Underlined = new language.

12VAC35-108- Noncenter-based Service Specific

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12VAC35-108-10. Definitions.

"Abuse" § 37.2-100 of the Code of Virginia means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Virginia Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to 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; and
7. Use of more restrictive or intensive services or denial of services to punish an individual or that is not consistent with his individualized services plan.

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

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

"Assertive community treatment service" or "ACT" means a self-contained interdisciplinary community-based team of medical, behavioral health, and rehabilitation professionals who use a team approach to meet the needs of an individual with severe and persistent mental illness. ACT teams:

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

2. Serve as the primary provider of all the services that an individual receiving ACT services needs;

3. Maintain a high frequency and intensity of community-based contacts;

4. Maintain a very low individual-to-staff ratio;

5. Offer varying levels of care for all individuals receiving ACT services, and appropriately adjust service levels according to individuals' needs over time;

6. Assist individuals in advancing towards personal goals with a focus on enhancing community integration and regaining valued roles (such as worker, family member, resident, spouse, tenant, or friend);

7. Carry out planned assertive engagement techniques including rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques;

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

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

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

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

"Behavior intervention" means those practices utilized by a provider to help an individual receiving services to achieve a positive outcome and to address challenging behavior in an individualized and safe manner. Behavior intervention practices shall be utilized in accordance with the individualized services plan; the provider's written policies and procedures governing safety (crisis prevention and intervention); and service expectations. The plan shall utilize the least restrictive treatment possible, and shall be based upon practices that are effective, therapeutic, and informed by evidence.

"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 and desires. Case management services include: identifying potential users of the service; assessing needs and planning services using a person centered approach; linking the individual to services and supports; assisting the individual directly to locate, develop, or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery and revising the service plan as indicated; discharge planning; and monitoring and advocating for individuals in response to their changing needs. "Case management service" does not include assistance in which the only function is maintaining service waiting lists or periodically contacting or tracking individuals to determine potential future service needs.

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

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

"Comprehensive assessment" means a comprehensive and written assessment that updates and finalizes the initial assessment. The comprehensive assessment shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context and shall be completed in a time period appropriate to the nature and scope of the service provided. The comprehensive assessment includes all relevant social, psychological, medical, and level of care information as the basis for the development of the person-centered comprehensive ISP. The comprehensive assessment may be completed at the time of initial assessment if it includes all elements of the comprehensive assessment. In the event a comprehensive assessment is completed at the time of an initial assessment the provider is not required to update the assessment.

“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.

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

"Day support service" means structured programs of training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills for adults with a developmental disability provided to groups or individuals in nonresidential community-based settings. Day support services shall focus on enabling the individual to attain or maintain his highest potential level of functioning. Day support services shall offer opportunities for peer interaction and community integration and are designed to enhance the following: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, social skills, medication management, prevocational skills, and transportation skills.

"Developmental disability" as defined by § 37.2-100 of the Code of Virginia means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to age nine years, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) of this definition if the individual, without services and supports, has a high probability of meeting those criteria later in life.

"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.

"Emergency services (crisis intervention)" means unscheduled and sometimes scheduled crisis intervention, and referral assistance provided over the telephone or face-to-face, if indicated, available 24 hours a day and seven days per week. Emergency services shall provide immediate mental health care in the most appropriate and least restrictive environment available to include the home or community to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention or experiencing crisis events originating from behavioral or mental health support needs. Emergency services shall include assessment, short-term counseling designed to stabilize the individual and care coordination. Emergency services also may include walk-ins, home visits, office visits, jail

interventions, and preadmission screening activities associated with the judicial process or telephone contacts.

“Full time employee” means, with respect to any month, an employee who is employed on average at least 30 hours of service per week as defined by 26 U.S.C. §4980H. (c)(4). "Group home or community residential service" means a congregate service providing 24-hour direct awake supervision in a community-based home having eight or fewer residents. Services include supervision, supports, counseling, and training in activities of daily living for individuals whose individualized services plan identifies the need for the specific types of services available in this setting.

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

"Individual" or "individual receiving services" as defined by § 37.2-100 of the Code of Virginia means a current direct recipient of public or private mental health, developmental, or substance abuse treatment, rehabilitation, or habilitation services and includes the terms "consumer," "patient," "resident," "recipient," or "client." When the term is used in this chapter, the requirement applies to every individual receiving licensed services from the provider.

“Individual support plan” means a comprehensive, person-centered plan for an individual receiving developmental disability services that sets out the supports and actions to be taken during the year by each provider, as detailed in each provider’s plan for supports to achieve the desired outcomes and goals. The individual support plan shall be developed collaboratively by the individual; the individual’s family or caregiver, as appropriate; providers; the support coordinator; and other interested parties.

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

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

"Initial assessment" means an assessment conducted prior to or at admission to determine whether the individual meets the service's admission criteria; what the individual's immediate service, health, and safety needs are; and whether the provider has the capability and staffing to provide the needed services. An assessment is not a service.

“Initial individualized service plan” or “Initial ISP” means a written plan developed and implemented within 24 hours of admission to address immediate service, health, and safety needs as identified within the individual’s initial assessment.

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

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

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work.

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

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

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

"Medication error" means an error in administering a medication to an individual and includes when any of the following occur: (i) the wrong medication is given to an individual, (ii) the wrong individual is given the medication, (iii) the wrong dosage is given to an individual, (iv) medication is given to an

individual at the wrong time or not at all, or (v) the wrong method is used to give the medication to the individual.

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

"Mental Health Skill Building" or "MHSS" means goal-directed training and supports used to enable restoration of an individual to the highest level of baseline functioning and achieve and maintain community stability and independence in the most appropriate least restrictive environment. MHSS services shall provide face to face activities, instruction, interventions, and goal-directed trainings designed to restore functioning that are defined in the ISP. MHSS shall include goal-directed training in the following areas: (i) functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring health, nutrition, and physical condition, with goals towards self-monitoring and self-regulation of all of these activities.

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

"Neglect" as defined by § 37.2-100 of the Code of Virginia means 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.

"Noncenter-based day support service" means structured programs of training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills for adults with a developmental disability provided to groups or individuals in nonresidential community-based settings. Noncenter-based day support services shall focus on enabling the individual to attain or maintain his highest potential level of functioning and promote inclusion and independent participation in his community. Noncenter-based day support services shall offer individuals typical activities of community life equal to those available to the general population.

"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.

"Plan for supports" means a provider's plan for supporting the individual in achieving the individual's desired outcomes and facilitating the individual's health and safety. The provider's plan for supports is one component of the individual support plan.

"Provider" as defined by § 37.2-403 of the Code of Virginia means any person, entity, or organization, excluding an agency of the federal government by whatever name or designation, that delivers (i) services to individuals with mental illness, developmental disabilities, or substance abuse or (ii) residential services for persons with brain injury. The person, entity, or organization shall include a hospital as defined in § 32.1-123, community services board, behavioral health authority, private provider, and any

other similar or related person, entity, or organization. It shall not include any individual practitioner who holds a license issued by a health regulatory board of the Department of Health Professions or who is exempt from licensing pursuant to § 54.1-3501, 54.1-3601, or 54.1-3701.

"Qualified mental health professional" or "QMHP" means a person who by education and experience is professionally qualified and registered by the Board of Counseling in accordance with 18VAC115-80 to provide collaborative mental health services for adults or children. A QMHP shall not engage in independent or autonomous practice. A QMHP shall provide such services as an employee or independent contractor of the department or a provider licensed by the department.

"Qualified mental health professional-adult" or "QMHP-A" means a person who by education and experience is professionally qualified and registered with the Board of Counseling in accordance with 18VAC115-80 to provide collaborative mental health services for adults. A QMHP-A shall provide such services as an employee or independent contractor of the department or a provider licensed by the department. A QMHP-A may be an occupational therapist who by education and experience is professionally qualified and registered with the Board of Counseling in accordance with 18VAC115-80.

"Qualified mental health professional-child" or "QMHP-C" means a person who by education and experience is professionally qualified and registered with the Board of Counseling in accordance with 18VAC115-80 to provide collaborative mental health services for children. A QMHP-C shall provide such services as an employee or independent contractor of the department or a provider licensed by the department. A QMHP-C may be an occupational therapist who by education and experience is professionally qualified and registered with the Board of Counseling in accordance with 18VAC115-80.

"Qualified mental health professional-eligible" or "QMHP-E" means a person receiving supervised training in order to qualify as a QMHP in accordance with 18VAC115-80 and who is registered with the Board of Counseling.

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

"Recovery" means a journey of healing and transformation enabling an individual with a mental illness to live a meaningful life in a community of his choice while striving to achieve his full potential. For individuals with substance abuse (substance use disorders), recovery is an incremental process leading to positive social change and a full return to biological, psychological, and social functioning. For individuals with 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.

"Home/Noncenter-based respite care service" means providing temporary, short-term, time-limited substitute care on an episodic or routine basis of an individual for the purpose of providing relief to the individual's unpaid primary care giver. Persons providing respite care are recruited, trained, and supervised by a licensed provider. Respite services are provided in the individual's home or place of residence, in the community.

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

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

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

"School-based therapeutic day treatment for children and adolescents" means individualized and structured therapeutic interventions that serve (i) children and adolescents from birth through age 17, and under certain circumstances up through 21, with serious emotional disturbances, or substance use disorders, or co-occurring disorders or (ii) children and adolescents from birth through age seven who are at risk of serious emotional disturbance, or substance use disorder, or co-occurring disorders. Therapeutic day treatment interventions are provided within a school setting and in coordination with school programming during the school day or to supplement the school day or year, such as after school hours or during summer school. This service combines psychotherapeutic interventions with education and mental health or substance abuse treatment to provide supports so at-risk children maintain placement within their school and home. This service shall include assessment, interventions to build daily living skills or enhance social skills, care coordination, and individual, group, or family counseling.

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

"Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical means so that the individual cannot leave it. Seclusion shall only be utilized within an inpatient hospital and only in an emergency.

"Service" as defined by § 37.2-403 of the Code of Virginia means

1. Planned individualized interventions intended to reduce or ameliorate mental illness, developmental disabilities, or substance abuse through care, treatment, training, habilitation, or other supports that are delivered by a provider to persons with mental illness, developmental disabilities, or substance abuse. 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

2. Planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports provided in residential services for persons with brain injury.

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

"Supportive in-home service" (formerly supportive residential) means the provision of community support services and other structured services to assist individuals, to strengthen individual skills, and that provide environmental supports necessary to attain and sustain independent community residential living. Services include drop-in or friendly-visitor support and counseling to more intensive support, monitoring, training, in-home support, respite care, and family support services. Services are based on the needs of the individual and include training and assistance.

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

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

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

medium and retrievable in a perceivable form and whether an electronic signature authorized by Chapter 42.1 (§ 59.1-479 et seq.) of Title 59.1 is or is not affixed.

12VAC35-108-20. Services.

Providers shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. The following services shall require a home and noncenter-based license:

1. Assertive community treatment service (ACT);
2. Noncenter-based day support service;
3. Intensive in-home service;
4. Mental health skill building;
5. Home/Noncenter-based respite care service;
6. Supportive in-home service; and
7. School-based therapeutic day treatment for children and adolescents.

12VAC35-108-30. Service descriptions.

A. Assertive community treatment services include ongoing assessment; case management; nursing; support for wellness self-management; psychopharmacological treatment, administration, and monitoring; co-occurring substance use disorder services that are non-confrontational, trauma-informed, person-centered that consider interactions of mental illness and substance use, and has goals determined by the individual; psychotherapy; psychiatric rehabilitation; work-related services that follow evidence-based supported employment principles; support for resuming education; skill-teaching to family members, significant other, and broader natural support systems that are directed exclusively to the well-being and benefit of the individual; collaboration with families and assistance to individuals with children; assistance in obtaining and maintaining safe, decent, and affordable housing that follows the individual's preferences in level of independence and location, consistent with an evidence-based supportive housing model; direct support to help individuals obtain legal and advocacy services, financial support, money-management services, medical and dental services, transportation, and natural supports in the community; mobile crisis assessment, interventions to prevent or resolve potential crises, and admission to and discharge from psychiatric hospitals; assistance in developing and maintaining natural supports and social relationships; medication education, assistance, and support; and peer support services.

B. Noncenter-based day support services include routine supports, skill-building, and safety supports in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills for adults with a developmental disability provided to groups or individuals in nonresidential, community-based settings. Noncenter-based day support services include community coaching and community engagement. These activities are conducted at naturally occurring times and in a variety of natural settings in which the individual may actively interact with persons without disabilities, other than those who are being paid to support the individual. The activities shall enhance the individual's involvement with the community and facilitate the development of relationships and natural supports.

C. Intensive in-home services are services for children and adolescents that includes 24-hour per day emergency response; crisis treatment; individual and family counseling; life, parenting, and communication skills; and case management and coordination with other services. Intensive in-home services provide modeling, and include interventions that increase functional and therapeutic interpersonal relations between family members in the home.

Intensive in-home services shall include one parent or legal guardian or responsible adult with whom the individual is living, with the goal of keeping the individual with the family.

D. Mental health skill building services (MHSS) are for adults and include direct face-to-face goal-directed training in the following areas: (i) functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring health, nutrition, and physical condition, with goals towards self-monitoring and self-regulation of all of these activities. MHSS may include symptom management, assistance with adherence to psychiatric and physical health medication treatment plans, training to promote skills to manage personal hygiene, food preparation and the maintenance of personal adequate nutrition, money management, and use of community resources. MHSS training usually takes place in a community setting.

E. Home/Noncenter-based respite care services include supports with: ADLs; monitoring of health status or physical condition; prescribed use of medication and other medical needs; preparation and eating of meals; housekeeping activities, such as bed-making, cleaning, or the individual's laundry; safety; participation in social, recreational, and community activities; and accompanying the individual to appointments or meetings.

F. Supportive in-home services include drop-in or friendly-visitor support and counseling to more intensive support, monitoring, training, in-home support, respite care, and family support services. Services are based on the needs of the individual and include training and assistance. These services normally do not involve overnight care by the provider; however, due to the flexible nature of these services, overnight care may be provided on an occasional basis.

G. School-based therapeutic day treatment for children and adolescents (TDT) includes: assessment; interventions to build daily living skills or enhance social skills; care coordination; and individual, group, or family counseling. School-based TDT includes services offered during the normal hours of operation for school during the calendar school year in the school setting; services offered after school hours during the school year as an after school program by the school system; and, TDT services offered outside of the school year during summer school, run by the school system.

12VAC35-108-40. Screening.

A. Providers shall implement screening policies and procedures that include:

1. Identification, qualification, training, and responsibilities of employees responsible for screening;
2. Minimum required elements of screening for a home and noncenter-based setting including:
   a. Date of contact;
   b. Legal name, preferred name, date of birth, sex and gender of the individual;
   c. Address and telephone number of the individual, if applicable;
   d. The reason or reasons why the individual is requesting services;
   e. Current diagnoses and medical conditions;
   f. Medical symptoms;
   g. Psychoactive and other medications currently being used, including recent increases, decreases, discontinuation, misuse or overdose of prescription medication;
   h. Recent or current substance use or dependence including risk for intoxication or substance withdrawal; and

i. Status of the individual, including his referral to other services, further assessment, placement on a waiting list for service, 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.

C. The provider shall review all elements of the screening at the time of assessment to ensure all elements are up to date.

12VAC35-108-50. Assessment.

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

B. The provider shall actively involve the individual and authorized representative, if applicable, in the preparation of initial and comprehensive assessments and in subsequent reassessments. In these assessments the provider shall consider the individual's needs, strengths, goals, preferences, and abilities within the individual's cultural context.

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

D. Assessment is an ongoing activity. The provider shall make reasonable attempts to obtain previous assessments or relevant history, and assessments and relevant history for services the individual is receiving concurrently from other providers. Assessments and relevant history from other providers shall be incorporated into the provider's assessment of the individual, as required by subsection F, and the creation of the individual's ISP, as required by 12VAC35-108-60.

E. Providers shall utilize an assessment tool that meets the requirements in subsection F for an initial assessment and subsection G for a comprehensive assessment. Providers may utilize a standardized state or federally sanctioned assessment tool that does not meet the criteria in these regulations as long as the tool is approved by the department.

F. 1. An assessment shall be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall complete, or obtain information from other qualified providers in order to complete, an initial assessment detailed enough to determine whether the individual qualifies for admission and to initiate an ISP for those individuals admitted to the service. 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;
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. 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 interventions and outcomes that were unsuccessful, and the provider should ensure previous assessments are utilized to note these interventions as required by 12VAC35-108-50 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 health or substance use issues;
9. History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma;
10. Legal competency status 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; and
15. As applicable, fall risk, communication methods or needs, and mobility and adaptive equipment needs.

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

12VAC35-108-60. Individualized services plan (ISP)/ Individualized supports plan /Service planning.

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

1. Providers of developmental services shall develop and implement a plan for supports, which is a component of the comprehensive individual support plan, no later than 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 the initial person-centered plan for supports, for the first 60 days. An ongoing comprehensive plan for supports shall be completed within 60 days of admission.

2. Providers of mental health or substance abuse services shall develop and implement the initial ISP no later than 24 hours after admission to address immediate service, health, and safety needs and shall continue 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. The provider shall implement a person-centered comprehensive ISP based upon the nature and scope of services as soon as possible after admission but no later than 30 days after admission.

C. If an individual has a case manager informed choice shall be governed by 12VAC35-xxx-xxx. If the individual does not have a case manager, development of the initial ISP and the comprehensive ISP shall be based on the respective assessment with the participation and informed choice of the individual receiving services.

1. To ensure the individual's participation and informed choice, the following shall be explained to the individual or 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.

12VAC35-108-70. ISP requirements.

A. The initial ISP shall be based on the individual's immediate service, health, and safety needs identified in the initial assessment. The initial ISP shall include:

1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing each need documented within the individual's assessment. This includes documentation that the individual's needs and preferences are consistent with a provider operated home and noncenter-based setting;
2. Services, 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;
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; and
5. Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies.

B. The comprehensive ISP shall be based on the individual's needs, strengths, abilities, personal preferences, goals, and natural supports identified in the comprehensive assessment. The ISP shall include:

1. Relevant and attainable goals, measurable objectives, and specific strategies for addressing needs documented within the individual's assessment including documentation that the individual's needs and preferences are consistent with a home/noncenter-based setting;
2. Services and supports required to accomplish the goals including relevant psychological, mental health, substance abuse, behavioral, medical, rehabilitation, training, and nursing needs and supports;
3. The frequency of the provision of services and supports to accomplish the individual's goals;
4. The role of the individual and others, including the individual's family if appropriate, in implementing the service plan;
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, if indicated by the individual's assessment;
8. A crisis or relapse plan, if applicable;
9. Target dates for accomplishment of goals and objectives;
10. Identification of employees or contractors responsible for coordination and integration of services, including employees of other agencies, if applicable;
11. A transportation plan, if applicable;

12. Recovery plans, if applicable;
13. Services the individual elects to self-direct, if applicable; and
14. Projected discharge plan and estimated length of stay within the service.

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 or the authorized representative for documentation of 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 it was unattainable. 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 12VAC35-108-80 E.

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 the distribution of the ISP within the individual's record.

D. The provider shall designate a person who shall be responsible for developing, implementing, reviewing, and revising each individual's ISP in collaboration with the individual or authorized representative, as appropriate.

E. Employees or contractors who are responsible for implementing the ISP shall demonstrate a working knowledge of the objectives and strategies contained in the individual's current ISP, including an individual's detailed health and safety protocols.

1. Providers shall educate and train employees or contractors who are responsible for implementing the ISP on the objectives and strategies contained within the individual's current ISP;
2. After each training on the individual's current ISP, providers shall maintain documentation of the employee or contractor's education, training, and competency demonstrated through supervision.
3. When changes occur to an individual's ISP, employees or contractors who are responsible for implementing the ISP shall be made aware of the changes, and shall be competent to implement the revised ISP.

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

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

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

I. A copy of the individual's most current ISP shall be readily accessible, at all times, including by staff providing direct care services while services are being provided.

12VAC35-108-80. 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. Reassessments shall include documented justification that the individual's needs continue to require a provider-operated home and noncenter-based setting.

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

C. Providers shall complete changes to the ISP, if necessary or if desired by the individual, as a result of the reassessment. 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 necessary as a result of a reassessment, providers shall complete changes to medical protocols or shall collaborate with other providers to ensure, changes to medical protocols are made. This shall include medical equipment protocols, if appropriate.

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 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 and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made.
2. A review of the ISP shall document evidence of or lack of progression toward or achievement of a specific targeted outcome for each goal and objective.
3. For goals and objectives that were not accomplished by the identified target date, or goals and objectives the individual has not made progression toward, the provider and any appropriate treatment team members, i.e., other service providers and support members, shall meet to review the reasons for lack of progress and provide the individual an opportunity to make an informed choice of how to proceed. The provider shall retain documentation of this meeting and the individual's informed choice within the individual's record. Documentation of the quarterly review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services.
4. A review of the ISP shall note the individual's family involvement, if any, in the individual's treatment;
5. A review of the ISP shall note if the individual no longer needs the intensity of care provided within a home/noncenter-based setting;
5. A review of the ISP shall note the individual's progress towards discharge; and
6. A review of the ISP shall note the status of the individual's discharge planning.

F. The provider shall ensure after each reassessment that the individual's most current ISP is easily accessible by the provider, at all times including by direct care staff while services are being provided to the individual.

12VAC35-108-90. Progress notes or Other Documentation.

A. The provider shall have a policy or process to ensure that progress notes are consistent in format across the provider's service.

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 legible and readable;
2. Record events of the individual's interaction with the staff writing the progress note, including care provided and events relevant to diagnosis and treatment or care of the individual;
3. Have a narrative component;
4. Describe follow-up care that is needed or note which objective within the ISP will be focused on the next time the individual receives services; and
5. Be signed and dated by the staff who rendered the service.

C. The provider shall document in the individual's record if the individual no longer needs the intensity of care provided within a home and noncenter-based setting.

D. Progress notes shall be entered into the individual's record each time the individual receives services.

E. Communication logs, information notes and supervision notes shall not be considered progress notes.

12VAC35-108-100. Health care policy.

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

1. How medical care needs will be assessed including circumstances that will prompt the decision to obtain 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 provide, arrange, or support the individual with the provision of medical and dental services identified at admission.
4. To what extent the provider will provide, 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 communicate the results of any physical examinations, medical assessments, and any diagnostic tests, treatments or examinations conducted by the provider to the individual and authorized representative, as appropriate.
6. How the provider will keep accessible to staff and contractors on duty the names, addresses, and phone numbers of the individual's medical and dental providers.
7. 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 provider shall implement written policies to identify any individuals who are at risk for falls, and develop and implement a fall prevention and management plan and program for each at risk individual.

C. The provider shall implement written infection control measures including the use of universal precautions.

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

12VAC35-108-110. Provider staffing plan.

A. The provider shall implement a written staffing plan that includes the types, roles, and numbers of employees and contractors that are required to provide the service. This staffing plan shall reflect the:

1. Needs of the individuals receiving services;

2. Types of services offered;

3. Service description;

4. Number of individuals to receive services at a given time; and

5. Adequate number of staff required to safely evacuate all individuals during an emergency.

B. The provider shall develop a written transition staffing plan for new services, added locations, and changes in capacity.

C. The provider shall meet the following staffing requirements related to supervision.

1. The provider shall describe how employees, volunteers, contractors, and student interns will be supervised in the staffing plan and how that supervision will be documented.

2. Supervision of employees, volunteers, contractors, and student interns shall be provided by persons who have experience working with individuals receiving services and in providing the services outlined in the service description.

3. Supervision shall be appropriate to the services provided and the needs of the individual. Supervision shall be documented.

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.

5. Supervision of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature such as 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.

6. Supervision of mental health, substance abuse, or co-occurring services that are of a supportive or maintenance nature, such as mental health supports, shall be provided by a QMHP-A, a licensed mental health professional, or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions. An individual who is a QMHP-E may not provide this type of supervision.

7. Supervision of developmental services shall be provided by a person with at least one year of documented experience working directly with individuals with 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.

8. 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 with 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.

D. 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.

E. Staff in direct care positions providing 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.

12VAC35-108-120. Staffing

A. Assertive community treatment service (ACT) shall meet the following staffing requirements:

1. Services are delivered by interdisciplinary teams.
2. ACT teams shall have sufficient staffing composition to meet the varying needs of individuals receiving services from the team as required by these regulations. Each ACT team shall meet the following minimum position and staffing requirements:

a. Team leader - one full time LMHP with three years of experience in the provision of mental health services to adults with serious mental illness; or one full time registered QMHP-A with at least three years of experience in the provision of mental health services to adults with serious mental illness who was employed by the provider as a team leader prior to July 1, 2020. The team leader shall oversee all aspects of team operations and shall provide direct services to individuals in the community.

b. Nurses - ACT nurses shall be full-time employees or contractors with the following minimum qualifications: A registered nurse shall have one year of experience in the provision of mental health services to adults with serious mental illness. A licensed practical nurse shall have three years of experience in the provision of mental health services to adults with serious mental illness.

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

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

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

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

d. Co-occurring disorder specialist - one full-time co-occurring disorder specialist, who shall be a LMHP, registered QMHP, or certified substance abuse specialist (CSAC) with training or experience working with adults with co-occurring serious mental illness and substance use disorder.

e. ACT Peer specialists - one or more full-time equivalent peer recovery specialists who is or has been a recipient of mental health services for severe and persistent mental illness. The peer specialist shall be a certified peer recovery specialist (CPRS), or shall become certified in the first year of employment. The peer specialist shall be a fully integrated team member who provides peer support directly to individuals and provides leadership to other team members in understanding and supporting individuals' recovery goals.

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

g. Psychiatric care provider - one physician who is board certified in psychiatry or who is board eligible in psychiatry and is licensed to practice medicine in Virginia, or a psychiatric nurse practitioner practicing within the scope of practice as defined in 18VAC90-30-120. An equivalent ratio of 16 hours of psychiatric time per 50 individuals must be maintained. The psychiatric care provider shall be a fully integrated team member who attends team meetings and actively participates in developing and implementing each individual ISP.

h. Generalist clinical staff - additional clinical staff with the knowledge, skill, and ability required, based on the population and age of individuals receiving services, to carry out rehabilitation and support functions, at least 50 percent of whom shall be LMHPs, QMHP-As, QMHP-Es, or QPPMHs.

(1) Small ACT teams shall have at least one generalist clinical staff;

(2) Medium ACT teams shall have at least two generalist clinical staff; and

(3) Large ACT teams shall have at least three generalist clinical staff.

2. Staff to individual ratios for ACT Teams:

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

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

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

B. ACT teams shall be available to individuals 24 hours per day and shall operate a minimum of 12 hours each weekday and eight hours each weekend day and each holiday.

C. ACT team shall make crisis services directly available 24 hours a day but may arrange coverage through another crisis services provider if the team coordinates with the crisis services provider daily. The ACT team shall operate an after-hours on-call system and be available to individuals by telephone or in person.

D. The ACT team shall have 24-hour responsibility for directly responding to psychiatric crises, including meeting the following criteria:

1. The team shall be available to individuals in crisis 24 hours per day, seven days per week, including in person when needed as determined by the team;

2. The team shall be the first-line crisis evaluator and responder for individuals receiving services from the team; and

3. The team shall have access to the practical, individualized crisis plans developed to help them address crises for each individual receiving services.

B. Noncenter-based day support service shall meet the following requirements:

1. Be in groups of no more than 3 individuals; and
2. Be provided services based on a 1:1 ratio.

C. Intensive in-home service shall meet the following staffing requirements:

1. Have an LMHP who is responsible for the clinical oversight of the program;
2. Provide individual and family which shall be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP; and
3. Provide emergency assistance available 24 hours a day, seven days a week.

D. Mental health skill building services shall only be rendered by a LMHP, LMHP-S, LMHP-R, LMHP-RP, QMHP-A, QMHP-E or QPPMH under the supervision QMHP-A, a QMHP-C, a QMHP-E or an LMHP, LMHP-S, LMHP-R or LMHP-RP. -

E. Home/Noncenter-based respite care services can be provided to two people in the same home by the same provider, but the hours shall be split.

F. Supportive in-home service may be provided individually or simultaneously to more than one individual living in the home, depending on the individual's needs.

G. School-based therapeutic day treatment (TDT) for children and adolescents shall meet the following staffing requirements:

1. Be rendered by a LMHP, LMHP-S, LMHP-R, LMHP-RP; or a QMHP-C or QMHP-E under the supervision of an LMHP, LMHP-R, LMHP-RP or LMHP-S; and
2. Individual, Group and Family Counseling shall be provided by a LMHP, LMHP-S, LMHP-R or a LMHP-RP.

12VAC35-108-130. Medication management.

A. Any staff responsible for medication administration shall have successfully completed a medication training program approved by the Virginia Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications before the staff can administer medication.

B. The provider shall develop and implement written policies and procedures regarding the delivery and administration of prescription and nonprescription medications used by individuals that shall:

1. Address identification of the staff member responsible for routinely communicating to the prescriber the effectiveness of prescribed medications, any adverse reactions, or any suspected side effects;
2. Address the use of medication orders such that if the provider administers medications or supervises self-administration of medication in a service, a current medication order for all medications the individuals receives shall be maintained on site;
3. Address training for individuals receiving services in the self administration of medication and recognition of side effects; and
4. Address training for individuals receiving services who self administer medication on the methods for storage and safekeeping of medication.

C. Any individual whose ISP indicates self administration is an appropriate objective shall receive training on how to administer his own medications:

1. No individual shall be permitted to self-administer medications if the individual's ISP indicates self administration of medications until he demonstrates the competency to do so. Competency shall be defined by the provider's policies and procedures; and

2. The provider shall have a procedure to follow regarding the daily medication log for each individual who self-administers. The procedure shall be reflected within the individual's ISP.

D. Individuals who self administer their own medications shall be assessed for competency to self - administer during each reassessment, as governed by 12VAC35-108-80.

E. Drugs designated for a particular individual shall be immediately removed from the individual's current medication supply if discontinued by the individual's physician or other prescriber.

F. The provider shall ensure that all prescribed pro re nata (PRN) medications are present within the individual's medication supply.

1. Providers shall ensure that all medications administered PRN by staff have specific indications for use. This may require that the provider discuss the parameters of administering the PRN medications with the prescriber.

2. The provider shall follow up with the individual's prescriber if a PRN medication is not effective, or if the prescription is no longer necessary.

12VAC35-108-140. Medication errors and drug reactions.

In the event of a medication error or adverse drug reaction:

1. First aid shall be administered if indicated.

2. Employees or contractors shall promptly contact a poison control center, pharmacist, nurse or physician and shall take actions as directed.
3. The individual's physician shall be notified as soon as possible unless the situation is addressed in standing orders.
4. All actions taken by employees or contractors shall be documented, such as in incident reports and progress notes.
5. The provider shall review medication errors at least quarterly as part of the quality assurance in 12VAC35-106-600.
6. Medication errors and adverse drug reactions shall be recorded in the individual's medication log.

12VAC35-108-150. Written policies and procedures for crisis or emergency interventions; required elements.

A. The provider shall implement written policies and procedures, as approved by the department, for prompt intervention in the event of a crisis or a behavioral, medical, or psychiatric emergency that may occur during screening and referral, at admission, or during the period of service provision,. A crisis or behavioral, medical, or psychiatric emergency as referred to in this section is a situation that poses an imminent risk to the individual or others and cannot be addressed within the scope of the provider's services, but does not include events that require the use of behavior intervention and supports as discussed within 12VAC35-106-530.

B. The policies and procedures shall include:

1. The provider's definition of a crisis or behavioral, medical, or psychiatric emergency;
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;
3. Employee or contractor responsibilities; and
4. Location of the face sheet with emergency medical information as required by 12VAC35-106-490.
5. How and to what extent the provider will respond to any crisis that occurs after hours, as appropriate, based on the provider's licensed service type.

12VAC35-108-160. Medication administration and storage or pharmacy operation.

A. A provider responsible for medication administration and medication storage or pharmacy operations shall comply with:

1. The Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia);
2. The Virginia Board of Pharmacy regulations;
3. The Virginia Board of Nursing regulations; and
4. Applicable federal laws and regulations relating to controlled substances.

12VAC35-108-170. Discharge planning.

A. Providers shall implement policies and procedures that include:

1. Identification, qualification, training, and responsibilities of employees responsible for discharge planning.
2. Completion of a discharge plan prior to an individual's discharge that:
    a. Involves the individual or his authorized representative and reflects the individual's preferences to the greatest extent possible consistent with the individual's needs.
    b. Involves mental health, substance abuse, developmental disability, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services that the individual will need upon discharge, or transfer to another provider, and identifies the public or private agencies or persons that have agreed to provide them.

c. Providers of respite services typically provided for less than 30 days shall develop a discharge plan no later than 48 hours prior to discharge. Providers of all other home noncenter-based services shall develop a discharge plan seven days prior to discharge.

B. Providers shall follow the elements for discharge per 12VAC35-106-460.

12VAC35-108-180. Emergency preparedness and response plan.

A. The scope of emergency preparedness in relation to this section applies to disasters as defined by §44-146.16 of the Code of Virginia.
B. The provider shall develop a written emergency preparedness and response plan that shall address how staff will respond in the event a disaster occurs during the provision of services, or in the event a disaster will impact the provision of services. The provider's plan shall address all of its services and locations.

Article 2. ACT.

12VAC35-108-190. ACT admission and discharge criteria.

A. Individuals must meet the following admission criteria:

1. Diagnosis of a severe and persistent mental illness, predominantly schizophrenia, other psychotic disorder, or bipolar disorder that seriously impairs functioning in the community. Individuals with a sole diagnosis of substance use disorder, developmental disability, personality disorder, or brain injury, are not eligible for services.
2. Significant challenges to community integration without intensive community support including persistent or recurrent difficulty with one or more of the following:
    a. Performing practical daily living tasks;
    b. Maintaining employment at a self-sustaining level or consistently carrying out homemaker roles; or
    c. Maintaining a safe living situation.
3. High service needs indicated due to one or more of the following:
    a. Residence in a state hospital or other psychiatric hospital but clinically assessed to be able to live in a more independent situation if intensive services were provided or anticipated to require extended hospitalization, if more intensive services are not available;
    b. Multiple admissions to or at least one recent long-term stay (30 days or more) in a state hospital or other acute psychiatric hospital inpatient setting within the past two years; or a recent history of more than four interventions by psychiatric emergency services per year;

c. Persistent or very recurrent severe major symptoms (e.g., affective, psychotic, suicidal);
d. Co-occurring substance addiction or abuse of significant duration (e.g., greater than six months);
e. High risk or a recent history (within the past six months) of criminal justice involvement (e.g., arrest or incarceration);
f. Ongoing difficulty meeting basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless; or
g. Inability to consistently participate in traditional office-based services.

B. Individuals receiving ACT services should not be discharged for failure to comply with treatment plans or other expectations of the provider, except in certain circumstances as outlined. Individuals must meet at least one of the following criteria to be discharged:

1. Change in the individual's residence to a location out of the service area;
2. Death of the individual;
3. Incarceration of the individual for a period to exceed a year or long term hospitalization (more than one year); however, the provider is expected to prioritize these individuals for ACT services upon the individual's anticipated return to the community if the individual wishes to return to services and the service level is appropriate to his needs;
4. Choice of the individual with the provider responsible for revising the ISP to meet any concerns of the individual leading to the choice of discharge; or
5. Significant sustained recovery by the individual in all major role areas with minimal team contact and support for at least two years as determined by both the individual and ACT team.

12VAC35-108-200. ACT contacts.

A. The ACT team shall have sufficient capacity to provide multiple contacts per week to individuals experiencing severe symptoms or significant problems in daily living. The team shall provide a minimum aggregate average of three contacts per individual per week. A minimum aggregate average of two hours, per individual per week shall be face to face.

B. Each individual receiving ACT services shall be seen face-to-face by an employee or contractor as specified in the individual's ISP. Providers shall document all attempts to make contact and if contact is not made, the reasons why contact was not made.

12VAC35-108-210. ACT service daily operation and progress notes.

A. ACT teams shall conduct daily organizational meetings Monday through Friday, *or at least four days a week*, at a regularly scheduled time to review the status of all individuals and the outcome of the most recent employee or contractor contact, assign daily and weekly tasks to employees and contractors, revise treatment plans as needed, plan for emergency and crisis situations, and to add service contacts that are identified as needed.

B. A daily log that provides a roster of individuals in the ACT services program and documentation of services provided and contacts made with them shall be maintained and utilized in the daily team meeting. There shall also be at least a weekly individual progress note documenting services provided in accordance with the ISP or attempts to engage the individual in services.

12VAC35-108-220. ACT assessment.

The provider shall solicit the individual's own assessment of his needs, strengths, goals, preferences, and abilities to identify the need for recovery oriented treatment, rehabilitation, and support services and the status of his environmental supports within the individual's cultural context. With the participation of the individual, the provider shall assess:

1. Psychiatric history, mental status and diagnosis, including the content of an advance directive;
2. Medical, dental, and other health needs;
3. Extent and effect of drug or alcohol use;
4. Education and employment, including current daily structured use of time, school or work status, interests and preferences, and supports and barriers to educational and employment performance;
5. Social development and functioning, including childhood and family history, religious beliefs, leisure interests, and social skills;
6. Housing and daily living skills, including the support needed to obtain and maintain decent, affordable housing integrated into the broader community; the current ability to meet basic needs such as personal hygiene, food preparation, housekeeping, shopping, money management, and the use of public transportation and other community based resources;
7. Family and social network, including the current scope and strength of an individual's network of family, peers, friends, and co-workers, and their understanding and expectations of the team's services;
8. Finances and benefits, including the management of income, the need for and eligibility for benefits, and the limitations and restrictions of those benefits; and
9. Legal and criminal justice involvement, including guardianship, commitment, representative payee status, and experience as either a victim or an accused person.

12VAC35-108-230. ACT service requirements.

ACT shall document that the following services are provided consistent with the individual's assessment and ISP:

1. Ongoing assessment to ascertain the needs, strengths, and preferences of the individual;
2. Case management;
3. Nursing;
4. Support for wellness self-management, including the development and implementation of individual recovery plans, symptom assessment, and recovery education;
5. Psychopharmacological treatment, administration, and monitoring;
6. Co-occurring diagnosis substance use diagnosis substance use disorder services that are non-confrontational, trauma-informed, person-centered, consider interactions of mental illness and substance use, and have goals determined by the individual;
7. Empirically supported interventions and psychotherapy;
8. Psychiatric rehabilitation, which may include skill-building, coaching, and access to necessary resources to help individuals with personal care, safety skills, money management, grocery shopping, cooking, food safety and storage, purchasing and caring for clothing, household maintenance and cleaning skills, social skills, and use of transportation and other community resources;

9. Work-related services that follow evidence-based Supported Employment principles, such as direct assistance with job development, locating preferred jobs, assisting the individual through the application process, and communicating with employers;
10. Support for resuming education;
11. Support, education, consultation, and skill-teaching to family members, significant others, and broader natural support systems, which shall be directed exclusively to the well-being and benefit of the individual;
12. Collaboration with families and assistance to individuals with children;
13. Assistance in obtaining and maintaining safe, decent, and affordable housing that follows the individual's preferences in level of independence and location, consistent with an evidence-based supportive housing model;
14. Direct support to help individuals obtain legal and advocacy services, financial support, money-management services, medical and dental services, transportation, and natural supports in the community;
15. Mobile crisis assessment, interventions to prevent or resolve potential crises, and admission to and discharge from psychiatric hospitals;
16. Assistance in developing and maintaining natural supports and social relationships;
17. Medication education, assistance, and support; and
18. Peer support services, such as coaching, mentoring, assistance with self-advocacy and self-direction, and modeling recovery practices.