7.12.2022 DBHDS Initial Draft NEW Case Management Service Chapter ('overhaul' of the Licensing Regulations)

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Case Management Service Chapter- 12VAC35-110

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12VAC35-110-10. Definitions

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

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

1. Rape, sexual assault, or other criminal sexual behavior;

2. Assault or battery;

3. Use of language that demeans, threatens, intimidates, or humiliates the individual;

4. Misuse or misappropriation of the individual's assets, goods, or property;

5. Use of excessive force when placing an individual in physical or mechanical restraint;

6. Use of physical or mechanical restraints on an individual that is not in compliance with federal and state laws, regulations, and policies, professional accepted standards of practice, or his individualized services plan; or

7. Use of more restrictive or intensive services or denial of services to punish an individual or that is not consistent with his individualized services plan.

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

"Authorized representative" means a person permitted by law or 12VAC35-115 to authorize the disclosure of information or consent to treatment and services or participation in human research. "Care," "treatment," or "support" means the individually planned therapeutic interventions that conform to current acceptable professional practice and that are intended to improve or maintain functioning of an individual receiving services delivered by a provider.

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

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

"Comprehensive assessment" means a comprehensive and written assessment that updates and finalizes the initial assessment. The comprehensive assessment shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context and shall be completed in a time

period appropriate to the nature and scope of the service provided. The comprehensive assessment includes all relevant social, psychological, medical, and level of care information as the basis for the development of the person-centered comprehensive ISP. The comprehensive assessment may be completed at the time of initial assessment if it includes all elements of the comprehensive assessment. In the event a comprehensive assessment is completed at the time of an initial assessment the provider is not required to update the assessment.

"Contracted employee" or "contractor" means a person that enters into an agreement with a provider to provide specialized services for a specified period of time.

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

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

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

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

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

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

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

"Family" means an individual's biological family or that family in which an individual is raised. For the purpose of this chapter, it shall also mean family of choice or the group of people in an individual's life that satisfies the typical role of family as a support system.

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

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"Individualized services plan" or "ISP" means a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An ISP is person-centered, empowers the individual, and is designed to meet the needs and preferences of the individual. The ISP is developed through a partnership between the individual and the provider and includes an individual's treatment plan, habilitation plan, person-centered plan, or plan of care, which are all considered individualized service plans. For the purpose of this chapter and for individuals with a primary diagnosis of a developmental disability, this term shall also mean an individualized supports plan, or the plan for supports, or "Part 5," that includes the supports activities and support instructions that are tailored specifically to the preferences of the individual and that support the accomplishment of the individual's outcomes.

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

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

"Legal guardian" means a person appointed by the court to make decisions regarding the personal affairs of an incapacitated person, including a person appointed under Chapter 20 (§ 64.2-2000 et seq.).

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

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

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

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

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

"Planning team" means the team that is consulted to plan the individual's plan for supports. The planning team shall at a minimum consist of the individual receiving services and the case manager, and any legally required authorized representative including legal guardians. The planning team may include the individual's family or family of choice, or other identified persons, as desired by the individual.

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

a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to §§ 54.1-2901, 54.1-3001, 54.1-3501, 54.1-3601, and 54.1-3701 of the Code of Virginia.

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

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

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

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

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

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

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

12VAC35-110-20. Services

Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. The case management service shall require a case management license.

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12VAC35-110-30. Service Description

Case management services shall be designed to assist individuals, their family members, family of choice, and other identified persons, as desired by the individual, in accessing needed medical, psychological, psychiatric, social, educational, vocational, residential, and other support services that are responsive to the individual's needs. Case management services provide support essential for the individual to live in the community and in developing the individual's desired lifestyle. Case management services include identifying and reaching out to potential users of the service; assessing needs and planning services; linking the individual to services and supports; assisting the individual directly to locate, develop, or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; discharge planning; and advocating for individuals in response to their changing needs. "Case management service" does not include assistance in which the only function is maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs. The terms "support coordination" and "care coordination" are used in certain communities to identify providers of targeted case management services.

12VAC35-110-40. Service requirements.

Providers shall document that the services below are performed consistent with the individual's assessment and ISP.

1. Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;

2. Making collateral contacts with family members, family of choice, and other persons as desired by the individual with properly authorized releases to promote implementation of the individual's ISP;

3. Assessing needs and planning services to include developing an ISP;

4. Linking the individual to those community supports that are most likely to promote the personal habilitative or rehabilitative and life goals of the individual as identified in the ISP;

5. Assisting the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;

6. Ensuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems;

7. Monitoring service delivery through: contacts with the individual receiving services, family, family of choice, or other persons as desired by the individual, and service providers; and periodic site and home visits, as appropriate, to assess the quality of care and satisfaction of the individual;

8. Providing follow up instruction, education, and guidance to support the individual to develop relationships that promote the goals in the ISP;

9. Advocating for the individual with others, such as other providers and other human service agencies and systems, in response to changing needs and preferences, which shall be reflected in the ISP;

10. Planning for transitions in the individual's life;

11. Knowing and monitoring the individual's health status, including any medical conditions, medications and potential side effects; and assisting the individual in accessing primary care and other medical and dental services, as needed; and

12. Understanding the capabilities of services to meet the individual's identified needs and preferences and to serve the individual without placing the individual, other participants, or staff at risk of serious harm.

12VAC35-110-50. Screening.

A. Providers shall implement screening policies and procedures that include:
   1. Identification, qualification, training, and duties of employees responsible for screening;
   2. Minimum required elements of screening for case management services including:
      a. Date of contact;
      b. Name, date of birth, biological sex, and gender identity of the individual;
      c. Contact information, including address, telephone number, and email address of the individual, if applicable;
      d. Name and contact information of identified family or other persons, as desired by the individual;
      e. Reason why the individual is requesting services;
      f. Current diagnoses;
      g. Medical symptoms;
      h. Medications currently being used, including recent increases, decreases or discontinuation, misuse or overdose of prescription medication;
      i. Recent or current substance use or dependence including risk for intoxication or substance withdrawal; and
      j. Status of the individual including his referral to other services, further assessment, placement on a waiting list for services, or admission to the service.
   3. Methods to identify other appropriate services to assist individuals who are not admitted.

B. The provider shall retain documentation of the individual's screening for six months. Documentation shall be included in the individual's record if the individual is admitted to the service.

12VAC35-110-60. Assessment.

A. The provider shall implement a written assessment policy. The policy shall define how assessments will be conducted and documented.

B. The provider shall actively involve the individual, authorized representative, if applicable, and any identified family, family of choice, or other persons as desired by the individual, in the preparation of initial and comprehensive assessments. In these assessments the provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

C. The assessment policy shall designate appropriately qualified employees or contractors who are responsible for conducting, obtaining or updating assessments and coordinating medical screenings. These employees or contractors shall have experience in working with the needs of individuals who are being assessed, the assessment tool or tools being utilized, and knowledge of the array of services that the individuals may require.

D. Assessment is an ongoing activity. The provider shall make reasonable attempts to obtain previous assessments or relevant history. The provider shall use previous assessments or relevant history within the course of treatment, if applicable, as noted within subsection G 5.

E. Providers shall utilize standardized state or federally sanctioned assessment tools as approved by the department, or utilize their own assessment tools that shall meet the requirements laid out in subsection F for an initial assessment, and subsection G for a comprehensive assessment.

F. An assessment shall be initiated prior to or at admission to the service. With the participation of the individual, individual's authorized representative, if applicable, and any identified persons as desired by the individual, the provider shall complete, or obtain information from other qualified providers in order to complete, an initial assessment detailed enough to determine whether the individual qualifies for admission and to initiate an ISP for those individuals who are admitted to the service.

1. The initial assessment shall assess immediate service, health, and safety needs, and at a minimum include the individual's:

a) Diagnosis;
b) Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of needs;
c) Current medical issues;
d) Current medications;
e) Current and past substance use or abuse, including co-occurring mental health and substance abuse disorders; and
f) At-risk behavior to self and others; and
g) Risk factors that will impact the individual's ability to seek treatment or continue to participate in services.

2. For providers treating substance use disorder, at the time of the initial assessment the provider shall:

a) Identify individuals with a high-risk for medical complications or who may pose a danger to themselves or others; and
b) Assess substances used and time of last use;

3. The comprehensive assessment may be completed at the time of initial assessment if it includes all elements noted within subsection G. In the event a comprehensive assessment is completed at the time of an initial assessment, the provider is not required to update the assessment unless a reassessment is medically or clinically indicated.

G. A comprehensive assessment shall update and finalize the initial assessment, unless the comprehensive assessment is completed at the time of initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur 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. It shall address:

1. Onset and duration of needs;

2. Social, behavioral, developmental, and family history and supports;

3. Cognitive functioning including strengths and weaknesses;

4. Employment, vocational, and educational background;

5. Previous interventions and outcomes including unsuccessful interventions and outcomes, and the provider shall ensure previous assessments are utilized to note these interventions as required by 12VAC35-110-50 D;

6. Financial situation, financial resources, financial support and benefits, and whether the individual has the means to meet his financial needs;

7. Health history and current medical care needs, to include:

    a. Allergies, including allergies to food and medications;

    b. Recent physical complaints and medical conditions;

    c. Nutritional needs;

    d. Chronic conditions;

    e. Communicable diseases;

    f. Restrictions on physical activities if any;

    g. Restrictive protocols or special supervision requirements;

    h. Past serious illnesses, serious injuries, and hospitalizations;

    i. Serious illnesses and chronic conditions of the individual's parents, siblings, and significant others in the same household; and

    j. Current and past substance use including alcohol, prescription and nonprescription medications, and illicit drugs.

8. 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 illness or substance use issues;

9. History of abuse, neglect, sexual or domestic violence, or other trauma including psychological trauma;

10. Legal competency including authorized representative, commitment, and representative payee status;

11. Relevant criminal charges or convictions and probation or parole status;

12. Daily living skills;

13. Housing arrangements;

14. Ability to access services including transportation needs;

15. As applicable, fall risk, communication needs, and mobility and adaptive equipment needs;

16. Leisure and recreation information; and

17. Individual empowerment, self-advocacy and volunteerism information.

H. Case managers shall meet with each individual face-to-face as dictated by the individual's needs. At face-to-face meetings, the case manager shall: (i) observe and assess for any previously unidentified risks, injuries, needs, or other changes in status; (ii) assess the status of previously identified risks, injuries, or needs, or other changes in status; (iii) assess whether the individual's service plan is being implemented appropriately and remains appropriate for the individual; and (iv) assess whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs.

I. The provider shall retain documentation of the individual's assessments in the individual's record for a minimum of six years after the individual's discharge in accordance with § 54.1-2910.4 of the Code of Virginia.

12VAC35-110-70. Individualized services plan (ISP); Individualized supports plan; Service planning.

A. The provider shall actively involve, through face-to-face contacts, the individual and authorized representative, as appropriate, in the development, review, and revision of a person-centered ISP. The individualized services planning process shall be consistent with laws protecting confidentiality, privacy, human rights of individuals receiving services, and rights of minors.

1. Providers of developmental services shall develop and implement a plan for supports, which is a component of the comprehensive individual support plan, 24 hours after admission. The initial plan for supports shall address immediate health and safety needs, may include assessment activities, and shall continue in effect until the ongoing comprehensive plan of supports is developed or the individual is discharged, whichever comes first. Providers shall collaborate with the individual's planning team to develop and implement this initial person-centered plan for supports, which may include assessment activities for the first 60 days. An ongoing comprehensive plan for supports shall be completed after 60 days. A provider may complete an ongoing comprehensive plan for supports prior to 60 days.

2. Providers of mental health and substance abuse services shall develop and implement the initial ISP 24 hours after admission to address immediate service, health, and safety needs and shall continue implementation until the comprehensive ISP is developed or the individual is discharged, whichever comes first. The provider shall develop and implement an initial person-centered ISP for the first 30 days.

B. 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. Providers of short-term intensive services that are typically

provided for less than 30 days shall implement a comprehensive ISP no later than 48 hours after admission.

C. The initial ISP and the comprehensive ISP shall be developed based on the respective assessment with the participation and informed choice of the individual receiving services

1. To ensure the individual's participation and informed choice, the following shall be explained to the individual or his authorized representative, as applicable, in a reasonable and comprehensible manner:
   a) The proposed services to be delivered;
   b) Any alternative services that might be advantageous for the individual; and
   c) Any accompanying risks or benefits of the proposed alternative services.

2. If no alternative services are available to the individual, it shall be clearly documented within the ISP or within documentation attached to the ISP, that alternative services were not available as well as any steps taken to identify if alternative services were available.
3. Whenever there is a change to an individual's ISP it shall be clearly documented within the ISP or within documentation attached to the ISP that:
   a. The individual participated in the development of or revision to the ISP;
   b. The proposed and alternative services and their respective risks and benefits were explained to the individual or the individual's authorized representative, and;
   c. The reasons the individual or the individual's authorized representative chose the option included in the ISP.

12VAC35-110-80. ISP requirements.

A. The case manager shall work with the individual, the individual's authorized representative and the individual's other service providers, where applicable, and other persons as desired by the individual, to complete an individualized, person-centered initial ISP. The initial ISP shall be based on the individual's immediate service, health, and safety needs identified in the initial assessment. The case manager shall complete a distinct, separate, initial case management ISP, even if the individual receives additional services. The initial ISP shall include:
   1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing each need documented within the individual's assessment;
   2. Services and supports and frequency of services required to accomplish the goals including relevant psychological, mental health, substance abuse, behavioral, developmental, medical, rehabilitation, training, and nursing needs and supports;
   3. The role of the individual and others, including the individual's family if appropriate in implementing the service plan;
   4. Target dates for accomplishment of goals and objectives;
   5. Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies; and
   6. The activities, services and supports of each provider including those of the case manager.

B. The case manager shall work with: the individual; the individual's authorized representative; and the individual's other service providers, where applicable; and any persons as desired by the individual, to complete the individualized, person-centered, comprehensive ISP. The comprehensive ISP shall be based on the individual's needs, strengths, abilities, personal preferences, goals, and natural supports identified in the comprehensive assessment. The case

manager shall complete a distinct, separate, comprehensive case management ISP, even if the individual receives additional services. The comprehensive ISP shall include:

1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing each need documented within the individual's assessment.
2. Services and supports required to accomplish the goals including relevant psychological, mental health, substance abuse, behavioral, developmental, medical, rehabilitation, training, and nursing needs and supports;
3. The frequency at which services and supports must be provided to accomplish the individual's goals;
4. The role of the individual and others, including the individual's family if appropriate, in implementing the ISP;
5. A communication plan for individuals with communication barriers, including language barriers;
6. A behavioral support or treatment plan, if applicable;
7. A safety plan that addresses identified risks to the individual or to others, including a fall risk plan;
8. A crisis or recovery plan, if applicable;
9. Target dates for accomplishment of goals and objectives;
10. Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies;
11. A transportation plan, if applicable
12. Recovery plans, if applicable;
13. Services the individual elects to self-direct, if applicable;
14. Projected discharge plan and estimated length of stay within the service; and
15. The activities, services and supports of each provider including those of the case manager.

C. Both the initial and comprehensive ISP shall be signed and dated at a minimum by the person responsible for implementing the plan and the individual receiving services and the authorized representative, if applicable, in order to document agreement.
    1. If the signature of the individual receiving services or the authorized representative cannot be obtained, the provider shall document attempts to obtain the necessary signature and the reason why it was unobtainable. The provider shall continue to make attempts to obtain the necessary signature for the length of time the ISP is in effect. An attempt to obtain the necessary signature shall occur at a minimum each time the provider reviews the ISP as required by 12VAC35-110-XX.
    2. The ISP shall be distributed to the individual and others authorized to receive it, prior to the implementation of the ISP. The provider shall document within the individual's record that the ISP was distributed.

D. The case manager shall be responsible for developing, implementing, reviewing, and revising each individual's ISP in collaboration with the individual, the individual's authorized representative, if applicable, and other persons, as desired by the individual. The case manager shall also be responsible for monitoring the individual's other service provider's implementation of the ISP, if applicable.

E. The case manager responsible for implementing the ISP, and for monitoring the individual's other service provider's implementation of the ISP, shall demonstrate a working knowledge of the objectives and strategies contained in the individual's current ISP. This shall include knowledge of an individual's detailed health and safety protocols.

1. The case manager shall revise the ISP as appropriate based on the changing needs and preferences of the individual.
2. When changes occur to an individual's ISP, the case manager shall notify affected providers and other persons as appropriate.

F. When a case management agency provides more than one service to an individual, the agency may maintain a single document that contains individualized objectives and strategies for each service provided.

G. Whenever possible the identified goals in the ISP shall be written in the words of the individual receiving services.

H. The provider shall use signed and dated progress notes to document the implementation of the goals and objectives contained within the ISP.

I. A copy of the individual's most current ISP shall be readily accessible to the case manager during the provision of case management services.

12VAC35-110-90. Reassessments and ISP reviews.

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

B. The provider shall actively involve the individual, the individual's authorized representative and other service providers, if applicable, in reassessments. The provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

C. Providers shall complete changes to the ISP as a result of any reassessment, if necessary or if desired by the individual. If an assessment indicates no changes to the ISP are necessary, the provider shall document that no changes are necessary and the reasoning.

D. If a reassessment indicates changes are necessary, case managers shall collaborate with other providers to ensure changes are made to medical, behavioral, or any other corresponding protocols.

E. The provider shall complete quarterly reviews of the ISP in writing at least every three months from the date of the implementation of the comprehensive ISP or whenever there is a reassessment. The review of the ISP shall be conducted in a person-centered manner, to determine if services are being delivered as described within the ISP. The individual receiving services and the authorized representative, if applicable, shall be included in the ISP review, to determine if the individual is satisfied with the services provided.

1. A review of the ISP shall evaluate the individual's progress toward meeting the ISP's goals or outcomes, objectives or support activities, and the continued relevance of the ISP's objectives and strategies or support instructions. The provider shall update the goals, outcomes, objectives, support activities, support instructions, and strategies contained in the ISP, if indicated, and implement any updates made.

2. A review of the ISP, shall document evidence of progress or lack thereof toward or achievement of goals or outcomes.

3. For goals or outcomes that were not accomplished by the identified target date, or for which no progress was made, the provider and any appropriate planning team members, shall meet to review the reasons for lack of progress. The provider shall offer the individual an opportunity to make an informed choice of how to proceed. The provider shall retain documentation of this meeting and the individual's informed choice within the individual's record.

4. Quarterly reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due.

5. A review of the ISP shall note the:

a. Involvement of the individual's family or other persons as desired by the individual, if any, involved in the individual's treatment;
b. Individual's progress towards discharge, if appropriate; and
c. Status of the individual's discharge planning, if appropriate.

G. After each reassessment, the provider shall ensure that the individual's most current ISP is easily accessible to the case manager and at the location where the individual receives services.

12VAC35-110-100.Progress notes or other documentation.

A. The provider shall have a policy or process to ensure that progress notes or other documentation are consistent in format across the provider's service. The policy shall include the timeframe in which progress notes shall be entered into the individual's record.

B. The provider shall use signed and dated progress notes or other documentation to document the services provided. Progress notes shall at a minimum:
   1. Be consistent across the provider's services;
   2. Be legible and readable;
   3. Record events of the individual's interaction with the clinical staff writing the progress note, including care provided and events relevant to diagnosis and treatment or care of the individual;
   4. Have a narrative component;
   5. Describe needed follow-up care or note which objective within the ISP will receive focus the next time the individual receives services; and
   6. Be signed and dated by the clinical staff entering the progress note.

C. Communication logs and supervision notes shall not be considered progress notes.

12VAC35-110-110. Enhanced Case Management Contacts.

A. Individuals who: (i) receive services from providers having conditional or provisional licenses; (ii) have more intensive behavioral or medical needs as defined by the supports for intensity scale ("SIS") category representing the highest level of risk to individuals; (iii) have an interruption of service greater than 30 days; (iv) encounter the crisis system for a serious crisis or for multiple less-serious crises within a three-month period; (v) have transitioned from a training center within the previous 12 months; or (vi) reside in congregate settings of 5 or more individuals, shall have enhanced case management contacts.

B. For enhanced case management, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least once every two months there shall be a visit in the individual's place of residence.

12VAC35-110-120. Health care policy.

A. The provider shall implement a policy appropriate to the scope and level of service the provider provides that addresses the facilitation and coordination of adequate and appropriate medical care. This policy shall describe:

1. How a case manager will ensure medical care needs will be assessed, including circumstances that will prompt the facilitation of obtaining a medical assessment.
2. How ISPs will address any medical care needs appropriate to the scope and level of service.
3. To what extent the provider will arrange or support the individual with the provision of medical and dental services identified at admission.
4. To what extent the provider will arrange, or support the individual with the provision of routine ongoing and follow-up medical and dental services after admission.
5. How the provider will help to ensure the individual's additional providers, if appropriate, communicate the results of any physical examinations, medical assessments, and any diagnostic tests, treatments, or examinations to the individual and authorized representative, as appropriate.
6. How the provider will ensure to keep on file the names, addresses, and phone numbers of the individual's medical and dental providers and ensure this information is up to date.
7. To what extent the provider will ensure a means for facilitating and arranging, as appropriate, transportation to medical and dental appointments and medical tests.
8. How the provider will ensure the provision of emergency medical services for each individual.

B. The case management agency shall implement written policies to identify any individuals who are at risk for falls. If the individual has been identified as at risk for falls by a DBHDS licensed provider or a health care professional, the case manager shall obtain the assessment. The case manager shall ensure that a fall prevention and management plan and program for the individual is implemented across providers appropriately.

C. The provider shall report outbreaks of infectious diseases to the Department of Health pursuant to § 32.1-37 of the Code of Virginia.

12VAC35-110-130. Qualifications of employees or contractors

A. Employees or contractors providing case management services shall have knowledge, as demonstrated through education, training, or supervision as noted within their personnel file, of:

1. Services and systems available in the community including primary health care, support services, eligibility criteria and intake processes, and generic community resources;

2. The nature of serious mental illness, developmental disability, substance use disorders, or co-occurring disorders depending on the individuals receiving services, including clinical and developmental issues;

3. Different types of assessments, including functional assessment, and their uses in service planning;

4. Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;

5. Types of mental health, developmental, and substance use disorder programs available in the locality;

6. The service planning process and major components of a service plan;

7. The use of medications in the care or treatment of the population served; and

8. All applicable federal and state laws and regulations;

9. Documentation of such demonstration shall be maintained within the person's personnel file

B. Employees or contractors providing case management services shall demonstrate the following skills and abilities through supervision as noted within their personnel files:

1. Identifying and documenting an individual's need for resources, services, and other supports;

2. Using information from assessments, evaluations, observation, and interviews to develop service plans or supports plans;

3. Identifying and documenting how resources, services, and natural supports such as family or other persons as desired by the individual can be utilized to promote achievement of an individual's personal habilitative or rehabilitative and life goals;

4. Coordinating the provision of services by diverse public and private providers.

5. Work as team members, maintaining effective inter-agency and intra-agency working relationships;

6. Work independently performing position duties under general supervision; and

7. Engage in and sustain ongoing relationships with individuals receiving services.

D. Case managers serving individuals with developmental disability shall complete the DBHDS core competency-based curriculum within 30 days of hire.

12VAC35-110-140. Case manager choice.

The provider shall implement a written policy describing how individuals are assigned case managers and how they can request a change of anassigned case manager.