Office of Licensing

Question: Will current providers be allowed to add new service (s) during this time?
Answer: Only current providers licensed for 07-006, that are currently providing 23hour crisis (CRC) service will be allowed to apply for either the 02-040 and/or 02-041 CRC license.

Question: When will the final draft of the regulations be available?
Can you provide a link to the actual Regulations that are added?
Answer: The Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services [12 VAC 35 - 105] will be updated to reflect the new crisis services section by COB July 17, 2024.

Question: Will the updated regulation be posted in draft status before 7/17/24?
Answer: The Amendments to ensure that licensing and human rights regulations support high-quality mental health services can be accessed through https://townhall.virginia.gov/L/ViewXML.cfm?textid=18410. By COB, July 17, 2024 the Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services [12 VAC 35 - 105] will be updated to reflect Part VIII: Crisis Services.

Question: Will there be additional trainings?
Can you provide a training for organizations to start the process with apply for Crisis Services?
Answer: Crisis Services Training was held on July 10, 2024. The PowerPoint, recorded webinar, and other helpful tools may be found on the OL Website and are listed below:
Crisis Services Regulatory Training Recorded Webinar (July 2024)
Crisis Services Regulatory Training PowerPoint (July 2024)
At A Glance Crisis Chart (July 2024)
DBHDS Policy & Procedure Attestation Form for CRC and CSU Services (July 2024) – MUST BE DOWNLOADED
DBHDS Seclusion Attestation Form for CRC and CSU Services (July 2024) – MUST BE DOWNLOADED
Within the next few months, the Office of Licensing will be hosting another virtual training, this time for new applicants and providers not currently licensed for crisis services but who are interested in becoming licensed. Due to capacity restrictions within TEAMS, the training is limited to two people per provider organization. The slide presentation will be sent out to providers soon after the training concludes via constant contact and will be posted on the Office of Licensing website, so anyone who did not attend will be able to access the information shortly after the presentations.

Question: Does the term "safety plan" mean CEPP?
For 23 hour crisis services are a CEPP and safety plan both needed or does the CEPP meet the requirements for the safety plan?
Answer: *Crisis education and prevention plan" or "CEPP" is a new regulatory term. A CEPP is a department approved, individualized, client-specific document that provides a concise, clear, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist an individual who may be experiencing a behavioral loss of control. The goal of the CEPP is to identify problems that have arisen in the past or are emergent in order to map out strategies that offer tools for the natural support system to assist the individual in addressing and deescalating problems in a healthy way and provide teaching skills that the individual can apply independently.*

Providers of crisis services for individuals with developmental disabilities are required to develop and implement a crisis education and prevention plan (CEPP), which can be used in lieu of a safety plan, if appropriate. If used as a safety plan, it must be developed and implemented immediately after admission.

Providers of crisis services are required to develop a person-centered safety plan immediately after admission that shall continue in effect until discharge from the provider's crisis service.

Question: Hanover County CSB only provides preadmission screenings as a crisis service. Hanover holds a Crisis Stabilization license because OLS determined it to be the most appropriate license to cover preadmission screenings. Please provide guidance on how the regulations referenced on the attached chart impact CSBs that provide Prescreening services only. More specifically, does OLS have a documentation guide for CSBs that only prescreen? Will we be audited based on the new Crisis Stabilization license criteria even though we only deliver the preadmission screening service and do not provide any of the services on the continuum? We are trying to get clarification on what regulations we are required to meet for CSB's that only prescreen. Our license reflects crisis stabilization, as that is what it was automatically moved to after crisis intervention was removed, and some of the requirements of the crisis stabilization regs do not seem appropriate in this case. For example, a treatment plan when someone is prescreened and ultimately TDO'd. Any guidance you can provide would be very helpful!
Answer: As noted during the training provided on July 10, 2024, there are no changes to emergency services, prescreening and the ECO/TDO process. Emergency Services are not affected by these regulatory changes. Therefore, the crisis services regulatory requirements do not apply to CSBs providing emergency services. The Department has determined the best method to lay out the expectations and goals for Emergency services is the performance contract. The activities associated with Emergency Services are nestled under Outpatient Srv/Crisis Stabilization (License #07-006). Information related to billing Medicaid for prescreenings can be found in the Department of Medical Assistance Services (DMAS) Mental Health Services Manual, Appendix G: Comprehensive Crisis and Transition services. Please refer to page 5 of Appendix G located on the DMAS website: Mental Health Services | MES (virginia.gov)

Question: Will licensing specialist notify providers for unannounced inspections prior to coming out for the inspection via email, or the connect portal?
Answer: Inspections will be announced unless they coincide with the required licensing visit which is required to be unannounced.

Question: If we do not plan to use seclusion and no changes to any of our services, do we still have to submit new licenses modifications? Or just apply for a new license when the time comes?
Answer: If there are no changes to your service and you are not providing CRC services you do not need to take any actions at this time.

Question: Where can you find the attestation forms on the site?
Answer: Both the DBHDS Policy and Procedure Attestation From for CRC and CSU Services and the DBHDS Seclusion Attestation From for CRC and CSU Services can be found on the Office of Licensing Website under the section Training and Technical Assistance.
DBHDS Policy & Procedure Attestation Form for CRC and CSU Services (July 2024) – MUST BE DOWNLOADED
DBHDS Seclusion Attestation Form for CRC and CSU Services (July 2024) – MUST BE DOWNLOADED

Question: Please confirm that we will not have to go through multiple service reviews if we currently have a license extension for 07-006 that was continued by our licensing specialist in March of this year. Just want to be sure our staff are prepared for all the upcoming visits.
Answer: At this time providers who are transitioning to the new CRC licenses of 02-040 or 02-041 and providers adding seclusion to their CSU 01-019 or 01-020 services, will have onsite inspections.

Question: We will not do seclusions, which attestation form do we complete when we turn in our modification for CSU and CRC services?
Answer: For currently licensed providers of a CSU, the following attestations forms are required to be submitted *only* if you plan to utilize seclusion. For the CRC service applying for the new CRC service license (02-040 and 02-041) both attestation forms must be submitted. Even if you do not plan to utilize seclusion, you must still submit the DBHDS Seclusion Attestation Form.
DBHDS Policy & Procedure Attestation Form for CRC and CSU Services (July 2024) – MUST BE DOWNLOADED
DBHDS Seclusion Attestation Form for CRC and CSU Services (July 2024) – MUST BE DOWNLOADED

Question: Are there new service codes defined for the new services?
Answer: There are new services codes for providers applying to be approved for CRC/23-hour crisis stabilization services. They are:
02-040: A mental health center-based crisis receiving center (23-hour crisis stabilization) service for adults
02-041: A mental health center-based crisis receiving center (23-hour crisis stabilization) service for children and adolescents

Question: Mobile Crisis, Community Stabilization, and 23 hour crisis Services have I believe been licensed under the same license with DBHDS. Are these separate services not being broken out into different licenses?
Answer: The only new license that is being separated out is for 23-hour crisis stabilization/CRC services which are the 02-040 (adults) and 02-041 (children/adolescents). Providers who are currently licensed for 07-006, may keep that license to provide Mobile Crisis Response and/or Community Based Stabilization.

Question: is it mandatory for providers to link the client for psychiatric evaluation within 24 hours for crisis mobile?
Answer: This is not a DBHDS licensing requirement or a requirement of the Division of Crisis Services. Additionally, this is not a DMAS requirement. DMAS requirements include care coordination; and develop and implement an appropriate discharge plan based on the needs of the individual.

Question: If we already had the 07-006 license and now we have to submit documentation for the new license codes, if we wanted to add crisis residential services, would we have to wait another 6 months? We were already licensed for these services in the beginning, was just planning on adding this additional residential service.
Answer: At this time, only current providers licensed for 07-006, that are currently providing 23-hour crisis stabilization (CRC) service will be allowed to apply for either the 02-040 and/or 02-041 CRC license. After the priority to transfer those providers who are currently providing the 23-hour crisis stabilization service is complete, then OL will begin to process new providers who would like to add this service.

Question: Are agencies already providing 23 hour crisis stabilization services able to continue that service until the modification is submitted and approved?
If you operating under your original license will you be able to operate while your modification is still pending?
When will the services go into effect? When will CRC need new license to operate 23 Hour?
Answer: Yes, all providers will be required to be in compliance within 90 days after 7-17-2024. Our office suggests submitting a modification as soon as possible to ensure this date is met.

Question: My current license has a 07-006 this is crisis stabilization for adults/children/adolescents. How will the new license be issued to cover these services? I offer 23 hour crisis and community stabilization. Before changes mobile, community and 23-hour was covered under this one number.
Answer: If you are currently licensed for 07-006 and currently provide 23-hour crisis stabilization/CRC service, and you intend to continue to provide 23-hour crisis stabilization service, you must apply for the new 23-hour crisis stabilization/crisis receiving center (CRC) service license for either 02-040 (Adults) and/or 02-041 (adults/adolescents). If your agency plans to continue to provide mobile crisis and community stabilization services, then you must maintain your 07-006 license. If your agency plans to provide both CRC services for adults and CRC services for children, then you will need to submit two separate service modifications, one for adults (02-040 Adults) and 02-041 (Children/Adolescents)

Question: In CRC 23 Hour does the clinician have to be on site to conduct the initial assessment.
Answer: No, the clinician does not have to be available in person, but they have to be available via telemedicine. Telemedicine requires both an audio and visual connection. "Telemedicine services" as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment, regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire. Nothing in this section shall preclude coverage for a service that is not a telemedicine service, including services delivered through real-time audio-only telephone.

Question: If the provider is located in an office building what is the option for the agency to provide laundering services for the clients receiving 23 Hour?
Answer: 12VAC35-105-1910.C states that, *Upon admission, the provider shall offer to launder the individual's clothes.* If the provider does not have the appropriate facilities to launder clothing, then the provider would need to take the clothes to a laundromat or make other arrangements such as contracting with a laundry service.

Question: Our QA person stated that for CRC you do not count holidays or weekends in the timeframe to have assessments or ISPs completed. She stated as long as it is not declared as being systemic by licensing it is not a problem. Is that true?
Answer: A CRC service is required to be provided 24 hours a day, 7 days a week, 365 days a year. Requirements outlined in this section refer to calendar days.

Question: Regarding 105-1910 for CRC - does that literally translate to having 6 persons in service at the CRC requires the program to have 6 recliners (or beds), for example?
Answer: Regulation 12VAC35-105-1910.B states that, *Crisis receiving center providers shall arrange for each individual to have a recliner or bed. Crisis stabilization unit and REACH CTH providers shall arrange for each individual to have a bed.* Additionally, as it relates to bathrooms, providers of CRC services must demonstrate compliance with 12VAC35-105-1930.P, *Each provider shall make available at least one toilet, one hand basin, and a shower or bath for every four individuals. Providers of children's residential services shall:*
1. Make available at least one toilet, one hand basin, and one shower or bathtub in each living unit;
2. Make available at least one bathroom equipped with a bathtub in each facility;
3. Make available at least one toilet, one hand basin, and one shower or tub for every eight individuals for facilities licensed before July 1, 1981;
4. Make available one toilet, one hand basin, and one shower or tub for every four individuals in any building constructed or structurally modified after July 1, 1981. Facilities licensed after December 28, 2007, shall comply with the one-to-four ratio; and
5. The maximum number of staff members on duty in the living unit shall be counted in determining the required number of toilets and hand basins when a separate bathroom is not provided for staff.

Question: can you please clarify how we submit the updated assessment policy and any other policies and procedures that need to be submitted/uploaded
Answer: Providers currently licensed for CRC under 07-006 must submit a Service Modification Application and all required documents in CONNECT. Ensure the following documents are also included:

- Updated Service Description with the following documents attached (uploaded as one file):
- DBHDS Policy and Procedure Attestation Form for a CRC and CSU Service
- DBHDS Seclusion Attestation Form
- Note: Providers who plan to use seclusion must send the seclusion policy to OHR directly
- Six crisis policies and procedures updated to comply with new regulatory requirements
- Written Staffing Plan and Staffing Schedule

Please refer to the Office of Licensing website for the CRISIS Regulatory Training PPT, in which the requirements are thoroughly reviewed:
Crisis Services Regulatory Training PowerPoint (July 2024)

Question: When we switch to the new license, is it a conditional license provided?
If a provider's current 07-006 license is a triennial, with that provider still receive a conditional license when converting to the new 02-040?
Answer: Providers transitioning to the new CRC licenses, 02-040 or 02-041, will be issued a conditional license.

For CRC services (02-040 or 02-041), once the provider has demonstrated compliance with the regulations as part of the quality review, the provider will be granted a Conditional License.
• Pursuant to Code of Virginia §37.2-415, a Conditional License may be granted to a provider to operate a new service to permit the provider to demonstrate compliance with all licensing standards.

Following the issuance of the Conditional License, a representative from the Office of Licensing will conduct an unannounced onsite inspection to determine compliance with the Rules and Regulations for Licensing Providers which includes the crisis criteria as part of the inspection process.
• Providers will need to demonstrate substantial compliance with these regulations prior to the issuance of an annual license.

Question: Are we able to continue to operate CRC after 7/17/24 without having the updated license? Please advise. Thank you!
Answer: If a provider has already been operating a CRC under their current 07-006 license, they may continue to operate. However, providers have 90 days from 7/17/24 to transition to the new CRC license(s). They MUST submit the appropriate service modification with all required attachments as outlined in the training, to add either 02-040 (adults) and/or 02-041 (children/adolescents) CRC service to be able to continue to provide the service.

Question: If CRC is currently on our license and we have been providing services but not billing, will we still be considered for expedited review and approval?
Answer: Only providers who have billed for CRC services will be prioritized at this time.

Question: Does everyone need to update 6 policies regardless of whether they are making changes to their service lines? for instance, we do not plan to use seclusion. do we need to udpate?
Answer: All providers of crisis services must ensure they read the new Crisis regulations and ensure all their policies and procedures are updated accordingly. Only providers requesting to transition to the new CRC license (02-040 or 02-041) or current CSUs (01-019 or 01-020) who plan to provide seclusion, must submit a modification application with the required policies along with the two attestation forms. Even if you do not plan to provide seclusion, you must still submit the DBHDS Seclusion Attestation Form.
DBHDS Policy & Procedure Attestation Form for CRC and CSU Services (July 2024) – MUST BE DOWNLOADED
DBHDS Seclusion Attestation Form for CRC and CSU Services (July 2024) – MUST BE DOWNLOADED

Question: Does there have to be a nurse at the RCU at all times?
May you please clarify the requirement regarding in person nursing at residential CSU facilities? The DMAS manual indicates that providers have until 11/30/24 to have on site nursing 24/7. Are licensing regulations requiring in person nursing 24/7 as of 7/17/24?
Answer: Residential Crisis stabilization Units (CSU) are required to provide nursing services in accordance with 1940.C.3. *Nursing services shall be provided by either an RN or an LPN. Nursing staff shall be available in person 24 hours per day, seven days per week. LPNs shall work directly under the supervision of a physician, nurse practitioner, or an RN.* The new crisis regulations became effective 7-17-24. Providers are being given a 90-day grace period to become fully compliant with the crisis regulations. However, for providers transitioning from teh 07-006 license to the new CRC/23-hour crisis stabilization license (02-040 or 02-041); or providers currently licensed as a CSU (01-019 or 01-020) but requesting approval to use seclusion, must submit proof of compliance with staffing requirements as part of the modification process consistent with instructions given during the training provided on July 10, 2024.

Question: For clarity, no isp will be needed for mobile crisis response? Also community stabilization discharges aren't due until 30 days after discharge?
Answer: Only a crisis safety plan is required for mobile crisis response. For community-based crisis stabilization, providers are required to develop and implement a discharge policy, provide discharge instructions prior to the date of discharge, and complete a discharge summary within 30 days of discharge. Please refer to the At A Glance Crisis Chart (July 2024) which will assist in determining which regulations are applicable to each crisis service.

Question: Are ISPs required for both community crisis stabilization and mcr services?
Answer: Both a crisis safety plan and a crisis ISP are required for community-based crisis stabilization. Only a crisis ISP is required mobile crisis response.

Question: I currently have a mobile crisis licensed, is this a 07-006? If this is, do I need a service modification?
Answer: Please refer to your license addendum to ensure you currently have the 07-006 license. You must have this license in order to provide mobile crisis response services. If mobile crisis response is the only service currently being provided under the 07-006 license, then no modifications required. However, if your agency is also currently providing 23-hour crisis stabilization/CRC services under the 07-006 license, then a service modification is required to add either the 02-040 (adults) or 02-041 (children/adolescents) service to provide that service.

Question: Hello, if I have MCR and community stabilization programs. Will I need to transition or update the license on CONNECT? If so, by what date? Also, I will need to compile my new policies into one document to upload on Connect? I need the step-by-step guide.
Answer: If you are currently licensed for 07-006 and provide Mobile Crisis Response and Community Based Crisis Stabilization Services and have never provided 23-hour crisis stabilization/CRC service under your 07-006 license, then you do not need to transition or update your license. You also do not need to upload any documents to CONNECT. Your policies will be reviewed the next time the Office of Licensing completes an inspection or investigation. Providers are being given a 90-day grace period from 7-17-2024 to achieve compliance with the new regulations.

Office of Human Rights

Question: Will the use of seclusion, restraint, and time out policies and procedure also need to be established by July 17th?
Answer: If you are an existing provider that utilized restraint and/or timeout, previous OHR-approved policies and procedures for restraint and time out should currently be in place. If you are an eligible entity seeking to transition your license type to include CRC or CSU, and the organization seeks to utilize seclusion, policies and procedures that address the use of seclusion along with the "Existing Provider Human Rights Compliance Verification Checklist" (HRCVC) will need to be submitted and approved prior to the use of seclusion. Written policies and procedures specific to the use of seclusion must be established on the date the HRCVC is submitted for approval.

Question: Will DBHDS provide a training on seclusion? How will this be measured?
Answer: The DBHDS Office of Human Rights (OHR) currently has training titled "Restriction, Behavioral Treatment Plans (BTPs), & Restraints" that address the use of seclusion. To register for this and all other training offered by the OHR refer to the "Community Provider Training Calendar" located under the "Resources for Licensed Providers" Tab of the OHR webpage. The OHR portion of the Crisis Regulatory Training is also available on the OHR webpage.

Question: Please describe and define what constitutes a "qualified professional" specific to the review of a seclusion or restraint incident. Would a staff that is a certified TOVA trainer be a qualified professional or is this referring to an licensed staff.
Answer: "qualified professional" is not a defined term in the Human Rights Regulations but the "qualifications" of staff involved in the use of seclusion should be rooted in standard best-practice and evident in a provider's policies as well as the assigned role/staff job description. It should be clear that the staff who are entrusted with actions assigned by regulation to a "qualified professional" have appropriate experience, knowledge and training consistent with the task they are performing. Specific to the "qualified professional" referenced in section 12VAC35-115-110, providers must ensure that only staff that have been trained in the proper and safe use of seclusion perform, monitor, or end the use of seclusion; and that that staff is involved in the care of the individual.

Question: For the policies that require OL and OHR review and approval. What is the method of submission to get those policies approved by OL and OHR. I am assuming OL will be an Info mod or portal message in CONNECT. But not sure about OHR.
Answer: Please note that this process is facilitated outside of CONNECT and directly with the Office of Human Rights via OHRpolicy@dbhds.virginia.gov
Providers currently licensed for CRC under 07-006 who are applying to transition to 02-040 or 02-041, or providers currently licensed for a mental health residential crisis stabilization service under 01-019 and 01-020 that WILL implement seclusion must: EMAIL to OHRPolicy@dbhds.virginia.gov:
1) a completed Existing Provider Compliance Verification Checklist that includes a response to questions about the use of seclusion, restraint and/or timeout AND
2) a (Behavior Management) Policy that addresses the organizations use of seclusion and addresses all elements outlined in 12VAC35-115-110
The Existing Provider Human Rights Compliance Verification Checklist is available on the OHR webpage and is referenced in the Office of Human Rights section of the Office of Licensing "DBHDS Seclusion Attestation Form".

Question: If there is a fire emergency onsite, would a delay in helping those with physical disabilities evacuate the building count as seclusion?
Answer: Providers must have written procedures in place to address all known potential delays in helping individuals who are receiving services to evacuate from the services setting in any type of emergency (see 12VAC35-115-50 and 12VAC35-115-60)
Per 12VAC35-115-30 "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 or verbal means, so that the individual cannot leave it.

Question: This is a question for office of human rights. Being that I am a provider who diagnose and prescribe. If we can stabilize someone with medications, why is this considered a restraint during crisis situations. Inpatient facilities can medicate to stabilize but we can't? That kind of makes it hard because who wants to keep filling out CHRIS reports in order to treat clients appropriately. This is a part of stabilizing in the community.
Answer: By definition (see 12VAC35-115-30), a restraint is the use of a mechanical device, medication, and/or physical intervention to prevent an individual from moving his body to engage in a behavior that places him or others at imminent risk. When an individual is involuntarily administered a medication that is not in a behavioral emergency this is referred to as a pharmacological restraint. CHRIS reports to the Office of Human Rights (OHR) are required in instances of improper use of restraint; or when the provider receives a complaint about the use of restraint. Unless there is a known improper use or complaint, every instance of pharmacological restraint is not reportable to OHR in CHRIS. Inpatient facilities licensed and operated by DBHDS are also subject to compliance with the Human Rights Regulations. There is also the requirement for an annual report of instances of seclusion and restraint per 230(C)(2).

Question: Why would I need to add seclusion to my license? What are the pros and cons of it.
Answer: The decision to utilize seclusion rests with the licensed provider and should be based on the provider's ability to comply with all corresponding state and feral laws and regulations, and constructed around the provider philosophy and staff knowledge, skills and expertise. Per 12VAC35-115-110 only providers of residential facilities for children licensed under 12VAC35-46, an inpatient hospital, and after July 17th, CRCs or CSUs can make this decision.

Question: Do the updates regulations for Restraint/Time-out/Seclusion that were presented for Crisis Service providers, also apply to other types of DBHDS licensed providers who have policies for restraint/time-out/seclusion (such as DD waiver providers)? Or do the updates ONLY apply for Crisis Services?
Answer: As of 7/17/2024 regulation 12VAC35-115-110(C)(3) has been updated as follows (*please see underlined text as to the newly added amendment to the regulation): <u>Seclusion may be used only in an emergency and only in facilities operated by the department</u>: residential facilities for children that are licensed under Regulations for Children's Residential Facilities (12VAC35-46); inpatient hospitals; <u>and crisis receiving center or crisis stabilization units that are licensed under Part VIII (12VAC35-105-1830 et seq.) of 12VAC35-105.</u> Therefore, the "updates" now also apply to providers seeking to transition (or begin services) as a Crisis Receiving Centers (CRC) or Crisis Stabilization Unit (CSU).

Question: Will a new provider require to submit a seclusion policy if their not practicing it?
Answer: No but entirely new providers, who do not currently have a DBHDS-license to provide any service must complete the "Human Rights Compliance Verification Checklist" (HRCVC) as well as submit their Complaint Resolution Policy describing compliance with 12VAC35-115-175 to

OHRPolicy@dbhds.virginia.gov. There is a space on the HRCVC for new providers that do not intend to use seclusion as an emergent response to indicate that they will NOT use seclusion. Existing providers who decide to offer CSU or CRC services for the first time must complete and submit the "Existing Provider Human Rights Compliance Verification Checklist" and indicate on the Checklist whether they will or will NOT use seclusion as an emergent response. Providers that will use seclusion must also submit a Policy.

Question: Regarding 115-110 (C)(17) - There are adverse behavioral events that would suggest the need for seclusion, which could include aggression. Is it the intent of this regulation that Face to Face monitoring means a staff member is in the room with someone who might be agitated and aggressive?
Answer: The intent of 12VAC35-115-110.C.13 and C.17 are to ensure that video or audio monitoring or surveillance is not substituted to replace face to face observation and assessment of the individual. Additionally 12VAC35-115-110.C.8.c. requires assurance of health and wellness during seclusion, and that an individual is released from seclusion immediately when criteria is met.

Question: Regarding 105-1930 - if you have previously received email notification that your use of cameras is approved by OHR, will that suffice for changing to the 02-040 license? Or is there a specific form or process that needs to be completed?
Answer: If an existing provider has already received approval of their policy for the use of audio/video monitoring, another approval is not required. If there are changes to the Policy, the revised policy must be reviewed, consult your assigned or Regional Advocate for more information.

Division of Crisis Services

Question: Can a QMHPP (Qualified Mental Health Paraprofessional) be on a Mobile Crisis Team?
Answer: No, Qualified Mental Health Paraprofessionals are not allowed to be on MCR teams. Please see the Office of Licensing Regulations and DMAS' Appendix-G for a list of approved team compositions.

Question: I understood you to say that REACH was only available for residents in the state of Virginia. What happens to individuals who are in crisis, and visiting the state and are IDDD?
Answer: REACH often provides mobile crisis response (MCR) services to individuals who are not residents of VA. Individuals who are not residents of Virgina, should not be admitted to the REACH Crisis Therapeutic Home.

Question: For TDOs - Can law enforcement transfer custody to the CRC and then the CRC transfer them to the CSU?
Answer: No, individuals under a TDO status should not be admitted to a CRC, as the CRC is a voluntary service. However, an individual under TDO status could present at a CITAC. In such cases, the individual is typically held at the CITAC until transportation to the accepting facility occurs.

Question: Can community-based crisis stabilization (in-home, non-residential) be used as a step-down from IP hospitalization the same way that a CSU acts as a step-down from IP? If so, how will IP facilities complete those referrals?
Answer: Either the IP facility or the prospective provider can contact the MCO directly to make the referral.

Question: For MCR training Some QMHPS have took the course but have not received their certificates . why is that?
Answer: A certificate is typically issued once the entire MCR training course is complete. If there are staff who have not received their certificates, please contact the Regional HUB for assistance.

Question: We're licensed under 07-006 but not billing - will that be an issue?
Answer: If a provider is licensed to provide 07-006 but is not billing, the provider is still subject to Office of Licensing Regulations.

Question: Are Community Stab staff now also required to have GPS devices (like Mobile Crisis)?
Answer: No, only providers of Mobile Crisis Response (MCR staff) are required to have GPS devices.

Question: can transfer of custody of a ECO take place from CITAC to CRC
Answer: No, individuals under an ECO are being involuntarily detained, and the CRC is a voluntary service. If the ECO is RELEASED, then the individual may be admitted to the CRC.

Question: The REACH CTHs have never historically been required to provide 24 hour nursing; we use Med Techs who are on site 24 hours / day but the RN/LPNs are not a 24 hour staffing plan and never have been required as such. I was under the impression that only the CTHs who elected to operate as a CSU would be held to the 24 hour nursing requirement AND that we would have until November to staff up due to the grace being extended by DMAS on the requirement. Will additional funding be provided and support in getting the REACH CTHs statewide up to this new code?

Answer: Crisis Therapeutic Homes (CTHs) are required to meet the same standards as Crisis Stabilization Units (CSUs), as outlined in the OL Regulations and DMAS Appendix G. The Department is aware of the costs associated with 24-hour nursing coverage and will be submitting a budget request to the General Assembly for an increase in the REACH budget to accommodate this requirement.

Question: Did I mishear the earlier presenter state that these services are only available to Virginia residents? We provide services on the DC border and have an airport in our locality so OFTEN serve non-VA residents who have a crisis in Arlington (we understand we cannot bill DMAS)
Answer: REACH often provides mobile crisis response (MCR) services to individuals who are not residents of VA. Individuals who are not residents of Virgina, should not be admitted to the REACH Crisis Therapeutic Home. Additionally, the REACH program located in NOVA has provided training to various stakeholders (airport staff) on a number of topics including crisis de-escalation.

Question: Can Community Stabilization Services be provided at the provider's office setting?
Answer: Community Stabilization is a non-center, community-based service. Services are provided in community locations where the individual lives, works, participates in services, or socializes. Therefore, when appropriate community-based stabilization services can be offered in an office setting. Please note that the service is not appropriate in a group setting.

Question: Can you please clarify on where Crisis Support Services (Crisis Intervention, Crisis Prevention and Crisis Stabilization) covered in the FIS, CL, and BI waivers (12VAC30-122-350) fall within the scope of these new regulations?
Answer: Essentially, if a provider is serving an individual that has either a FIS, CL, or BI waiver, then the provider needs to ensure that they comply with the elements/requirements noted within: Developmental Disabilities Waivers (BI, FIS, CL)- https://vamedicaid.dmas.virginia.gov/sites/default/files/2024-05/MHS%20-%20Appendix%20G%20%28updated%208.21.23%29_Final.pdf

Question: Our question about the TDOs is the CITAC for our region is co-located with the CRC. When a patient comes in on an ECO and the 8 hours is reached and the patient is then a TDO to safety net state hospital bed while bed placement is being found. The patient is not accepted in the CRC but is being cared for in the same location while bed placement is found.
Answer: For those individuals under ECO or TDO status- There are times when an individual presents to a CRC and is assessed to need a higher level of care such as a CSU or inpatient setting. If the individual is under either an ECO or TDO status and is awaiting a bed at either a CSU or an inpatient setting, providers are encouraged to find an isolated space to keep the individual safe during the waiting period. For example, the individual can wait in the CITAC (if there is one on-site) or in another room. The take-a-way: Individuals under ECO or TDO status and awaiting a bed at another facility should not be placed in the milieu with other CRC guests.

Question: Can the individuals in the CITAC and CRC be co-mingled? Example: An individual was brought in on an ECO and a TDO was petitioned but no bed was found. The individual is waiting for bed placement – can the individual be co-mingled on the CRC side while waiting for placement due to two additional individuals were brought in on an ECO and those beds were needed?
Answer: For those individuals under ECO or TDO status- There are times when an individual presents to a CRC and is assessed to need a higher level of care such as a CSU or inpatient setting. If the individual is

under either an ECO or TDO status and is awaiting a bed at either a CSU or an inpatient setting, providers are encouraged to find an isolated space to keep the individual safe during the waiting period. For example, the individual can wait in the CITAC (if there is one on-site) or in another room. The take-a-way: Individuals under ECO or TDO status and awaiting a bed at another facility should not be placed in the milieu with other CRC guests.