foot habits and that meet dietary needs of individuals served.

Goal: Employees strive to improve job performance

Objective: 95% of employees and contractors receive an annual performance evaluation by the end of the fiscal year.

Schedule for monitoring data – quarterly reports will be provided to the quality committee

12VAC35-105-620.B - The quality improvement program utilizes standard quality improvement tools, including root cause analysis.
Tip – Best practice is to include the quality improvement tools and models the provider will utilize. (Reminder - 12VAC35-105-160.E.2 requires a Root Cause Analysis Policy)

Example – Quality Improvement Model and Tools

The provider will follow the Plan, Do, Study, Act (PDSA) model for quality improvement efforts.
The provider will conduct Root Cause Analysis (RCA) in accordance with its RCA Policy and to identify the underlying causes of a problem.

12VAC35-105-620.C.4 – The quality improvement plan shall monitor implementation and effectiveness of approved Corrective Action Plans pursuant to 12VAC35-105-170.
As noted in Guidance for a Quality Improvement Program, anytime a provider is issued a licensing report, the provider should review their quality improvement plan to determine whether the current plan is sufficient to address the concerns identified in the licensing report and to monitor compliance with the provider's pledged CAP. If the current quality improvement plan is not sufficient, then the provider will need to update the plan accordingly. Providers should have a clear written plan for how they will evaluate their current quality improvement plan to determine if it is sufficient to address the concerns identified in the licensing report and to monitor their pledged CAPs. The written plan shall include the person responsible for the reviews as well as how each review will be documented and stored, so that compliance may be determined by the licensing specialist during review.

Example – Corrective Action Plan Monitoring

When the provider is issued licensing reports, the provider will monitor the implementation of the approved CAPs. Leadership will be responsible for reviewing the quality improvement plan and determining whether it is sufficient for monitoring pledged CAPs or whether the plan should be updated accordingly.

Example 1- The provider receives a licensing report related to medication errors. The provider reviewed the current QI plan and determine that the measurable goal related to reducing medication errors is sufficient for monitoring implementation of the CAP.

Example 2 – The provider receives a licensing report for failure to have a RCA policy. The provider's approved CAP included implementation of a RCA policy. The provider reviewed the current QI plan and decided to update the plan to include monitoring of the RCA policy to determine if the new RCA policy was appropriate and whether established thresholds for conducting more detailed root cause analyses were sufficient in addressing serious incidents. Once the policy has been monitored for effectiveness, the CAP will no longer be subject to monitoring. The person designated for risk management will be responsible for reporting.

12VAC35-105-620.C.5 - The quality improvement plan shall include ongoing monitoring and evaluation toward meeting established goals and objectives.
Tip – Best practice is to establish a quality committee that regularly meets to review progress and documents ongoing monitoring of goals.

Example – Ongoing monitoring and evaluation

The provider's quality committee will meet quarterly to review progress toward the established goals and objectives. As the results of data collection are analyzed, the provider will look for trends, identify progress in meeting the goals and objectives, whether the goals should be revised, and consider whether a quality improvement initiative is necessary. A report of quarterly data is attached as an appendix to the quality improvement plan.

12VAC-35-105.620.E - Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning shall be part of the provider's quality improvement plan. The provider shall implement improvements, when indicated.
While a survey is not required, the quality improvement plan shall outline how the input from individuals receiving services and their authorized representatives, if applicable, will be obtained and how the provider will use this input.

Example – Stakeholder input

The provider will conduct customer satisfaction surveys on an annual basis. Results of the surveys will be reviewed by the quality committee to determine possible quality improvement initiatives.

Tip – Best practice is to include the process the provider will use to evaluate the quality improvement plan.

Example – Quality Improvement Plan Evaluation

The provider will evaluate the quality improvement plan for its effectiveness at least annually. This review will include evaluation of the components of the quality improvement program and the efficacy of the plan. The results of the evaluation will assist with the development of quality improvement initiatives and/or goals and objectives.

Online Resources for developing a Quality Improvement Plan:
CMS Guide for Developing a QAPI Plan
CMS QAPI
Agency for Healthcare Research and Quality

The Office of Licensing webpage includes a Guidance and Technical Assistance section which includes Quality Improvement-Risk Management Resources.
Guidance for Quality Improvement Program

DBHDS - Office of Licensing

SAMPLE Root Cause Analysis Policy

Disclaimer: This document is provided for educational purposes **only**. The provider's policy on conducting root cause analyses could be a separate policy or could be incorporated into the provider's serious incident reporting policy. If the provider chooses to incorporate their root cause analysis policy into their serious incident reporting policy, the header for the document should clearly mark that the policy addresses both regulations. This document is not a template for a root cause analysis (RCA) policy.

Providers should also reference Guidance for Serious Incident Reporting.

12VAC35-105-20 defines a root cause analysis as "a method of problem solving designated 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."

Providers shall consider the following questions when developing a root cause analysis policy, so that the policy clearly outlines the procedures the provider will follow. The provider should reference the regulatory language (italicized below) in order to guide their policy while making the policy appropriate for their organization's size and population served.

When is an RCA required?

12VAC35-105-160.E – a root cause analysis shall be conducted by the provider within 30 days of discovery of Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider's premises.

While the regulation outlines when an RCA is required, the provider may choose to include additional times or situations when an RCA is to be completed.

What should be included in an RCA?

12VAC35-105.160.E.1 - The root cause analysis shall include at least the following information:

a. A detailed description of what happened;
b. An analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and
c. Identified solutions to mitigate its reoccurrence and future risk of harm when applicable,

A provider may have a certain form or format that is utilized for ensuring that the above information is included.

Who will complete the RCA?

It is recommended that the provider's policy outline who will complete the RCA. The staff assigned to conduct the RCA would vary depending on the situation/incident and the provider's policy could include that the provider's leadership may assign RCA team members. This section could also

include the process involved such as submitting the completed RCA to a supervisor and/or committee/team for review.

What are the provider's requirements for the timeframe for conducting the RCA?

The regulations require that the RCA be conducted within 30 days of discovery of Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider's premises.

How will recommendations and/or actions be implemented and monitored for effectiveness?

The provider could outline how the recommendations will be made to a supervisor or a committee/team. Based on the provider's policy, recommendations implemented should be monitored for effectiveness. For example, if a new process is recommended, the policy could outline who will ensure that the process is outlined, implemented and monitored for the desired outcome.

When will a more detailed RCA will be conducted?

When identifying thresholds, consider what is best for the organization because the purpose of the RCA process is to help the provider mitigate reoccurrence of serious incidents and make systemic improvements.

12VAC35-105-160.E.2 - *The provider shall develop and implement a root cause analysis policy for determining when a more detailed root cause analysis, including convening a team, collecting and analyzing data, mapping processes, and charting causal factors, should be conducted. At a minimum, the policy shall require for the provider to conduct a more detailed root cause analysis when:*

a. *A threshold number, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II serious incidents occur to the same individual or at the same location within a six-month period;*

Example
A partial hospitalization program at one (1) location serves 25 individuals.
The provider's RCA policy states that when three (3) or more of the same Level II serious incidents occur to the same individual or at the same location within a six (6) month period, the provider conducts a more detailed RCA. The provider reports a Level II serious incident involving a serious injury onsite in May and two Level II serious injuries involving different individuals onsite in August. Based on the provider's RCA policy, a more detailed RCA is conducted because the threshold was met when three of the same Level II serious incidents occurred at the same location within six months.

Example
A supportive in-home provider for thirty (30) individuals with developmental disabilities has an RCA policy that states a more detailed RCA will be conducted when two (2) or more similar incidents occur to the same individual within a six (6) month period.

The provider reports a Level II serious incident involving a fall with fracture during the provision of services in December, and the same individual sustains a fall with fracture during the provision of services in March. The provider conducts a more detailed RCA because their policy is that two similar incidents occur to the same individual within a six-month period.

b. *Two or more of the same Level III serious incidents occur to the same individual or at the same location within a six-month period;*

Example
An Intensive in-home provider serving fifty (50) individuals has an RCA policy that when two or more of the same Level III serious incidents occur to the same individual within a six-month period, the provider will conduct a more detailed RCA.
The provider reports a Level III serious incident of a suicide attempt by an individual that results in hospital admission in March. In June, the provider reports a Level III serious incident of a suicide attempt that results in hospital admission by the same individual. The provider conducts a more detailed RCA in accordance with the provider's policy.

c. *A threshold number, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II or Level III serious incidents, occur across all of the provider's locations within a six-month period; or*

Example
A supervised living residential service provider with three (3) locations serving 6-8 individuals per location has a policy that when three (3) similar Level II or Level III serious incidents occur across all of the provider's locations within a six- month period, the provider will conduct a more detailed RCA. In July the provider reports a missing individual at Location A; in August, the provider reports a missing individual at Location B; in September, the provider reports a missing individual at Location A. The provider conducts a more detailed RCA in accordance with the provider's policy.

Example
A day support program has two locations serving 25-30 individuals with developmental disabilities at each location. The provider has a policy that when two (2) similar Level II or Level III serious incidents occur across all of the provider's locations within a six- month period, the provider will conduct a more detailed RCA. In December, one Level II serious incident of choking requiring physical aid by another person occurs at Location A; in May, a Level II serious incident involving choking which required physical aid by another person occurs at Location B. The provider conducts a more detailed RCA in accordance with the provider's policy.

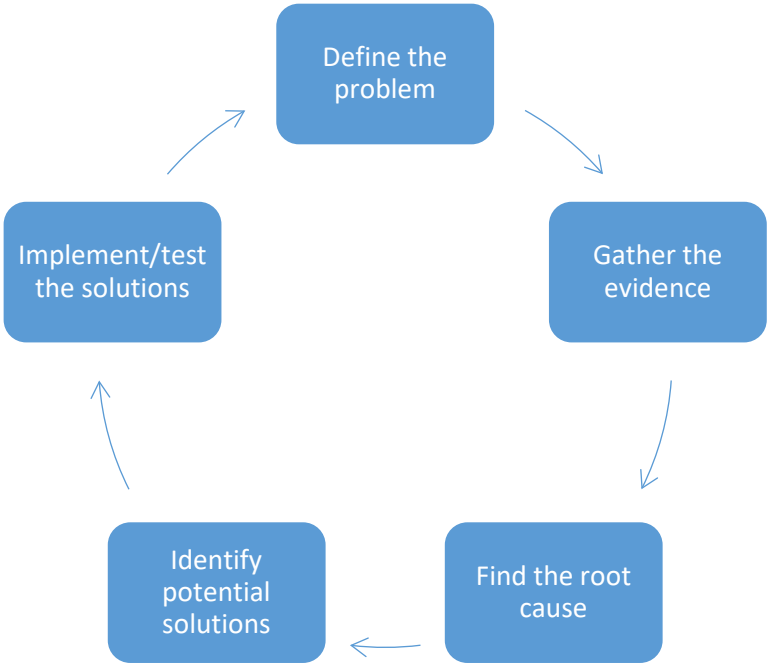
d. *A death occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.*

Example
A developmental services group home reports a death of an individual. The individual with no known medical conditions died of a massive heart attack. The provider's RCA policy requires an RCA for any death that occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.

Example
An individual is receiving services at a substance abuse intensive outpatient location and during service the individual experiences a seizure and suddenly dies. The individual had no known medical conditions. The provider conducts a more detailed RCA because this was a Level III serious incident that was not expected in advance or based on the person's known medical condition.

What is a more detailed RCA?
The provider's RCA policy would include what is involved in a more detailed RCA. This would vary depending on the provider's size and population served. During an Office of Licensing review, the provider would provide proof that the policy was followed. A more detailed RCA could include:

- Convening a team;
- Collecting and analyzing data;
- Mapping processes;
- Charting causal factors;
- Identifying systemic issues;
- Making recommendations to leadership; and/or
- Implementing recommendations and then testing to ensure desired outcomes are achieved.



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SAMPLE Risk Management Plan

Disclaimer - This document is for educational purposes only and is not intended as a template for a risk management plan. This sample provides suggestions for an organization to consider when developing their own risk management plan pursuant to 12VAC35-105-520.B. *The italicized language is provided as an example.* Licensed providers should refer to the regulations and the Guidance for Risk Management when developing a risk management plan as well as other resources on the DBHDS webpage.

The regulatory requirements and Guidance are noted below in bold. The "tips" in the highlighted sections are best practices for consideration when developing a risk management plan.

12VAC35-105-20 – "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."

Risk management plans are based on assessed risks, potential risks, and include the strategies and efforts needed to mitigate those risks. Each organization's risks vary depending on the provider's size, population served, and unique risks associated with the provider's business model. The risk management plan may be a standalone plan or it may be integrated into the provider's quality improvement plan. The risk management plan may apply to just one of the provider's services or the entire provider organization. If the risk management plan applies to the entire provider organization, the plan should clearly identify each of the licensed services the plan applies to and how it applies to each service.

Office of Licensing Guidance for Risk Management states "the provider should review and update the plan at least annually or any time the provider identifies a need to review and update the plan based on ongoing quality review and risk management activities."
Tip – Best practice is to include the date and applicable signatures at the top or bottom of the document. Revisions could also be noted and dated in this section.

Example:
Date _____ *Signature* _____ *Title of Person* _____
Review/Revision date: _____

Tip - Best practice is to include an introduction regarding the purpose of the risk management plan and how it is tied to the organization's mission and vision.

Example - Introduction

The provider's risk management plan supports the organization's mission and vision. The risk management plan seeks to continuously improve safety and minimize or prevent errors and events that result in harm through proactive risk management activities. Acknowledging that safety is everyone's responsibility, the organization strives to ensure the safety of individuals, employees, visitors, and others through the identification, mitigation, early detection, monitoring, evaluation, and control of risks.

This section could also reference other policies, procedures, protocols or plans that represent the organization's quality and risk management programs.

Tip – Best practice is to include a section regarding leadership's role in the organization's risk management program. Leadership's commitment to a culture of safety and the importance of identifying and addressing risks could be outlined. Leadership has the responsibility for ensuring adequate resources are available for risk management activities.

Example - Leadership

The leadership of the organization is committed to promoting safety and has the overall responsibility for the effectiveness of the risk management program including managing adverse events occurring with individuals served, staff, visitors, and organizational assets. Leadership supports a non-punitive culture that promotes awareness and empowers staff to identify risk-related issues.

Based on the organization's size and structure, this section could then outline designated committees that are charged with monitoring risks and reviewing the impact of risk reduction strategies.

Tip – Best practice is to include a section outlining the roles and responsibilities related to risk management.

Example – Role and Responsibilities of the person designated for the risk management function.

Working with leadership, the risk manager is responsible for creating, implementing, and evaluating the outcomes of the risk management plan. (Note – the job description of the staff member responsible for risk management shall also include this information).

Based on the organization's size and structure, this section could describe how the risk manager coordinates with infection control, quality improvement, patient safety, and environment of care management. The section could also outline how all employees are responsible for reporting serious incidents, safety concerns, and medication errors.

12VAC35-105-520.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.

I. Identification Example:

The organization will identify risks through:

- *Serious incident reporting*
- *Infectious disease reporting*
- *Safety inspections (hazardous chemicals, unsafe conditions, equipment, smoke detector/fire extinguisher checks)*
- *Financial reports (fiscal accountability pursuant to 12VAC35-105-210)*
- *Documented medication errors (12VAC35-105.780.5 - review medication errors at least quarterly)*
- *Instances of property damage or loss*
- *Personal injury sustained on provider's premises*
- *Emergency management preparedness and response*
- *Systemic risk assessment reviews (12VAC35-105-520.C)**

Example – Risk Assessment Reviews

The annual systemic risk assessment review shall be conducted by the risk management committee and documented by the risk manager. The findings of the risk assessment will assist the provider in the next steps of monitoring/reducing/minimizing risks as prioritized by the provider.

The list above is an example. Each organization's risk identification processes will vary depending on the size and scope of the organization.

*As noted in the Guidance for Risk Management an annual risk assessment review is a necessary component of a provider's risk management plan. The review should include consideration of harms and risks identified and lessons learned from the provider's quarterly reviews of all serious incidents conducted pursuant to 12VAC35-105-160.C, including an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents.

12VAC35-105-520.D – The systemic risk assessment process shall incorporate uniform risk triggers and thresholds as defined by the department.

DBHDS has defined risk triggers and thresholds as care concerns which are identified through the Incident Management Unit's review of serious incident reporting. If the provider does not have any identified care concerns, the provider should include documentation of how they would review/address if care concerns do arise. The provider may want to consider incorporating this into their Risk Management Plan.

II. Monitoring Example:

The organization's risk management committee will review and monitor data during monthly risk management committee meetings. The committee will identify year-over-trends and patterns and use baseline data to assess the effectiveness of its risk management system.

While the committee structure allows for maintaining minutes to document discussion, recommendations, and actions, an organization may not have an established committee. If a committee is not established, the provider could outline the process developed to review and document patterns identified and systemic actions taken.

III. Reducing/Minimizing Example:

The systemic risk assessment process conducted at least annually will assist the provider in implementing strategies to reduce/minimize risks.

Based on the risk assessment, the following strategies will be implemented to reduce/minimize risks:

- *Address healthcare acquired infections through increased hand hygiene training/compliance*
- *Minimize personal injury by conducting safety awareness training with employees*
- *Reduce liability by conducting frequent inspections to look for potential hazards related to the property*

This section could outline steps and/or efforts the provider will implement to address identified risks. The provider could look at the convergence of data. For example, how increased overtime may be impacting the rate of serious incidents.

Tip – Best practice is to include a section outlining training/communication.

Example – Employee training/communication

The provider recognizes that the effectiveness of risk management activities is dependent on the involvement of all employees and contractors. Through pre-service training and other promotional activities, risk reduction strategies will be highlighted.

This section could also include how the organization is committed to transparency with all stakeholders on emerging risks and risk reduction initiatives.

Tip – Best practice is to include a section outlining implementation and evaluation.

Example – Implementation and Evaluation

The organization will constantly evaluate risk reduction strategies to determine effectiveness in reducing/mitigating risks. As new issues are identified through systemic risk assessments,

the risk management plan will be reviewed and revised.

The section could also include how the plan will be reviewed in coordination with the quality improvement plan.

The Office of Licensing webpage includes a Guidance and Technical Assistance section which includes Quality Improvement-Risk Management Resources.

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Policy and Procedures Review & Required Forms

*All copies of policies, procedures, and forms should have regulation and page numbers and a "header" or "footer" indicating the date it was created or revised. Please DO NOT submit materials in plastic cover sheets or permanent binders. Incomplete applications will be returned to the applicant.

PROVIDER:	**LICENSE #:**
SERVICE:	**MANAGER:**
# OF LOCATIONS:	**DATE OF REVIEW:**

Regulation/Section		**Standard**	Date	Date
155.5a	**Prescreening & Discharge planning-applicable to CSBs ONLY**	Develop policies and procedures that include identification of employee or services responsible for prescreening & discharge planning		
160.E.2	**Root Cause Analysis**	The provider shall develop and implement a root cause analysis policy for determining when a more detailed root cause analysis, including convening a team, collecting and analyzing data, mapping processes, and charting causal factors, should be conducted. At a minimum, the policy shall require for the provider to conduct a more detailed root cause analysis when:		
	160.E.2.a.	A threshold number, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II serious incidents occur to the same individual or at the same location within a six-month period;		
	160.E.2.b.	Two or more of the same Level III serious incidents occur to the same individual or at the same location within a six-month period;		
	160.E.2.c.	A threshold number, as specified in the provider's policy based on the provider's size, number of locations, service type, number of individuals served, and the unique needs of the individuals served by the provider, of similar Level II or Level III serious incidents occur across all of the provider's locations within a six-month period; or		
	160.E.2.d.	d. A death occurs as a result of an acute medical event that was not expected in advance or based on a person's known medical condition.		
160.J.	**Serious Incident Reporting**	J. The provider shall develop and implement a serious incident management policy, which shall be consistent with this section and which shall describe the processes by which the provider will document, analyze, and report to the department information related to serious incidents.		
210.C	**Fiscal accountability**	The provider shall have written internal controls to minimize the risk of theft or embezzlement of provider funds		
220.1	**Indemnification (*Quote or policy required prior to policy approval*)**	Indemnity Coverage: General liability;		
220.2		Indemnity Coverage: Professional liability;		
220.3		Indemnity Coverage: Vehicular liability;		
220.4		Indemnity Coverage: Property damage.		
230	**Fee schedule**	Written schedule of rates and charges available upon request		
240.A	**Policy on funds of individuals receiving**	Addresses handling funds of individuals receiving, including providing for separate accounting of individual funds, addresses		

	services.	payees and assistance with money management		
	240.B	Documented financial controls to minimize theft		
	240.C	Surety bond or other assurance for security of funds		
☐ *Financial Information Form- expenditures and disbursement of Client's funds - 240.A* ☐ Staff involved ☐ Client involved ☐ Amount of funds ☐ Date ☐ Purpose				
270.	**Building modifications**	Addresses safety and continue service delivery if new construction or conversion, structural modifications or additions to existing buildings		
310.	**Weapons Policy**	Addresses use and possession of firearms, pellet guns, air rifles and other weapons on the facility's premises. Procedure for ensuring individuals' safety, contacting police, consequences for staff/consumers who have weapons in possession during services. Weapons must be:		
	310.1	In the possession of licensed security or sworn law-enforcement personnel;		
	310.2	Kept securely under lock and key; or		
	310.3	Used under the supervision of a responsible adult in accordance with policies and procedures developed by the facility for the weapons' lawful and safe use		
400.B.	**Background checks**	The provider shall develop a written policy for criminal history background checks and registry searches. The policy shall require at a minimum a disclosure statement stating whether the person has ever been convicted of or is the subject of pending charges for any offense and shall address what actions the provider will take should it be discovered that a person has a founded case of abuse or neglect or both, or a conviction or pending criminal charge.		
410	**Job Descriptions**	Each employee shall have a written job description that includes:		
	A.1	Job Description includes job title		
	410.A.2	Job Description includes duties & responsibilities		
	410.A.3	Job Description includes title of supervisor		
	410.A.4	Job Description includes minimum KSAs, training, education, & background screenings, CPR, first aid, & behavioral intervention training, if warranted		
450.	**Employee training and development**	Addresses retraining for:		
	450	Serious incident reporting,		
	450	Medication administration,		
	450	Behavior intervention, and		
	450	Emergency preparedness.		
	450	Infection control, to include flu epidemics		
		Training and development documented in employee personnel records.		
☐ *Staff Orientation Form for Employees, Contractors, Volunteers and Students - 440 (include space for staff/supervisor signatures)* ☐ Objectives and philosophy of the provider; ☐ Confidentiality ☐ Human rights regulations ☐ Applicable personnel policies; ☐ Emergency preparedness procedures; ☐ Person-centeredness				

☐ Infection control practices and measures; ☐ Other policies and procedures that apply to specific positions and specific duties and responsibilities; ☐ 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.				
☐ *Staff Training and Development Form* -450 .6 Retraining in: ☐ Serious Incident Reporting, ☐ Medication administration, ☐ Behavior intervention, ☐ Emergency preparedness, ☐ CPR/First Aid, ☐ Infection control, including flu epidemics, ☐ Human Rights				
470.	**Employees notification of policy changes**	Addresses process used to advise employees or contractors of policy changes		
480.	**Employee or contractor performance evaluation**	Addresses evaluation of employee or contractor performance		
☐ *Performance Evaluation Form-- 480* ☐ Core Duties and Responsibilities ☐ Addresses Continued Training needs ☐ Staff Developmental Needs				
490.	**Written grievance policy**	Addresses method use to inform employees of grievance procedures		
☐ *Grievance Procedure Form- 490*				
500.A	**Students and volunteers**	The provider shall implement a written policy that clearly defines and communicates the requirements for the use and responsibilities of students and volunteers including selection and supervision.		
520.	**Risk management**	Risk management policy:		
	520.A	The provider shall designate a person responsible for the risk management function who has completed department approved training, which shall include training related to risk management, understanding of individual risk screening, conducting investigations, root cause analysis, and the use of data to identify risk patterns and trends.		
	520.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.		
	520.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:		
	520.C.1	The environment of care;		
	520.C.2	Clinical assessment or reassessment processes;		
	520.C.3	Staff competence and adequacy of staffing;		
	520.C.4	Use of high risk procedures, including seclusion and restraint; and		
	520.C.5	A review of serious incidents.		
	520.D	The systemic risk assessment process shall incorporate uniform risk triggers and thresholds as defined by the department.		
	520.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.		
	520.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.		

☐ *Facility Inspection Checklist Form 520.E* (Indicate N/A for items not used at the site for office spaces for home and non-center based services)

- ☐ Smoke detectors
- ☐ Fire extinguishers
- ☐ ER lighting
- ☐ First Aid Kit
- ☐ Needed repairs
- ☐ Extension cords
- ☐ Outside grounds
- ☐ Outside lighting
- ☐ Building exterior
- ☐ Floors
- ☐ Restrooms
- ☐ Cleanliness
- ☐ Safety hazards
- ☐ Washer/dryer
- ☐ Furniture
- ☐ Refrigerator/freezer
- ☐ Windows/screens
- ☐ Locks
- ☐ Laundry supplies
- ☐ Personal hygiene supplies
- ☐ Emergency food/water
- ☐ OSHA Kit
- ☐ Security alarms

530.	**Emergency preparedness and response plan**	Policy addresses:		
	530.A	The provider shall develop a written emergency preparedness and response plan for all of its services and locations that describes its approach to emergencies throughout the organization or community. This plan shall include an analysis of potential emergencies that could disrupt the normal course of service delivery including emergencies that would require expanded or extended care over a prolonged period of time. The plan shall address:		
	530.A.1	Specific procedures describing mitigation, preparedness, response, and recovery strategies, actions, and responsibilities for each emergency.		
	530.A.2	Documentation of coordination with the local emergency authorities to determine local disaster risks and community-wide plans to address different disasters and emergency situations.		
	530.A.3	The process for notifying local and state authorities of the emergency and a process for contacting staff when emergency response measures are initiated.		
	530.A.4	Written emergency management policies outlining specific responsibilities for provision of administrative direction and management of response activities, coordination of logistics during the emergency, communications, life safety of employees, contractors, students, volunteers, visitors, and individuals receiving services, property protection, community outreach, and recovery and restoration.		
	530.A.5	Written emergency response procedures for initiating the response and recovery phase of the plan including a description of how, when, and by whom the phases will be activated. This includes assessing the		

		situation; protecting individuals receiving services, employees, contractors, students, volunteers, visitors, equipment, and vital records; and restoring services. Emergency procedures shall address:		
	530.A.5.a	Warning and notifying individuals receiving services;		
	530.A.5.b	Communicating with employees and , contractors, and community responders;		
	530.A.5.c	Designating alternative roles and responsibilities of staff during emergencies including to whom they will report in the provider's organization command structure and when activated in the community's command structure		
	530.A.5.d	Providing emergency access to secure areas and opening locked doors;		
	530.A.5.e	Evacuation procedures, including for individuals who need evacuation assistance;		
	530.A.5.f	Conducting evacuations to emergency shelters or alternative sites and accounting for all individuals receiving services;		
	530.A.5.g	Relocating individuals receiving residential or inpatient services, if necessary;		
	530.A.5.h	Notifying family members or authorized representatives;		
	530.A.5.i	Alerting emergency personnel and sounding alarms;		
	530.A.5.j	Locating and shutting off utilities when necessary; and		
	530.A.5.k	Maintaining a 24 hour telephone answering capability to respond to emergencies for individuals receiving services.		
	530.A.6	Processes for managing the following under emergency conditions:		
	530.A.6.a	Activities related to the provision of care, treatment, and services including scheduling, modifying, or discontinuing services; controlling information about individuals receiving services; providing medication; and transportation services;		
	530.A.6.b	Logistics related to critical supplies such as pharmaceuticals, food, linen, and water;		
	530.A.6.c	Security including access, crowd control, and traffic control; and		
	530.A.6.d	Back-up communication systems in the event of electronic or power failure.		
	530.A.7	Specific processes and protocols for evacuation of the provider's building or premises when the environment cannot support adequate care, treatment, and services.		
	530.A.8	Supporting documents that would be needed in an emergency, including emergency call lists, building and site maps necessary to shut off utilities, designated escape routes, and list of major resources such as local emergency shelters.		
	530.A.9	Schedule for testing the implementation of the plan and conducting emergency preparedness drills. Fire and evacuation drills shall be conducted at least monthly.		

☐ *Fire Safety Drill Form - 530.E*

☐ Date/Shift/Time
☐ Staff participating
☐ Number of Clients
☐ Location of Fire
☐ Time started; time finished
☐ Total time
☐ Head count
☐ Problems noted
☐ Dated/signed

540.B	**Access to telephone in emergencies**	Providers shall have instructions for contacting emergency services and telephone numbers shall be prominently posted near the telephone including how to contact provider medical personnel, if appropriate.		
☐ *Emergency Preparedness Numbers Posted-540.B* ☐ Fire ☐ Police ☐ Poison control ☐ Administrator ☐ Nearest hospital, ☐ Ambulance service, ☐ Rescue squad and ☐ Other trained medical personnel				
570.	**Mission Statement**	Clearly defines services, philosophy, purpose, and goals.		
	Service description requirements			
580.	580.A	Ensures services are consistent with mission and available for public review		
	580.B	Offers structured program of care to meet the individuals' physical and emotional needs; provide protection, guidance and supervision; and meet the objectives of any required service plan to include:		
☐ Daily Schedule of Services - 580.B				
	580.C.1	Services goals;		
	580.C.2	A description of care, treatment, training, habilitation, or other supports provided;		
	580.C.3	Characteristics and needs of the individuals served;		
	580.C.4	Contract services, if any		
	580.C.5	Eligibility requirements of admission, continued stay and exclusion criteria		
	580.C.6	Service termination of treatment and discharge or transition criteria; and		
	580.C.7	Type and role of employees or contractors.		
	580.D	Revision of written service description whenever the service description changes		
	580.E	Provider does not implement services that are inconsistent with its most current service		
	580.F	The provider shall admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served.		
	580.G	In residential and inpatient services, addresses physical separation of children and adults in residential quarters and programming.		
	580.H	In SA services, addresses the timely and appropriate tx of SA abusing pregnant women		
	580.I	If the provider plans to serve individuals as of a result of a temporary detention order to a service, prior to admitting those individuals to that service, the provider shall submit a written plan for adequate staffing and security measures to ensure the individual can be served safely within the service to the department for approval. If the plan is approved, a stipulation will be displayed on license authorizing provider to serve individuals who are under temporary detention orders.		

590.	**Provider staffing plan**	Includes the type and role of employees and contractor that reflect:		
	590.A.1	Needs of the population served		
	590.A.2	Types of services offered		
	590.A.3	Service description		
	590.A.4	Number of people served at a given time		
	590.B	Transition staffing plan for new services, added locations, and changes in capacity.		
	590.C	Will meet the following staffing requirements related to supervision:		
	590.C.1	Shall describe how employees, volunteers, contractors, and student interns will be supervised in the staffing plan and how that supervision will be documented.		
	590.C.2	Supervision of employees, volunteers, contractors, and student interns shall be provided by persons who have experience in working with individuals receiving services and in providing the services outlined in the service description.		
	590.C.3	Supervision shall be appropriate to the services provided and the needs of the individual. Supervision shall be documented.		
	590.C.4	Supervision shall include responsibility for approving assessments and individualized services plans, as appropriate. This responsibility may be delegated to an employee or contractor who meets the qualification for supervision as defined in this section.		
	590.C.5	Supervision of *mental health, substance abuse, or co-occurring services* that are of an acute or clinical nature such as *outpatient, inpatient, intensive in-home, or 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.		
	590.C.6	Supervision of *mental health, substance abuse, or co-occurring services* that are of a supportive or maintenance nature, such as *psychosocial rehabilitation, mental health supports* shall be provided by a QMHP-A. An individual who is QMHP-E may not provide this type of supervision		
	590.C.7	Supervision of *developmental disability* services shall be provided by a person with at least one year of documented experience working directly with individuals who have developmental disability or other developmental disabilities and holds at least a bachelor's degree in a human services field such as sociology, social work, special education, rehabilitation counseling, nursing, or psychology. Experience may be substituted for the education requirement.		
	590.C.8	Supervision of *individual and family developmental disabilities support (IFDDS)* services shall be provided by a person possessing at least one year of documented experience working directly with individuals who have developmental disabilities and is one of the following: a doctor of medicine or osteopathy licensed in Virginia; a registered nurse licensed in Virginia; or a person holding at least a bachelor's degree in a human services field such as sociology, social work, special education, rehabilitation counseling, or psychology. Experience may be substituted for the education requirement.		
	590.C.9	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 licensed in Virginia; (ii) a psychiatrist who is a doctor of medicine or osteopathy specializing in psychiatry and licensed in Virginia; (iii) a psychologist who has a master's degree in psychology from a college or university with at least one year of clinical experience; (iv) a social worker who has a bachelor's degree in human services or a related field (social work, psychology, psychiatric evaluation, sociology, counseling, vocational rehabilitation, human services counseling, or other degree deemed equivalent to those described) from an accredited college or university with at least two years of clinical experience providing direct services to individuals with a diagnosis of brain injury; (v) a Certified Brain Injury Specialist; (vi) a registered nurse licensed in Virginia with at least one year of clinical experience; or (vii) any other licensed rehabilitation professional with one year of clinical experience.		
	590.D	Employs or contracts with persons with appropriate training, to meet the specialized needs- medical or nursing needs, speech, language or hearing problems or other needs, where specialized training is necessary		
	590.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.		
	590.F	Direct care staff who provide brain injury services shall have at least a high school diploma and two years of experience working with individuals with disabilities or shall have successfully completed an approved training curriculum on brain injuries within six months of employment		
600.	**Nutrition**			
	600.A.1	Written plan that for the provision of food services that ensures access to nourishing, well-balanced, healthful meals		
	600.A.2	Makes reasonable efforts to prepares foods that considers cultural background, personal preferences, and food habits and that meet the dietary needs of the individuals served; and		
	600.A 3	Assists individuals who require assistance feeding selves in a manner that effectively addresses any deficits.		
	600.B.	For residential and inpatient services, monitors each individual's food consumption		
610.	**Community participation**	Individuals receiving residential and day support services shall be afforded opportunities to participate in community activities that are based on their personal interests or preferences. The provider shall have written documentation that such opportunities were made available to individuals served.		
☐ Daily Nutrition Monitoring Form - 600.B				
620	**Monitoring & evaluating quality**			
	620.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.		
	620.B.	The quality improvement program shall utilize standard quality improvement tools, including root cause analysis, and shall include a		

		quality improvement plan.		
	620.C.	The quality improvement plan shall:		
	620.C.1	Be reviewed and updated at least annually;		
	620.C.2	Define measurable goals and objectives;		
	620.C.3	Include and report on statewide performance measures, if applicable, as required by DBHDS;		
	620.C.4	Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170; and		
	620.C.5	Include ongoing monitoring and evaluation of progress toward meeting established goals and objectives.		
	620.D.	The provider's policies and procedures shall include the criteria the provider will use to		
	620.D.1	Establish measurable goals and objectives;		
	620.D.2	Update the provider's quality improvement plan; and		
	620.D.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 recurrence of the cited regulatory violation or correct a systemic deficiency pursuant to 12VAC35-105-170.		
	620.E	Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning shall be part of the provider's quality improvement plan. The provider shall implement improvements, when indicated.		
645.	**Screening admission and referrals**			
	645.A	Written policies and procedures for initial contacts and screening, admissions, and referral of individuals to other services and designate staff to perform these activities.		
	645.B	Written documentation of an individual's initial contact and screening prior to his admission including the:		
	645.B.1	Date of contact;		
	645.B.2	Name, age, and gender of the individual;		
	645.B.3	Address and telephone number of the individual, if applicable		
	645.B.4	Reason why the individual is requesting services; and		
	645.B.5	Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or admission to the service.		
	645.C	Shall assist individuals who are not admitted to identify other appropriate services		
	645.D	Shall retain documentation of the individual's initial contacts and screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service		

☐ Client Screening Form - 645.B.1

☐ Date of initial contact
☐ Name, age, and gender of the individual
☐ Address and phone number, if applicable
☐ Reason why the individual is requesting services; and
☐ Disposition of the individual including his referral to other services for further assessment, placement on a waiting list for service, or

admission to the service				
650.A	**Assessment policy**	How assessments are conducted and documented ,		
	650.C	Designates employees or contractors responsible for assessments, have experience conducting assessments & experience with the assessment tool		

☐ Initial Assessment Form - 650.E

☐ Diagnosis;
☐ Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems
☐ Current medical problems;
☐ Current medications;
☐ Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and
☐ At-risk behavior to self and others.

☐ Comprehensive Assessment Form - 650

☐ Onset/duration of problems
☐ Social/behavioral/developmental/family history & supports
☐ Cognitive functioning including strengths and weaknesses;
☐ Employment/vocation/educational background
☐ Previous interventions/outcomes
☐ Financial resources/benefits
☐ Health history and current medical care needs
  ☐ Allergies
  ☐ Recent physical complaints & medical conditions
  ☐ Nutritional needs
  ☐ Chronic conditions
  ☐ Communicable diseases
  ☐ Restrictions on physical activities, if any
  ☐ Past serious illness, serious injuries & hospitalizations
  ☐ Serious illnesses & chronic conditions of individual's parents & siblings and significant others in the same household
  ☐ Current and past substance use including alcohol, prescription and nonprescription medications, and illicit drugs
☐ Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues;
☐ History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma;
☐ Legal status including authorized representative, commitment, and representative payee status;
☐ Relevant criminal charges or convictions and probation or parole status;
☐ Daily living skills
☐ Housing arrangements
☐ Ability to access services including transportation needs
☐ As applicable, and in all residential services, fall risk, communication methods or needs, and mobility and adaptive equipment needs

660	**Individualized services plan (ISP)**			
	660.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.		
	660.B	The provider shall develop and implement an initial person-centered ISP for the first 60 days for developmental services or for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first.		
	660.C.	The provider shall implement a person-centered comprehensive ISP as soon as possible after admission based upon the nature and scope		

		of services but no later than 30 days after admission for providers of mental health and substance abuse services and 60 days after admission for providers of developmental services.		
	660.D.	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.		
	660.D.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:		
	660.D.1.a	The proposed services to be delivered;		
	660.D.1.b	Any alternative services that might be advantageous for the individual; and		
	660.D.1.c	Any accompanying risks or benefits of the proposed and alternative services.		
	660.D.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 any steps taken to identify if alternative services were available.		
	660.D.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:		
	660.D.3.a	The individual participated in the development of or revision to the ISP;		
	660.D.3.b	The proposed and alternative services and their respective risks and benefits were explained to the individual or the individual's authorized representative; and		
	660.D.3.c	The reasons the individual or the individual's authorized representative chose the option included in the ISP.		

☐ ISP Requirements Form - 665

☐ Relevant and attainable goals, measurable objectives, and specific strategies for addressing each need;
☐ Services and supports and frequency of services required to accomplish the goals including relevant psychological, mental health, substance abuse, behavioral, medical, rehabilitation, training, and nursing needs and supports
☐ The role of the individual and others in implementing the service plan;
☐ A communication plan for individuals with communication barriers, including language barriers;
☐ A behavioral support or treatment plan, if applicable
☐ A safety plan that addresses identified risks to the individual or to others, including a fall risk plan;
☐ A crisis or relapse plan, if applicable
☐ Target dates for accomplishment of goals and objectives;
☐ Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies;
☐ Recovery plans, if applicable;
☐ Services the individual elects to self direct; and
☐ ISP shall be signed and dated at a minimum by the person responsible for implementing the plan and the individual receiving services or the authorized representative in order to document agreement. 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 why he was unable to obtain it.

☐ Reassessments and ISP Quarterly Review Form - 675.B

☐ Update ISP at least annually
☐ Review ISP at least every three months or revised assessment based on change
☐ Client’s progress toward meeting plan objectives
☐ Family involvement

☐ Continuing needs ☐ Progress toward discharge ☐ Status of discharge planning ☐ Revisions, if any ☐ Documentation that Client, and/or LAR are participants in developing the plan				
☐ Sample Daily Progress Notes Form - 680 ☐ Date ☐ Time ☐ Format ☐ Staff signature				
690.	**Orientation**	Implement written policy orientation of individuals and LAR to services (specify timeframe) includes:		
	690.B.1.	The mission of the provider;		
	690.B.2.	Confidentiality practices for individuals receiving services;		
	690.B.3.	Human rights and how to report violations;		
	690.B.4.	Participation in treatment and discharge planning;		
	690.B.5.	Fire safety and emergency preparedness procedures;		
	690.B.6.	The grievance procedure		
	690.B.7.	Service guidelines; including criteria for admission to and discharge or transfer from services;		
	690.B.8.	Hours and days of operation; and		
	690.B.9.	Availability of after-hours service.		
	690.B.10.	Any charges or fees due from the individual		
	690.C.	Security restrictions orientation—Correctional facilities only		
	691690.D.	Document orientation has been provided to individuals and the legal guardian/authorized representative (space for signature).		
☐ Client Orientation Form - 690 (include space for signatures) ☐ The mission of the provider or service ☐ Service confidentiality practices for individuals receiving services ☐ Human rights policies and procedures and how to report violations ☐ Participation in service and discharge planning ☐ Fire safety and emergency preparedness procedures ☐ The grievance procedure ☐ Service guidelines including criteria for admission to and discharge or transfer from services; ☐ Hours and days of operation ☐ Availability of after-hours service; and ☐ Any charges or fees due from the individual				
691.A	**Transition of individuals among service**.	Written procedures that define for the transition of an individual among services of the provider. At a minimum, addresses:		
	691.A.1	Continuity of service during and following transition;		
	691.A.2	Participation of the individual or his authorized representative, as applicable, in the decision to move and in the planning for transfer;		
	691.A.3	Transfer of the access to individual's record & ISP to the destination location;		
	691.A.4	Transfer summary; and		
	691.A.5	The process and timeframe for transmitting or accessing, where applicable, discharge summaries to the destination service;		
☐ Transfer Form - 691.B ☐ Reason for the individual's transfer ☐ Documentation of involvement by the individual or his authorized representative, as applicable, in the decision to and planning for				

the transfer ☐ Reason for transfer ☐ Current psychiatric and medical condition of the individual ☐ Updated progress on meeting the goals and objectives of the ISP ☐ Emergency medical information; ☐ Dosages of all currently prescribed medications and over-the-counter medications used by the individual when prescribed by the provider or known by the case manager ☐ Transfer date ☐ Signature of employee or contractor responsible for preparing the transfer summary				
693.A	**Discharge**	Addresses process to discharge of individuals from the service and termination of services to include medical or clinical criteria for discharge		
☐ Discharge Form - 693 ☐Reason for admission and discharge ☐Individual's participation in discharge planning ☐Individual's level of functioning or functional limitations ☐Recommendations on procedures, or referrals, and the status, and arrangements for future services ☐Progress made achieving the goals and objectives identified in the individualized services plan ☐Discharge date ☐Discharge medications, if applicable ☐Date the discharge summary was actually written/documented ☐ Documentation that resident, placing agency & LAR are participants in developing the plan ☐Signature of person who prepared summary				
700.A	**Written policies and procedures for crisis or emergency interventions; required elements.**	Written policies and procedures 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		
	700.B.	The policies and procedures shall include:		
	700.B.1.	A definition of what constitutes a crisis or behavioral, medical, or psychiatric emergency;		
	700.B.2.	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		
	700.B.3.	Employee or contractor responsibilities; and		
	700.B.4.	Location of emergency medical information for each individual receiving services, including any advance psychiatric or medical directive or crisis response plan developed by the individual, which shall be readily accessible to employees or contractors on duty in an emergency or crisis.		
710.A	**Documenting crisis intervention and emergency services.**	The provider shall develop a policy for documenting the provision of crisis intervention and emergency services. Documentation shall include the following:		
☐710.A Documenting crisis intervention and emergency services form ☐ Date and time; ☐ Description of the nature of or circumstances surrounding the crisis or emergency; ☐ Name of individual; ☐ Description of precipitating factors;				

☐ Interventions or treatment provided; ☐ Names of employees or contractors responding to or consulted during the crisis or emergency; and ☐ Outcome.				
720.	**Health care policy. (required for all services)**	Written policy, appropriate to the scope and level of service that addresses provision of adequate medical care. This policy shall describe how:		
	720.A.1	Medical care needs will be assessed;		
	720.A.2	Individualized services plans address any medical care needs appropriate to the scope and level of service;		
	720.A.3	Identified medical care needs will be addressed;		
	720.A.4	Provider manages medical care needs or responds to abnormal findings;		
	720.A.5	Provider communicates medical assessments and diagnostic laboratory results to individuals and authorized representatives.		
	720.A.6	Provider keeps accessible to staff the names, addresses, phone numbers of medical and dental providers		
	720.A.7	Provider ensures a means for facilitating and arranging, as appropriate, transportation to medical and dental appointments and medical tests when services cannot be provided on site.		
	720.B	Identifies any populations at risk for falls and to develop a prevention/management program.		
☐ Falls Assessment Form - 720.B ☐ Have a history of falls ☐ Are experiencing agitation or delirium; ☐ Are on medications, which may cause drowsiness ☐ Have a history of Hypotension ☐ Impaired mobility, ☐ Impaired vision, ☐ History of low or unstable blood sugar, ☐ Need frequent toileting, ☐ Are intoxicated, or withdrawing from alcohol or other drugs, and ☐ Have an impaired mental status.				
	720.C	In residential or inpatient service; provider shall either provide or arrange for provision of appropriate medical care. In other services, defines which instances will provide or arrange for appropriate medical and dental care and which instances will be referred.		
	720.D	Develops, documents and implements infection control measures, including the use of universal precautions		
	720.E	Shall report outbreaks of infectious diseases to the Department of Health pursuant to §32.1-37 of the Code of Virginia		
740.	**Physical examination**	Physical examinations in consultation with a qualified practitioner. Residential services administer or obtain results of physical exams within 30 days of admission. Inpatient services administer physical exams within 24 hrs of admission.		
	740.B	Physical examination shall include, at a minimum:		
	740.B.1	General physical condition (history and physical);		
	740.B.2	Evaluation for communicable diseases;		
	740.B.3	Recommendations for further diagnostic tests and treatment, if appropriate;		
	740.B.4	Other examinations indicated, if appropriate; and		
	740.B.5	The date of examination and signature of a qualified practitioner.		

	740.C	C. Locations designated for physical examinations shall ensure individual privacy		
☐ Client Physical Examination Form - 740 ☐ General physical condition (history and physical) ☐ Evaluation for communicable diseases ☐ Recommendations for further diagnostic tests and treatment, if appropriate ☐ Other examinations indicated, if appropriate ☐ The date of examination and signature of a qualified practitioner				
☐ Emergency (ER) Medical Information Form - 750 ☐ The name, address, and telephone number of: the individual's physician ☐ The name, address, and telephone number of a relative, legally authorized representative, or other person to be notified ☐ Medical insurance company name and policy or Medicaid, Medicare , or CHAMPUS number, if any; ☐ Currently prescribed medications and over-the-counter medications used by the individual ☐ Medication and food allergies ☐ History of substance abuse ☐ Significant medical problems or conditions ☐ Significant ambulatory or sensory problems ☐ Significant communication problems ☐ Advance directive, if one exists.				
760.	**Medical equipment**	Maintenance and use of medical equipment, including personal medical equipment and devices		
770.	**Medication management**	Written policies addresses:		
	770.1	Safe administration, handling, storage, and disposal of medications		
	770.2	Use of medication orders;		
	770.3	Handling of packaged medications brought by individuals from home or other residences;		
	770.4	Employees or contractors authorized to administer medication and training required		
	770.5	Use of professional samples; and		
	770.6	Window within which medications can be given in relation to the ordered time of administration.		
	770.B	Meds administered only by persons authorized by state law.		
	770.C	Meds administered only to the individuals for whom the medications are prescribed and administered as prescribed.		
	770.D	Maintained a daily log of all medicines received and refused by each individual. This log shall identify the employee or contractor who administered the medication.		
	770.E	If the provider administers medications or supervises self-administration of medication in a service, a current medication order for all medications the individual receives shall be maintained on site.		
	770.F	Promptly disposes 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.		
800.A	**Behavior interventions & supports**	Describes the use of behavior **interventions & supports**		
	800.A.1	Be consistent with applicable laws		
	800.A.2	Emphasize positive approaches (specify)		
	800.A.3	List & define behavior **interventions & supports**, from least to most restrictive		
	800.A.4	Protect the safety & well-being of individuals		
	800.A.5	Specify methods for monitoring their use (include debriefing, who monitors, use of behavioral interventions). All injuries reported to		

		Human Rights,		
	800.A.6	Specify methods for documenting their use		
	800.B	Policies developed, implemented & monitored (ongoing process) by employees trained in behavior **interventions & supports**		
	800.C	Policies & procedures available to individuals, families, guardians & advocates		
	800.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.		
☐ Monitoring Behavior Interventions & Supports Form - 800.A (5) (ongoing for use for trends, issues and training needs)				
810.	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. A behavioral treatment plan shall be developed, implemented, and monitored by employees or contractors trained in behavioral treatment.		
☐ Seclusion and/or Restraint Documentation Form - 830 ☐ Physician's order (N/A for many community program) ☐ Date and time ☐ Employees or contractors involved ☐ Circumstances and reasons for use ☐ Other behavior management techniques attempted ☐ Duration ☐ Type of technique used ☐ Outcomes, including documentation of debriefing and reports to guardians, Human Rights, or others as required.				
870.	**Written records management policy**	Describes confidentiality, accessibility, security, and retention of records pertaining to individuals, including:		
	870.A.1	Access, duplication and dissemination of information only to persons legally authorized according to federal and state laws;		
	870.A.2	Storage, processing and handling of active and closed records;		
	870.A.3	Storage, processing and handling of electronic records;		
	870.A.4	Security measures to protect records from loss, unauthorized alteration, inadvertent or unauthorized access, disclosure of information and transportation of records between service sites; physical and data security controls shall exist for electronic records;		
	870.A.5	Strategies for service continuity and record recovery from interruptions that result from disasters or emergencies including contingency plans, electronic or manual back-up systems, and data retrieval systems;		
	870.A.6	Designation of person responsible for records management; and		
	870.A.7	Disposition of records in event the service ceases operation. If the disposition of records would involve a transfer to another provider, the provider shall have a written agreement with that provider.		
	870.B	The records management policy shall be consistent with state and federal laws and regulations including:		
	870.B.1	Section 32.1-127.1:03 of the Code of Virginia;		
	870.B.2	42 USC § 290dd;		
	870.B.3	42 CFR Part 2; and		

	870.B.4	The Health Insurance Portability and Accountability Act (Public Law 104-191) and implementing regulations (45 CFR Parts 160, 162, and 164).		
	12 VAC 35-115-80.C (2)	Human Rights Regulations regarding when records may be released without consent.		
880.	**Documentation policy**			
	880.A	Defines all records address an individual's care and treatment and what each record contains.		
	880.B.	Defines a system of documentation that supports appropriate service planning, coordination, and accountability. At a minimum this policy shall outline:		
	880.B.1	The location of the individual's record;		
	880.B.2	Methods of access by employees or contractors to the individual's record; and		
	880.B.3	Methods of updating the individual's record by employees or contractors including frequency and format.		
	880.C.	Entries in the individual's record shall be current, dated, and authenticated by the person making the entry. Errors shall be corrected by striking through and initialing. A policy to identify corrections of record, if electronic		

☐ Client Face Sheet Form - 890.B
☐ Identification number unique for the individual
☐ Name of individual
☐ Current residence, if known
☐ Social security number
☐ Gender
☐ Marital status
☐ Date of birth
☐ Name of authorized representative, if applicable
☐ Name, address, and telephone number for emergency contact
☐ Adjudicated legal incompetency or legal incapacity if applicable; and
☐ Date of admission to service

☐ Individual's Service Record Form - 890.C
☐ Screening documentation;
☐ Assessments;
☐ Medical evaluation, as applicable to the service;
☐ Individualized services plans and reviews;
☐ Progress notes; and
☐ A discharge summary, if applicable

☐ Therapies- Individual/Group Form - 580.C.(2)
☐ Date
☐ Time
☐ Format
☐ Staff signature

☐ Release of Information Form – 12VAC35-115-80 (Human Rights)
☐ Specify what is to be released
☐ Specifically whom the information is being released to (specific person or position)
☐ Dated
☐ Notification it can be revoked
☐ Expiration date
☐ Signatures of resident & LAR

920.	**Review process for records**	Review process to evaluate both current and closed records for completeness, accuracy, and timeliness of entries		

☐ Record Review Form - 920 ☐ Addresses personnel records ☐ Addresses resident records ☐ MAR's ☐ Staff completing the review ☐ Follow-up needed				
1255	**Case Management Choice**	Written policy describing how individuals are assigned case managers and how they can request a change of their assigned case manager.		

DBHDS - Office of Licensing

Additional Policy & Procedure Requirements for ASAM Services

PROVIDER:	LICENSE #:
SERVICE: Medically Managed Intensive Inpatient – ASAM Level 4.0	DATE OF REVIEW:

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

Status	Regulation/Section		Standard
	§1430	**MM Intensive Inpatient Staff Criteria**	A medically managed intensive inpatient program shall meet the following staff requirements: p. 1260/19
		1430.1	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;
		1430.2	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;
		1430.3	Have staff who are knowledgeable about the biopsychosocial dimensions of addiction as well as biomedical, emotional, behavioral, and cognitive disorders;
		1430.4	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
		1430.5	All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.
	§1440	**MM Intensive Inpatient Program Criteria**	A medically managed intensive inpatient program shall meet the following programmatic requirements. The program shall:
		1440.1	Deliver services in a 24-hour medically managed, acute care setting and shall be available to all individuals within that setting;
		1440.2	Provide cognitive, behavioral, motivational, pharmacologic, and other therapies provided on an individual or group basis, depending on the individual's needs;
		1440.3	Provide, for the individual who has a severe biomedical disorder, physical health interventions to supplement addiction treatment;
		1440.4	Provide, for the individual who has stable psychiatric symptoms, individualized treatment activities designed to monitor the individual's mental health;
		1440.5	Provide planned clinical interventions that are designed to enhance the individual's understanding and acceptance of his addiction illness;
		1440.6	Provide family and caregiver treatment services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;

		1440.7	Provide health education services;
		1440.8	Make medication assisted treatment (MAT) available for all individuals admitted to the service. MAT may be provided by facility staff or coordinated through alternative resources; and
		1440.9	Comply with 12VAC35-105-1055 through 12VAC35-105-1130.
		12VAC35-105-1055.	In the service description the provider shall describe the level of services and the medical management provided.
		12VAC35-105-1060.	The provider shall establish cooperative agreements with other community agencies to accept referrals for treatment, including provisions for physician coverage if not provided on-site, and emergency medical care. The agreements shall clearly outline the responsibility of each party.
		12VAC35-105-1070.	The provider shall provide for designated areas for employees and contractors with unobstructed observation of individuals.
		12VAC35-105-1080.	
		1080.A	The provider shall document staff training in the areas of: 1. Management of withdrawal; and 2. First responder training.
		1080.B	Untrained employees or contractors shall not be solely responsible for the care of individuals.
		12VAC35-105-1090.	In detoxification service locations, at least two employees or contractors shall be on duty at all times. If the location is within or contiguous to another service location, at least one employee or contractor shall be on duty at the location with trained backup employees or contractors immediately available. In other managed withdrawal settings the number of staff on duty shall be appropriate for the services offered and individuals served.
		12VAC35-105-1100.	Employees or contractors on each shift shall document services provided and significant events in the individual's record.
	§1450	**MM Intensive Inpatient Admission Criteria**	Before a medically managed intensive inpatient program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:
		1450.1	Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate to high severity as defined by the DSM; and
		1450.2	Meet the admission criteria of Level 4.0 of ASAM, including the specific criteria for adult and adolescent populations
	§1460	**MM Intensive Inpatient Discharge Criteria**	Before a medically managed intensive inpatient program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:
		1460.1	Achieved the goals of the treatment services and no longer require ASAM 4.0 level of care;
		1460.2	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
		1460.3	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.
	§1470	**MM Intensive Inpatient Co-Occurring Enhanced Programs**	
		1470.A	Medically managed intensive inpatient co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals who assess and treat the

			individual's co-occurring mental disorders. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.
		1470.B	Medically managed intensive inpatient co-occurring enhanced programs shall offer individualized treatment activities designed to stabilize the individual's active psychiatric symptoms, including medication evaluation and management.

PROVIDER:	LICENSE #:
SERVICE: Medically Monitored Intensive Inpatient – ASAM Level 3.7	DATE OF REVIEW:

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

Status	Regulation/Section		Standard
	§1480	**MM Intensive Inpatient Staff Criteria**	A medically monitored intensive inpatient treatment program shall meet the following staff requirements. The program shall:
		1480.1	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;
		1480.2	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;
		1480.3	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;
		1480.4	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;
		1480.5	Have staff able to provide a planned regimen of 24-hour professionally directed evaluation, care, and treatment services;
		1480.6	Make MAT available for all individuals. MAT may be provided by facility staff or coordinated through alternative resources; and
		1480.7	Ensure 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.
	§1490	**MM Intensive Inpatient Program Criteria**	A medically monitored intensive inpatient treatment program shall meet the following programmatic requirements. The program shall:
		1490.1	Be made available to all individuals within the inpatient setting;
		1490.2	Provide a combination of individual and group therapy as deemed appropriate by a licensed mental health professional and included in an assessment and treatment plan. Such therapy shall be adapted to the individual's level of comprehension;
		1490.3	Make available medical and nursing services onsite to provide ongoing assessment and care of addiction needs;
		1490.4	Provide direct affiliations with other easily accessible levels of care or close coordination

			through referral to more or less intensive levels of care and other services;
		1490.5	Provide family and caregiver treatment services as deemed appropriate by a licensed mental health professional and included in an assessment and treatment plan;
		1490.6	Provide educational and informational programming adapted to individual needs. The educational and informational programming shall include materials designed to enhance the individual's understanding of addiction and may include peer recovery support services as appropriate;
		1490.7	Utilize random drug screening to monitor drug use and reinforce treatment gains;
		1490.8	Regularly monitor the individual's adherence in taking any prescribed medications; and
		1490.9	Comply with 12VAC35-105-1055 through 12VAC35-105-1130:
		12VAC35-105-1055.	In the service description the provider shall describe the level of services and the medical management provided.
		12VAC35-105-1060.	The provider shall establish cooperative agreements with other community agencies to accept referrals for treatment, including provisions for physician coverage if not provided on-site, and emergency medical care. The agreements shall clearly outline the responsibility of each party.
		12VAC35-105-1070.	The provider shall provide for designated areas for employees and contractors with unobstructed observation of individuals.
		12VAC35-105-1080.	
		1080.A	The provider shall document staff training in the areas of: 1. Management of withdrawal; and 2. First responder training.
		1080.B	Untrained employees or contractors shall not be solely responsible for the care of individuals.
		12VAC35-105-1090.	In detoxification service locations, at least two employees or contractors shall be on duty at all times. If the location is within or contiguous to another service location, at least one employee or contractor shall be on duty at the location with trained backup employees or contractors immediately available In other managed withdrawal settings the number of staff on duty shall be appropriate for the services offered and individuals served.
		12VAC35-105-1100.	Employees or contractors on each shift shall document services provided and significant events in the individual's record.
	§1500	**MM Intensive Inpatient Admission Criteria**	Before a medically monitored intensive inpatient program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:
		1500.1	Meet diagnostic criteria for a substance use disorder of the DSM or addictive disorder of moderate to high severity; and
		1500.2	Meet the admission criteria of Level 3.7 of ASAM, including the specific criteria for adult and adolescent populations.
	§1510	**MM Intensive Inpatient Discharge Criteria**	
		1510.A	Before a medically monitored intensive inpatient program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:
		1510.A.1	Achieved the goals of the treatment services and no longer require ASAM 3.7 level of care;
		1510.A.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
		1510.A.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.
		1510.B	Discharge planning shall occur for individuals and include realistic plans for the continuity of MAT services as indicated.
	§1520	**MM Intensive Inpatient Co-Occurring Enhanced Program**	
		1520.A	Medically monitored intensive inpatient co-occurring enhanced programs shall offer psychiatric services, medication evaluation, and laboratory services as indicated by the needs of individuals admitted to the service. A psychiatrist shall assess the individual by telephone within four hours of admission and in person with 24 hours following admission. An LMHP shall conduct a behavioral health-focused assessment at the time of admission. A registered nurse shall monitor the individual's progress and administer or monitor the individual's self-administration of psychotropic medications.
		1520.B	Medically monitored intensive inpatient co-occurring enhanced programs shall be staffed by addiction psychiatrists and appropriately credentialed behavioral health professionals who are able to assess and treat co-occurring psychiatric disorders and who have specialized training in behavior management techniques and evidence based practices. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service
		1520.C	Medically monitored intensive inpatient co-occurring enhanced programs shall offer planned clinical activities designed to promote stabilization of the individual's behavioral health needs and psychiatric symptoms and to promote such stabilization, including

PROVIDER:	LICENSE #:
SERVICE: Clinically Managed High-Intensity Residential – ASAM Level 3.5	DATE OF REVIEW:

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

Status	Regulation/Section		Standard
	§1530	**CM High-Intensity Residential Staff Criteria**	A clinically managed high-intensity residential care program shall meet the following staff requirements. The program shall:
		1530.1	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;
		1530.2	Offer onsite 24-hour-a-day clinical staffing by credentialed addiction treatment professionals and other allied health professionals, such as peer recovery specialists, who work in an interdisciplinary team;
		1530.3	Have clinical staff knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Staff shall be able to identify the signs and symptoms of acute psychiatric conditions. Staff shall have specialized training in behavior management techniques; and
		1530.4	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.
	§1540	**CM High-Intensity Residential Program Criteria**	A clinically managed high-intensity residential care program shall meet the following programmatic requirements. The program shall:
		1540.1	Provide daily clinical services, including a range of cognitive, behavioral, and other therapies in individual or group therapy; programming; and psychoeducation as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
		1540.2	Provide counseling and clinical interventions to teach an individual the skills needed for daily productive activity, prosocial behavior, and reintegration into family and community;
		1540.3	Provide motivational enhancement and engagement strategies appropriate to an individual's stage of readiness to change and level of comprehension;
		1540.4	Have direct affiliations with other easily accessible levels of care or provide coordination through referral to more or less intensive levels of care and other services;
		1540.5	Provide family and caregiver treatment services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
		1540.6	Provide educational, vocational, and informational programming adaptive to individual needs;

		1540.7	Utilize random drug screening to monitor progress and reinforce treatment gains as appropriate to an individual treatment plan;
		1540.8	Ensure and document that the length of an individual's stay shall be determined by the individual's condition and functioning;
		1540.9	Make a substance use treatment program available for all individuals; and
		1540.10	Make MAT available for all individuals. Medication assisted treatment may be provided by facility staff, or coordinated through alternative resources.
	§1550	**CM High-Intensity Residential Admissions Criteria**	
		1550.A	The individuals served by clinically managed high-intensity residential care are individuals who are not sufficiently stable to benefit from outpatient treatment regardless of intensity of service.
		1550.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:
		1550.B.1	Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate to high severity as defined by the DSM; and
		1550.B.2	Meet the admission criteria of Level 3.5 of ASAM.
	§1560	**CM High-Intensity Residential 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:
		1560.1	Achieved the goals of the treatment services and no longer require ASAM 3.5 level of care;
		1560.2	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
		1560.3	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.
	§1570	**CM High-Intensity Residential Co-Occurring Enhanced Programs**	
		1570.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.
		1570.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.
		1570.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.

PROVIDER:	LICENSE #:
SERVICE: Clinically Managed Population Specific High Intensity Residential – ASAM Level 3.3	DATE OF REVIEW:

Status	Regulation/Section		Standard
	§1580	**CM PS High-Intensity Residential Staff Criteria**	A high-intensity residential services program shall meet the following staff requirements. The program shall:
		1580.1	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;
		1580.2	Have allied health professional staff onsite 24 hours a day. At least one clinician with competence in the treatment of substance use disorder shall be available onsite or by telephone 24 hours a day;
		1580.3	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
		1580.4	Ensure 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.
	§1590	**CM PS High-Intensity Residential Program Criteria**	A high-intensity residential services program shall meet the following programmatic requirements. The program shall:
		1590.1	Provide daily clinical services that shall include a range of cognitive, behavioral and other therapies administered on an individual and group basis, medication education and management, educational groups, and occupational or recreation activities as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
		1590.2	Provide daily professional addiction and mental health treatment services that may include relapse prevention, exploring interpersonal choices, peer recovery support, and development of a social network;
		1590.3	Provide services to improve the individual's ability to structure and organize the tasks of daily living and recovery. Such services shall accommodate the cognitive limitations within this population;
		1590.4	Make available medical, psychiatric, psychological, and laboratory and toxicology services through consultation or referral as indicated by the individual's condition;
		1590.5	Provide case management, including ongoing transition and continuing care planning;
		1590.6	Provide motivational interventions appropriate to the individual's stage of readiness to change and designed to address the individual's functional limitations;
		1590.7	Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;
		1590.8	Provide family and caregiver treatment services as deemed appropriate by an assessment and treatment plan;

		1590.9	Utilize random drug screening to monitor progress and reinforce treatment gains;
		1590.10	Regularly monitor the individual's adherence to taking prescribed medications;
		1590.11	Make the substance use treatment program available to all individuals served by the residential care service; and
		1590.12	Make MAT available for all individuals. Medication assisted treatment may be provided by facility staff or coordinated through alternative resources.
	§1600	**CM PS High-Intensity Residential Admission Criteria**	Before a clinically managed, population-specific, high-intensity residential service program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:
		1600.1	Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate to high severity as defined by the DSM; and
		1600.2	Meet the admission criteria of Level 3.3 of ASAM.
	§1610	**CM PS High-Intensity Residential Discharge Criteria**	
		1610.A	Before a clinically managed, population-specific, high-intensity residential service program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:
		1610.A.1	Achieved the goals of the treatment services and no longer require ASAM 3.3 level of care;
		1610.A.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
		1610.A.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.
		1610.B	Discharge planning shall occur for individuals and include realistic plans for the continuity of MAT services as indicated.
	§1620	**CM PS High-Intensity Residential Co-Occurring Enhanced Programs**	
		1620.A	Clinically managed population-specific high-intensity residential services co-occurring enhanced programs shall offer psychiatric services, medication evaluation, and laboratory services. Such services shall be available by telephone within eight hours and onsite or closely coordinated offsite within 24 hours, as appropriate to the severity and urgency of the individual's mental condition.
		1620.B	Clinically managed population-specific high-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed psychiatrists and licensed mental health professionals who are able to assess and treat co-occurring mental disorders and who have specialized training in behavior management techniques. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.
		1620.C	Clinically managed population-specific high-intensity residential services co-occurring enhanced programs shall offer planned clinical activities designed to stabilize the individual's mental health problems and psychiatric symptoms and to maintain such stabilization, including medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental health disorder.

PROVIDER:	LICENSE #:
SERVICE: Clinically Managed Low-Intensity Residential – ASAM Level 3.1	DATE OF REVIEW:

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

Status	Regulation/Section		Standard	
	1630	**CM Low-I Residential Staff Criteria**		A clinically managed low-intensity residential services program shall meet the following staff requirements. The program shall:
		1630.1	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, and seven days a week. The program shall also provide allied health professional staff onsite 24 hours a day;	
		1630.2	Have clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use disorder and their treatment and are able to identify the signs and symptoms of acute psychiatric conditions;	
		1630.3	Have a team comprised of appropriately trained and credentialed medical, addiction, and mental health professionals; and	
		1630.4	Ensure 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.	
	1640	**CM Low-I Residential Program Criteria**		A clinically managed low-intensity residential services program shall meet the following programmatic requirements. The program shall:
		1640.1	Offer a minimum of five hours a week of professionally directed treatment in addition to other treatment services offered to individuals, such as partial hospitalization or intensive outpatient treatment the focus of which is stabilizing the individual's substance use disorder. Services shall be designed to improve the individual's ability to structure and organize the tasks of daily living and recovery;	
		1640.2	Ensure collaboration with care providers to develop an individual treatment plan for each individual with time-specific goals and objectives;	
		1640.3	Provide counseling and clinical monitoring to support successful initial involvement in regular, productive daily activity;	
		1640.4	Provide case management services;	
		1640.5	Provide motivational interventions appropriate to the individual's stage of readiness to change and level of comprehension;	
		1640.6	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;	
		1640.7	Include the ability to arrange for needed procedures as appropriate to the severity and urgency of the individual's condition;	
		1640.8	Provide family and caregiver treatment and peer recovery support services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;	

		1640.9	Provide addiction pharmacotherapy and the ability to arrange for pharmacotherapy for psychiatric medications;
		1640.10	Utilize random drug screening to monitor progress and reinforce treatment gains;
		1640.11	Make a substance abuse treatment program available to all individuals; and
		1640.12	Make MAT available for all individuals. Medication assisted treatment may be provided by facility staff or coordinated through alternative resources.
	1650	**CM Low-I Residential Admission Criteria**	Before a clinically managed low-intensity residential service program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:
		16550.1	Meet diagnostic criteria for a substance use disorder or addictive disorder of moderate to high severity as defined by the DSM; and
		1650.2	Meet the admission criteria of Level 3.1 of ASAM
	1660	**CM Low-I Residential Discharge Criteria**	Before a clinically managed low-intensity residential service program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:
		1660.1	Achieved the goals of the treatment services and no longer require ASAM 3.1 level of care;
		1660.2	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
		1660.3	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.
	1670	**CM Low-I Residential Co-Occurring Enhanced Programs**	
		1670.A	Clinically managed low-intensity residential services co-occurring enhanced programs shall offer psychiatric services, including medication evaluation and laboratory services. Such services shall be provided onsite or closely coordinated offsite, as appropriate to the severity and urgency of the individual's mental condition.
		1670.B	Clinically managed low-intensity residential services co-occurring enhanced programs shall be staffed by appropriately credentialed licensed mental health professionals who are able to assess and treat co-occurring disorders with the capacity to involve addiction-trained psychiatrists. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.
		1670.C	Clinically managed low-intensity residential services co-occurring enhanced programs shall offer planned clinical activities that are designed to stabilize the individual's mental health problems and psychiatric symptoms and to maintain such stabilization, including medication education and management and motivational and engagement strategies. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental disorder.

PROVIDER:	LICENSE #:
SERVICE: SA Partial Hospitalization – ASAM Level 2.5	DATE OF REVIEW:

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

Status	Regulation/Section		Standard
	§1680	**SA PH Staff Criteria**	A substance abuse partial hospitalization program shall meet the following staff requirements. The program shall:
		1680.1	Have an interdisciplinary team of addiction treatment professionals, including counselors, psychologists, social workers, and addiction-credentialed physicians. Physicians treating individuals in this level shall have specialty training or experience in addiction medicine;
		1680.2	Have staff able to obtain and interpret information regarding the individual's biopsychosocial needs;
		1680.3	Have staff trained to understand the signs and symptoms of mental disorders and to understand and be able to explain the uses of psychotropic medications and their interactions with substance-related disorders; and
		1680.4	Ensure 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.
	§1690	**SA PH Program Criteria**	A substance abuse partial hospitalization program shall meet the following programmatic requirements. The program shall:
		1690.1	Offer no fewer than 20 hours of programming per week in a structured program. Services may include individual and group counseling, medication management, family therapy, peer recovery support services, educational groups, or occupational and recreational therapy;
		1690.2	Provide a combination of individual and group therapy as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
		1690.3	Provide medical and nursing services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
		1690.4	Provide motivational enhancement and engagement strategies appropriate to an individual's stage of readiness to change and level of comprehension;
		1690.5	Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;
		1690.6	Provide family and caregiver treatment services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
		1690.7	Provide educational and informational programming adaptable to individual needs;
		1690.8	Ensure and document that the length of service shall be determined by the individual's condition and functioning;
		1690.9	Make emergency services available by telephone 24 hours a day, seven days a week when the program is not in session; and
		1690.10	Make MAT available for all individuals. MAT may be provided by facility staff or

			coordinated through alternative resources.
	§1700	**SA PH Admission Criteria**	Before a substance abuse partial hospitalization program may admit an individual, the individual shall meet the criteria for admission as defined by the provider's policies. The provider's policy regarding admission shall at a minimum require the individual to:
		1700.1	Meet diagnostic criteria for a substance use disorder or addictive disorder as defined by the DSM; and
		1700.2	Meet the admission criteria of Level 2.5 of ASAM, including the specific criteria for adult and adolescent populations.
	§1710	**SA PH Discharge Criteria**	Before a substance abuse partial hospitalization program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:
		1710.1	Achieved the goals of the treatment services and no longer require ASAM 2.5 level of care;
		1710.2	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
		1710.3	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.
	§1720	**SA PH Co-Occurring Criteria**	
		1720.A	Substance abuse partial hospitalization co-occurring enhanced programs shall offer psychiatric services appropriate to the individual's mental health condition. Such services shall be available by telephone and onsite or closely coordinated offsite, within a shorter time than in a co-occurring capable program.
		1720.B	Substance abuse partial hospitalization co-occurring enhanced programs shall be staffed by appropriately credentialed mental health professionals who assess and treat co-occurring mental disorders. Intensive case management shall be delivered by cross-trained, interdisciplinary staff through mobile outreach and shall involve engagement-oriented addiction treatment and psychiatric programming. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.
		1720.C	Substance abuse partial hospitalization co-occurring enhanced programs shall offer intensive case management, assertive community treatment, medication management, and psychotherapy.

PROVIDER:	LICENSE #:
SERVICE: Substance abuse intensive outpatient – ASAM Level 2.1	DATE OF REVIEW:

"Substance abuse intensive outpatient service" means structured treatment provided to individuals who require more intensive services than is normally provided in an outpatient service but do not require inpatient services. Treatment consists primarily of counseling and education about addiction-related and mental health challenges delivered a minimum of 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.

Status	Regulation/Section		Standard
	§1730	**SA IOP Staff Criteria**	A substance abuse intensive outpatient services program shall meet the following staff requirements. The program shall:
		1730.1	Be staffed by interdisciplinary team of appropriately credentialed addiction treatment professionals, including counselors, psychologists, social workers, and addiction-credentialed physicians. Physicians shall have specialty training or experience in addiction medicine or addiction psychiatry;
		1730.2	Have program staff that are able to obtain and interpret information regarding the individual's biopsychosocial needs;
		1730.3	Have program staff trained to understand the signs and symptoms of mental disorders and to understand and be able to explain the uses of psychotropic medications and their interactions with substance use and other addictive disorders; and
		1730.4	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.
	§1740	**SA IOP Program Criteria**	A substance abuse intensive outpatient program shall meet the following programmatic requirements. The program shall:
		1740.1	Offer a minimum of three service hours per service day to achieve no fewer than nine hours and no more than 19 hours of programming per week in a structured environment;
		1740.2	Ensure psychiatric and other medical consultation shall be available within 24 hours by telephone and within 72 hours in person;
		1740.3	Offer consultation in case of emergency related to an individual's substance use disorder by telephone 24 hours a day, seven days a week when the treatment program is not in session;
		1740.4	Provide a combination of individual and group therapy as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
		1740.5	Have direct affiliations with other easily accessible levels of care or coordinate through referral to more or less intensive levels of care and other services;
		1740.6	Provide family and caregiver treatment and peer recovery support services as deemed appropriate by a licensed professional and included in an assessment and treatment plan;
		1740.7	Provide education and informational programming adaptable to individual needs and developmental status;
		1740.8	Ensure and document that the length of service shall be determined by the individual's condition and functioning; and

		1740.9	Make MAT available for all individuals. MAT may be provided by facility staff or coordinated through alternative resources.
	§1750	**SA IOP Admissions Criteria**	The provider's policy regarding admission shall at a minimum require the individual to:
		1750.1	Meet diagnostic criteria for a substance use disorder or addictive disorder as defined by the DSM; and
		1750.2	Meet the admission criteria of Level 2.1 of ASAM, including the specific criteria for adult and adolescent populations
	§1760	**SA IOP Discharge Criteria**	Before a substance abuse intensive outpatient service program may discharge or transfer an individual, the individual shall meet the criteria for discharge or transfer as defined by the provider's policies, which shall include provisions for the discharge or transfer of individuals who have:
		1760.1	Achieved the goals of the treatment services and no longer require ASAM 2.1 level of care;
		1760.2	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
		1760.3	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.
	§1770	**SA IOP co-occurring enhanced programs**	
		1770.A	Substance abuse intensive outpatient services co-occurring enhanced programs shall offer psychiatric services appropriate to the individual's mental health condition. Such services shall be available by telephone and onsite or closely coordinated offsite, within a shorter time than in a co-occurring capable program.
		1770.B	Substance abuse intensive outpatient services co-occurring enhanced programs shall be staffed by appropriately credential mental health professionals who assess and treat co-occurring mental disorders. Capacity to consult with an addiction psychiatrist shall be available. All clinical staff shall be qualified by training and experience and appropriately licensed, certified, or registered by the appropriate health regulatory board to serve individuals admitted to the service.
		1770.C	Substance abuse intensive outpatient services co-occurring enhanced programs shall offer intensive case management, assertive community treatment, medication management, and psychotherapy.

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PROVIDER:	LICENSE #:
SERVICE: Substance Abuse Outpatient – ASAM Level 1.0	DATE OF REVIEW:

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

Status	Regulation/Section		Standard
	§1780	**SA OP Staff Criteria**	Substance abuse outpatient service programs shall meet the following staff requirements. The program shall:
		1780.1	Have appropriately credentialed or licensed treatment professionals who assess and treat substance-related mental and addictive disorders;
		1780.2	Have program staff who are capable of monitoring stabilized mental health problems and recognizing any instability of individuals with co-occurring mental health conditions;
		1780.3	Provide medication management services by a licensed independent practitioner with prescribing authority; and
		1780.4	Ensure 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.
	§1790	**SA OP Program Criteria**	Substance abuse outpatient service programs shall meet the following programmatic requirements. The program shall:
		1790.1	Offer no more than nine hours of programming a week;
		1790.2	Ensure emergency services shall be available by telephone 24 hours a day, seven days a week;
		1790.3	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;
		1790.4	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;
		1790.5	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;
		1790.6	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
		1790.7	Ensure through documentation that the duration of treatment varies with the severity of the individual's illness and response to treatment.
	§1800	**SA OP 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:
		1800.1	Meet diagnostic criteria for a substance use disorder or addictive disorder as defined

			by the DSM; and
		1800.2	Meet the admission criteria of Level 1.0 of ASAM, including the specific criteria for adult and adolescent populations.
	§1810	**SA OP 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:
		1810.1	Achieved the goals of the treatment services and no longer require ASAM 1.0 level of care;
		1810.2	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
		1810.3	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.
	§1820	**SA OP Co-Occurring Enhanced Program**	
		1820.A	Substance abuse outpatient services co-occurring enhanced programs shall offer ongoing intensive case management for highly crisis-prone individuals with co-occurring disorders.
		1820.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.
		1820.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.

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On-Site Review Preparation Checklist

*An on-site inspection **will not** be conducted, and a conditional license will not be issued until the applicant submits the completed "On-Site Preparation Checklist" to the assigned Licensing Specialist. In addition, the Licensing Specialist may need to request additional documentation from the applicant prior to the on-site inspection in order to assess the applicant's compliance with the Licensing Regulations. Please also note that at the time of the on-site inspection, the applicant should be proficient in and able to answer questions related to their service description, policies, and procedures.*

Provider Name: Click or tap here to enter text.

Organization Number: Click or tap here to enter text.

Item #	Requirement	Regulation	Date Completed	Applicant Initials
1	*Staffing Schedule: including staff names, titles/credentials, all required training, and enough oriented staff to begin service operation (including relief staff)	12VAC35-105-40(B)(1) & 590		
2	*Documentation reflecting applicable work experience and education for staff	12VAC35-105-40(B)(2)		
3	Staff training completed in CPR, First Aid, Behavior Intervention, Serious Incident Reporting, Emergency Preparedness and Infection Control, and Medication Management, if applicable	12VAC35-105-450 & 460		
4	Criminal background checks and Central Registry (VDSS) searches **must be initiated** for all staff that will begin work. **a.** DBHDS BIU: **Malinda Roberts** at Malinda.Roberts@dbhds.virginia.gov or **804-786-6384** b. VDSS Central Registry: **804-726-7549** or crs_operations@dss.virginia.gov	12VAC35-105-400		
5	Human Rights Compliance Verification Form submitted to OHRpolicy@dbhds.virginia.gov; **Proof of approval by OHR**	12 VAC 35-105-150(4)		
6	*Proof of required indemnity coverage, as applicable	12VAC35-105-220		
7	*Updated and current proof of funds/line of credit to cover at least 90 days of operating expenses	12VAC35-105-40(A)(2)(a)		
8	Personnel: records must be complete and include evidence of completed applications for employment, evidence of required training and orientation, reference checks, and evidence of submitted background investigations	12VAC35-105-430		
9	A sample record for an individual receiving services	12VAC35-105-890		
10	*Certificate of Occupancy	12VAC35-105-260		
11	Regulations regarding the physical plant are in compliance	12VAC35-105-260 through 380		
12	A copy of the provider's **Final Policy Manual** (including all policies, procedures, and forms) as approved by the policy review specialist. The licensing specialist will give the final approval of the			

	policy manual prior to licensure.			

*Any documents marked by an asterisk must be submitted to the Licensing Specialist prior to the on-site inspection. Compliance with all other requirements will be confirmed at the time of the on-site inspection.