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Proposed Regulation
Agency Background Document

Agency name	Virginia Department of Behavioral Health and Developmental Services
Virginia Administrative Code (VAC) Chapter citation(s)	12VAC35-105
VAC Chapter title(s)	Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services
Action title	Amend the Licensing Regulations to align with enhanced behavioral health services
Date this document prepared	August 4, 2021

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

The General Assembly included the following requirements for the Department of Medical Assistance Services (DMAS) within Item 313 of the 2020 *Appropriation Act* (HB 2005, Chapter 56):

> *YYY.3. Effective on or after January 1, 2021, DMAS shall implement programmatic changes and reimbursement rates for the following services: assertive community treatment, multi-systemic therapy and family functional therapy.*

4. Effective on or after July 1, 2021, DMAS shall implement programmatic changes and reimbursement rates for the following services: intensive outpatient services, partial hospitalization programs, mobile crisis intervention services, 23 hour temporary observation services, crisis stabilization services and residential crisis stabilization unit services

In order to further the implementation of these programmatic changes, the General Assembly directed the Department of Behavioral Health and Developmental Services (DBHDS), within Item 318.B. of the 2020 *Appropriation Act*, to promulgate emergency regulations to ensure that the DBHDS licensing regulations support high quality, community-based mental health services and align with the changes being made to the Medicaid behavioral health regulations for the services funded in the budged that support evidence based, trauma-informed, prevention-focused and cost-effective services for members across the lifespan.

The amendments to the Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services ("Licensing Regulations") [12VAC35-105] contained in this action consist of only those changes that are necessary to align the DBHDS Licensing Regulations with anticipated changes to Medicaid behavioral health regulations by removing provisions that would conflict with newly funded behavioral health services and establishing new licensed services for those newly funded behavioral health services that cannot be nested under an existing DBHDS license.

As stated above, most of the anticipated newly funded behavioral health services are consistent with existing DBHDS licensed services. For these services, including functional family therapy, multisystemic family therapy, intensive outpatient services, partial hospitalization programs, mobile crisis intervention services, 23 hour temporary observation services, crisis stabilization services, and residential crisis stabilization unit services; only very minimal changes are included in this action. The existing license requirements for Program for Assertive Community Treatment (PACT) services, however, are inconsistent with the Assertive Community Treatment (ACT) services that will be funded as part of the behavioral health enhancement initiative (Project BRAVO). Substantive changes have been made to the service specific sections in the Licensing Regulations for this service to align licensing requirements with ACT service expectations. These changes are intended to ensure that providers licensed to provide ACT services adhere to a base level of fidelity to the ACT model.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

ACT: Assertive community treatment
CPRS: Certified peer recovery specialist
CSAC: Certified substance abuse counselor
DBHDS: Department of Behavioral Health and Developmental Services
DMAS: Department of Medical Assistance Services
FFT: Functional family therapy
FTE: Full-time equivalent
ICT: Intensive community treatment
LMHP: Licensed mental health professional
LPN: Licensed professional nurse
MST: Multi-systemic therapy
NP: Nurse practitioner
QMHP: Qualified mental health professional
RN: Registered nurse

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in Executive Order 14 (as amended, July 16, 2018), "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

The 2020 General Assembly, per Item 318.B. of the 2020 *Appropriation Act*, directed DBHDS to promulgate emergency regulations, to be effective within 280 days or less from the enactment of the *Act*, to ensure that licensing regulations support high quality community-based mental health services and align with the changes being made to the Medicaid behavioral health regulations.

Legal Basis

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

Section 37.2-203 of the Code of Virginia authorizes the State Board of Behavioral Health and Developmental Services to adopt regulations that may be necessary to carry out the provisions of Title 37.2 of the Code of Virginia and other laws of the Commonwealth administered by the DBHDS Commissioner or the department. On July 15, 2020, the State Board adopted the emergency amendments to regulation 12VAC35-105 and initiated a notice of intended regulatory action for the standard permanent process. The State Board of Behavioral Health and Developmental Services voted to adopt this proposed stage regulatory action on July 28, 2021.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's intended to solve.

The purpose of this regulatory action is to align the DBHDS Licensing Regulations with ongoing interagency efforts to enhance Virginia's behavioral health services system. The changes in this regulatory action will ensure that DBHDS's regulations for behavioral health providers align with changes to Medicaid funded behavioral health services in the Commonwealth by eliminating licensing provisions that conflict with Medicaid service expectations and creating new licensed services for those newly funded services that cannot be nested under an existing DBHDS licensed service.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

The substantive provisions of this regulatory action include:

1) The creation of a service definition and license for Mental Health Intensive Outpatient Service;
2) Revised definition of Substance Abuse Intensive Outpatient Service;
3) The creation of ACT as a newly licensed service in place of the previously licensed PACT service. This includes modification of the licensing requirements to align with the ACT service model and ensure that providers licensed to provide ACT services meet a basic level of fidelity to the ACT model;
4) Removal of the provisions of the regulations related to intensive community treatment (ICT) as it will no longer be a licensed service.

The new services defined in this action will ensure that Virginia's licensing regulations align with and support the Commonwealth's initiatives to enhance behavioral healthcare in Virginia and support high quality community-based mental health services.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

Virginia's behavioral health system is undergoing a multi-phased, interagency process of enhancing the behavioral health services available in the Commonwealth. This process requires coordination between agencies with responsibilities for licensing, funding, and overseeing the delivery of behavioral health services in the Commonwealth. The primary advantages of this regulatory action to the public are: 1) ensuring that Virginians have access to a continuum of high quality behavioral health services, 2) ensuring that a base level of model fidelity is adhered to by providers of ACT, and 3) aligning DBHDS licensing regulations and Medicaid service expectations to ensure that the licensing and funding of behavioral health services are congruent.

The aligning of DBHDS and DMAS regulations regarding behavioral health enhancement initiatives will prove an advantage to the Commonwealth because a continuum of publicly funded, high quality, community-based behavioral health services will reduce the need for more costly inpatient hospitalization.

There are no known disadvantages to the public or the Commonwealth to these regulatory changes.

Requirements More Restrictive than Federal

Identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements, or no requirements that exceed applicable federal requirements, include a specific statement to that effect.

There are no identified requirements which are more restrictive than applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

Identify any other state agencies, localities, or other entities particularly affected by the regulatory change. "Particularly affected" are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

Other State Agencies Particularly Affected

The DMAS regulations and funding streams are complementary to these regulations and the licensed services they address.

Localities Particularly Affected
Many community services boards provide behavioral health services, including PACT and ICT, and will be affected similarly to private providers, but no locality will be particularly affected.

Other Entities Particularly Affected

Any person, entity, or organization offering behavioral health services that is licensed by DBHDS will be affected.

Economic Impact

Pursuant to § 2.2-4007.04 of the Code of Virginia, identify all specific economic impacts (costs and/or benefits), anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Keep in mind that this is change versus the status quo.

Impact on State Agencies

For your agency: projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources	DBHDS will incur costs related to the promulgation of regulations, training for providers, and conducting additional inspections. Specifically, DBHDS will issue conditional licenses for six months and conduct an inspection to ensure regulatory compliance. DBHDS anticipates needing to conduct approximately 250 initial inspections after the first six month period. The outcome of those inspections will determine if an additional inspection is required later that year. Additional new initial inspections may be required if there are new providers as a result of this regulatory change. Additionally, the agency will need to provide technical assistance to providers, to include issuing corrective action plans (CAPs) and confirming implementation of the CAPs.
For other state agencies: projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.	None known.
For all agencies: Benefits the regulatory change is designed to produce.	The regulatory changes will ensure that the Licensing Regulations support high quality, community-based, behavioral health services and align with the changes being made to the Medicaid behavioral health regulations for the services funded in the budged that support evidence based, trauma-informed, prevention-focused and cost-effective services for members across the lifespan. This will lower the use of more costly inpatient hospitalization.

Impact on Localities

Projected costs, savings, fees or revenues resulting from the regulatory change.	Private and many community services board providers will be affected by new and changing services outlined in this regulation. Providers will incur costs applying for the new service licenses, and hiring and training staff in a manner that ensures service delivery is in alignment with regulatory requirements. **ACT** is an existing service that is being adjusted in a manner that increases service delivery requirements. The higher service level is expected to come at a higher cost, for which the new DMAS rates are expected to be sufficient for the increased costs. However, current ACT teams may experience temporary revenue declines while they adjust operations to align with the regulatory changes. **MFT/FFT** – These regulations will not have a fiscal impact on CSB providers. However, the associated DMAS state plan changes will have up-front costs such as hiring, reporting, and performance monitoring. **MH/IOP** is a newly licensed service, but existing outpatient programs will likely bill for these services. The fiscal impact is unknown. **Crisis** – There will be three new licenses created - 23 hour observation, community based crisis stabilization (72 hours), and mobile crisis. It is anticipated that this will require the CSBs to change their crisis operations. The fiscal impact is unknown.
Benefits the regulatory change is designed to produce.	The regulatory change will ensure that the Licensing Regulations support a continuum of high quality, community-based, behavioral health services and align with the changes being made to the Medicaid behavioral health regulations for the services funded in the budged that support evidence based, trauma-informed, prevention-focused and cost-effective services for members across the lifespan.

Impact on Other Entities

Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be	Providers of behavioral health services licensed by DBHDS, particularly PACT or ICT.

affected, include a specific statement to that effect.	
Agency's best estimate of the number of such entities that will be affected. Include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	DBHDS currently licenses 1,355 providers. Thirty-four provider organizations are currently licensed to provide PACT or ICT. There is no way to estimate the number of small businesses within the pool of all providers.
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	An unknown number of providers will need to submit an application for a new license for each service they seek to provide. Providers may incur costs hiring and training staff to align their operational practices with the regulatory requirements.
Benefits the regulatory change is designed to produce.	The regulatory change will ensure that the Licensing Regulations support high quality, community-based, behavioral health services across the Commonwealth and align with the changes being made to the Medicaid behavioral health regulations for the services funded in the budged that support evidence based, trauma-informed, prevention-focused and cost-effective services for members across the lifespan.

Alternatives to Regulation

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

There are no alternatives that would meet the essential purpose of the action. This action is brought under a mandate by the General Assembly.

Regulatory Flexibility Analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) establishing less stringent compliance or reporting

requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the regulatory change.

There are no other alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law that will assure the Commonwealth's compliance with the requirements within Item 318.B. of the 2020 *Appropriation Act*.

There are no exemptions of small providers from all or any part of the requirements contained in the regulatory change.

Periodic Review and Small Business Impact Review Report of Findings

If you are using this form to report the result of a periodic review/small business impact review that is being conducted as part of this regulatory action, and was announced during the NOIRA stage, indicate whether the regulatory change meets the criteria set out in Executive Order 14 (as amended, July 16, 2018), e.g., is necessary for the protection of public health, safety, and welfare; minimizes the economic impact on small businesses consistent with the stated objectives of applicable law; and is clearly written and easily understandable.

In addition, as required by § 2.2-4007.1 E and F of the Code of Virginia, discuss the agency's consideration of: (1) the continued need for the regulation; (2) the nature of complaints or comments received concerning the regulation; (3) the complexity of the regulation; (4) the extent to the which the regulation overlaps, duplicates, or conflicts with federal or state law or regulation; and (5) the length of time since the regulation has been evaluated or the degree to which technology, economic conditions, or other factors have changed in the area affected by the regulation. Also, discuss why the agency's decision, consistent with applicable law, will minimize the economic impact of regulations on small businesses.

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

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

Please see the attachment below that includes responses to all public comments received during the public comment period.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below.

DHBDS is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, (iii) the potential impacts of the regulation, and (iv) the agency's regulatory flexibility analysis stated in that section of this background document.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by email, mail, or fax to:

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Email: Chesna.Gore@dbhds.virginia.gov.

In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

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

Detail of Changes

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

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

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
20		Defines terms used within the Licensing Regulations, including: "Intensive community treatment service" or "ICT" "Program of assertive community treatment" or "PACT";	 Removes definition of Intensive community treatment service or "ICT" Removes definition of Program of assertive community treatment or "PACT".

		"Partial hospitalization" Substance Abuse Intensive Outpatient Service	Removes definition of "Partial Hospitalization" Updates definition of Substance Abuse Intensive Outpatient Service Adds new definitions for: • Assertive community treatment or "ACT." • Mental Health Intensive Outpatient Service.
30		Lists services for which providers may be licensed by DBHDS, including: Intensive community treatment (ICT) and Program of Assertive Community Treatment (PACT)	Adds "Mental health intensive outpatient service" as a DBHDS licensed service. Removes "Intensive community treatment (ICT)" and "Program of Assertive Community Treatment (PACT)" from list of licensed services, and replaces with "Assertive Community Treatment (ACT)"
1360		Defines admission and discharge criteria for Intensive Community Treatment (ICT) and Program of Assertive Community Treatment (PACT) providers	Changes Program of Assertive Community Treatment (PACT) to Assertive Community Treatment (ACT) Removes language related to ICT. Adds personality disorder and brain injury to the list of sole diagnoses that render an individual ineligible for ACT services. Updates the criteria for discharge. Makes the following non-substantive language changes: replaces "substance addition or abuse" with "substance use disorder".
1370		Defines the minimum treatment team and staffing requirements for ICT and PACT teams Requires • Requires ICT and PACT team leader to be a QMHP-A with at least three years' experience in the provision of mental health services to adults with serious mental illness.	Removes references to PACT and ICT Creates separate treatment team and staffing requirements for ACT teams. Makes substantive changes to ACT team staffing requirements to align with ACT service requirements, including • Requires ACT team leader to be a Licensed Mental Health Professional (LMHP), or a Registered Qualified Mental Health Professional-Adult (QMHP-A) if already employed by the employer as a team leader prior to July 1, 2020.

		• Requires ICT teams to be staffed with at least one full time nurse, and PACT teams to be staffed with at least two full time nurses, at least one of whom shall be a Registered Nurse (RN). • Requires ICT and PACT teams to have one full-time vocational specialist and one full-time substance abuse specialist • Requires a peer specialist who is a QPPMH or QMHP-A who is or has been a recipient of mental health services for severe and persistent mental illness. • Requires a psychiatrist who is a physician who is board certified in psychiatry or who is board eligible in psychiatry and is licensed to practice medicine in Virginia • Requires each team to have a psychiatrist on staff, who must be a physician who is board certified in psychiatry or who is board eligible in psychiatry. • N/A	• Differentiates nurse staffing requirements based on the size of the ACT Team. o Small ACT teams shall have at least one full-time nurse, who shall be either an RN or an LPN. o Medium ACT teams shall have at least one full time RN, and at least one additional full-time nurse, who shall be LPN's or RNs. o Large ACT teams shall have at least one full-time RN, and at least two additional full-time nurses who shall e LPNs or RNs. • Requires Vocational Specialist to be a registered QMHP with demonstrated expertise in vocational services through experience or education. • Requires ACT Co-occurring disorder specialist to 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. • Requires a peer recovery specialist to be a Certified Peer Recovery Specialist (CPRS) or certify as a CPRS within the first year of employment. • Allows a Psychiatric Nurse Practitioner practicing within the scope of practice of a Psychiatric Nurse Practitioner to fill the psychiatrist position on an ACT team. • Requires generalist clinical staff as follows:

		• Defines minimum staffing capacity for ICT and PACT teams. PACT teams shall have at least 10 full-time equivalent clinical employees or contractors. And PACT and ICT teams must maintain a minimum staff to individual ratio of 1:10. • N/A	○ Small ACT teams shall have at least one generalist clinical staff; ○ Medium ACT teams shall have at least two generalist clinical staff; ○ Large ACT teams shall have at least three generalist clinical staff. • Defines minimum staff to individual ratios that ACT teams must maintain based on the size of the team and the team's caseload. • Requires ACT teams to have 24-hour responsibility for directly responding to psychiatric crises, including meeting the following criteria: ○ The team shall be available to individuals in crisis 245 hours per day, seven days per week, including in person when needed as determined by the team; ○ The team shall be the first-line crisis evaluator and responder for individuals serviced by the team; and ○ The team shall have access to the practical, individualized crisis plans developed to help them address crises for each individual receiving services.
1380		Defines minimum number of contacts that ICT and PACT teams must make with individuals receiving services, and requires face-to-face contact, or attempts to make face-to-face contact with individuals in accordance with the individual's individualized services plan	• Removes references to ICT and PACT and replaces with ACT. • Language changes for clarity • Requires documentation of attempts to make contact with individuals
1390		Requires daily organizational meetings and progress notes	Removes references to ICT and PACT and replaces with ACT

		be maintained by ICT and PACT teams	
1410		Defines minimum service requirements for ICT and PACT teams Providers 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. Substance abuse assessment and treatment for individuals with a co-occurring diagnosis of mental illness and substance abuse ; 7. Individual supportive therapy; 8. Skills training in activities of daily living, social skills, interpersonal relationships, and leisure time; 9. Supportive in-home services; 10. Work-related services to help find and maintain employment; 11 . Support for resuming education; 12. Support, psychoeducation, consultation, and skill-teaching to family members, and significant others; 13. Collaboration with families and assistance to individuals with children;	Amends service requirements to align with ACT service expectations and philosophy. Providers shall document that the following services are provided consistent with the individual's assessment and ISP. 1. Ongoing assessment to ascertain the needs, strengths, and preferences of the individual; 2. Case management; 3. Nursing; 4. Support for wellness self-management, including the development and implementation of individual recovery plans, symptom assessment, and recovery education; 5. Psychopharmacological treatment, administration, and monitoring; 6. Co-occurring diagnosis substance use disorder services that are non-confrontational, trauma informed, person-centered, consider interactions of mental illness and substance use, and have goals determined by the individual; 7. Empirically supported interventions and psychotherapy; 8. Psychiatric rehabilitation to include skill-building, coaching, and access to necessary resources to help individuals with personal care, safety skills, money management skills, 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 to help find and maintain employment; 10. Support for resuming education; 11. Support, psychoeducation, consultation, and skill-teaching to family members, and 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 development of family and other natural supports;

		14. Direct support to help individuals secure and maintain decent, affordable housing that is integrated into the broader community and to obtain legal and advocacy services, financial support, money-management services, medical and dental services, transportation, and natural supports in the community; and 15. Mobile crisis assessment, interventions to prevent or resolve potential crises, and admission to and discharge from psychiatric hospitals.	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; and 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; 18. Peer support services, such as coaching, mentoring, assistance with self-advocacy and self-direction, and modeling recovery practices.

If the regulatory change is replacing an ***emergency regulation****, but* <u>*changes have been made*</u> *since the emergency regulation became effective,* <u>*also*</u> *complete Table 3 to describe the changes made* <u>*since*</u> *the emergency regulation.*

Table 3: Changes to the Emergency Regulation

Emergency chapter-section number	**New chapter-section number, if applicable**	**Current <u>emergency</u> requirement**	**Change, intent, rationale, and likely impact of new or changed requirements since emergency stage**
12VAC35-105-20		"Brain injury" means any injury to the brain that occurs after birth, but before age 65, that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. Brain injury does not include hereditary, congenital, or degenerative brain disorders or injuries induced by birth trauma.	"Brain injury" means any injury to the brain that occurs after birth~~, but before age 65,~~ that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. Brain injury does not include hereditary, congenital, or degenerative brain disorders or injuries induced by birth trauma. • Definition changed to align with changes from SB 1421. https://lis.virginia.gov/cgi-bin/legp604.exe?211+sum+SB1421

		"Intensive community treatment service" or "ICT" means a self-contained interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a full-time psychiatrist that: 1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illness, especially those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services; 2. Minimally refers individuals to outside service providers; 3. Provides services on a long-term care basis with continuity of caregivers over time; 4. Delivers 75% or more of the services outside program offices; and 5. Emphasizes outreach, relationship building, and individualization of services.	• Adds new definition of: "Clinically managed population specific high-intensity residential services" to match the definition in the action containing ASAM amendments to this chapter. • The definition and requirements related to ICT have been removed from the proposed stage draft. DMAS will no longer reimburse for ICT services beginning July 1, 2021 and the Office of Licensing will be phasing out the ICT license in favor of the Small ACT Team service license to more closely align with the standards and practices of high-fidelity Assertive Community Treatment.
		"Mental health intensive outpatient service" means a structured program of skilled treatment focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach. This service is provided weekly over a period of time for individuals requiring more intensive services than an outpatient service can provide, and may include individual, family or group counseling or psychotherapy; skill development and psychoeducational activities; certified peer support	"Mental health intensive outpatient service" means a structured program of skilled treatment services focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to treatment. This service is provided ~~weekly~~ over a period of time for individuals requiring more intensive services than an outpatient service can provide~~,~~ and may include individual, family, or group counseling or psychotherapy; skill development and psychoeducational activities; certified peer support services; medication management; and psychological assessment or testing.

		services; medication management; and psychological assessment or testing.	• Minor edits made to align with the definition of mental health intensive outpatient in the Amendments to align the General Regulations with ASAM criteria.
		N/A	"Mental health outpatient service" means treatment provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Mental health outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory, and other ancillary services, medical services, and medication services. Mental health outpatient service specifically includes: 1. Mental health services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; 2. Mental health services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or 3. Mental health services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia. • Definition of mental health outpatient was brought over from the Amendments to align the General Regulations with ASAM criteria to align the two actions.
		N/A	"Mental health partial hospitalization service" means time-limited active treatment interventions that are more intensive than outpatient services, designed to stabilize and ameliorate acute symptoms, and serve as an alternative to inpatient hospitalization or to reduce the length of a hospital stay. Partial hospitalization is provided through

			a minimum of 20 hours per week of skilled treatment services focused on individuals who require intensive, highly coordinated, structured, and inter-disciplinary ambulatory treatment within a stable environment that is of greater intensity than intensive outpatient, but of lesser intensity than inpatient. • Definition of mental health partial hospitalization was brought over from the Amendments to align the General Regulations with ASAM criteria to align the two actions.
		"Outpatient service" means treatment provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. "Outpatient service" specifically includes: 1. Services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; 2. Services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or 3. Services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.	• Definition of outpatient service was removed as service specific definitions have been included for mental health outpatient and substance abuse outpatient.

		"Partial hospitalization service"	Removes the term "partial hospitalization" within the definition section to align with the ASAM action. This has already been removed as a specific license and the definitions for both mental health and substance abuse partial hospitalization in the draft; that the drafting intent was to remove the general definition of partial hospitalization.
		N/A	"Substance abuse outpatient service" means a center based substance abuse treatment delivered to individuals for fewer than nine hours of service per week for adults or fewer than six hours per week for adolescents on an individual, group, or family basis. Substance abuse outpatient services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Substance abuse outpatient service includes substance abuse services or an office practice that provides professionally directed aftercare, individual, and other addiction services to individuals according to a predetermined regular schedule of fewer than nine contact hours a week. Substance abuse outpatient service also includes: 1. Substance abuse services operated by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; 2. Substance abuse services contracted by a community services board or a behavioral health authority established pursuant to Chapter 5 (§ 37.2-500 et seq.) or Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia; or 3. Substance abuse services that are owned, operated, or controlled by a corporation organized pursuant to the provisions of either Chapter 9 (§ 13.1-601 et seq.) or Chapter 10 (§ 13.1-801 et seq.) of Title 13.1 of the Code of Virginia.

		N/A	• Definition of substance abuse outpatient was brought over from the Amendments to align the General Regulations with ASAM criteria to align the two actions. "Substance abuse partial hospitalization services" means a short-term, nonresidential substance use treatment program provided for a minimum of 20 hours a week that uses multidisciplinary staff and is provided for individuals who require a more intensive treatment experience than intensive outpatient treatment but who do not require residential treatment. This level of care is designed to offer highly structured intensive treatment to those individuals whose condition is sufficiently stable so as not to require 24-hour-per-day monitoring and care, but whose illness has progressed so as to require consistent near-daily treatment intervention. • Definition of substance abuse partial hospitalization was brought over from the Amendments to align the General Regulations with ASAM criteria to align the two actions.
12VAC35-105-30		N/A	• The list of licensed services was updated to include clinically managed population specific high-intensity residential services, mental health outpatient, mental health partial hospitalization, substance abuse outpatient and substance abuse partial hospitalization and remove Intensive community treatment.
12VAC35-105-1360		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 or developmental disability, personality disorder, or brain injury, are not eligible for services.	A. Individuals must meet the following admission criteria: 1. Diagnosis of a severe and persistent mental illness, predominantly schizophrenia, other psychotic disorder, or bipolar disorder that seriously impairs functioning in the community. Individuals with a sole diagnosis of a substance use disorder, developmental disability, personality disorder, traumatic brain injury, or an autism spectrum disorder are not the intended service recipients and should not be referred to ACT if they do not have a co-occurring psychiatric disorder.

		B. Individuals receiving ~~PACT~~ ACT or ICT 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; 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 ICT or ACT team.	• Minor amendments made to align admission criteria with clinical best practices. B. Individuals receiving ~~PACT~~ ACT ~~or ICT~~ 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. ~~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~~ The individual and, if appropriate, the legally responsible person, choose to withdraw from services and documented attempts by the program to re-engage the individual with the service have not been successful; or 4. ~~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 ICT or PACT ACT team.~~ The individual and team determine that ACT services are no longer needed based on the attainment of goals as identified in the person centered plan and a less intensive level of care would adequately address current goals. • Amendments made to align discharge criteria with clinical best practices following the public comment period and individual provider meetings.
12VAC35-105-1370		A. Services are delivered by interdisciplinary teams. 1. ICT teams shall include the following positions: a. Team leader - one full-time QMHP-A with at least three	• The definition and requirements related to ICT have been removed from the proposed stage draft. DMAS will no longer reimburse for ICT services beginning July 1, 2021 and the Office of Licensing will be

		years experience in the provision of mental health services to adults with serious mental illness. The team leader shall oversee all aspects of team operations and shall routinely provide direct services to individuals in the community. b. Nurses - ICT 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. ICT teams shall have at least one qualified full-time nurse. c. One full-time vocational specialist and one full-time substance abuse specialist. These staff members shall provide direct services to individuals in their area of specialty and provide leadership to other team members to also assist individuals with their self-identified employment or substance abuse recovery goals. d. ICT peer specialists - one or more full-time equivalent QPPMH or QMHP-A who is or has been a recipient of mental health services for severe and persistent mental illness. 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. e. 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	phasing out the ICT license in favor of the Small ACT Team service license to more closely align with the standards and practices of high-fidelity Assertive Community Treatment. • Clarifying edits were made to the transition plan noted within subpart E, including adding a time limit to approved transition plans.

		expenditures, and provide receptionist activities. f. Psychiatrist - one physician who is board certified in psychiatry or who is board eligible in psychiatry and is licensed to practice medicine in Virginia. An equivalent ratio to 20 minutes (.008 FTE) of psychiatric time for each individual served must be maintained. The psychiatrist shall be a fully integrated team member who attends team meetings and actively participates in developing and implementing each individual ISP. 2. QMHP-A and mental health professional standards for ICT teams: a. At least 80% of the clinical employees or contractors on an ICT team, not including the program assistant or psychiatrist, shall be QMHP-As qualified to provide the services described in 12VAC35-105-1410. b. Mental health professionals - At least half of the clinical employees or contractors on an ICT team, not including the team leader or nurses and including the peer specialist if that person holds such a degree, shall hold a master's degree in a human service field. 3. Staffing capacity for ICT teams: a. An ICT team shall have at least five full-time equivalent clinical employees or contractors. b. ICT teams shall include a minimum number of employees (counting contractors but not counting the psychiatrist and program assistant) to maintain an employee to individual ratio of at least 1:10. c. ICT teams may serve no more than 80 individuals. …… 4. ACT teams shall have sufficient staffing composition to meet the varying needs of individuals served by the team as required by these	4 1. ACT teams shall have sufficient staffing composition to meet the varying needs of individuals served by the team as required by these regulations. Each ACT team shall meet the following

		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.	minimum position and staffing requirements: a. Team leader - one full time LMHP with three years of work experience in the provision of mental health services to adults with serious mental illness; a resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; a supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has 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. • The requirements for an ACT team leader were amended to also include LMHP-Es following the public comment period to address concerns related to work force shortages.
		….. 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,	c. Vocational specialist – one or more full-time vocational specialists, who shall be registered QMHP with demonstrated expertise in vocational services through experience or education. • Amended to clarify an ACT team may utilize more than one full-time vocational specialist, if appropriate. d. Co-occurring disorder specialist – one or more full-time co-occurring disorder

		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.	specialists, who shall be LMHP, a resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; a resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; a supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10; 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. • The requirements for a co-occurring disorder specialist were amended to also include LMHP-Es following the public comment period to address concerns related to work force shortages.
		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.	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 as a peer recovery specialist in accordance with 12VAC35-250, 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. • Clarifying edits were made to cross-reference to the regulatory requirements for certified peer recovery specialists.
		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	f. Program assistant - one full-time or two part-time program assistants ~~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.

		expenditures, and perform administrative support activities. ….. B. ICT and ACT teams shall meet daily Monday through Friday or at least four days per week to review and plan routine services and to address or prevent emergency and crisis situations. C. ICT teams shall operate a minimum of eight hours per day, five days per week and shall provide services on a case-by-case basis in the evenings and on weekends. 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. D. The ICT or 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.	• Language was amended to allow for one full-time or two part-time program assistants on an ACT team. ~~B. ICT and PACT ACT teams shall meet daily Monday through Friday or at least four days per week to review and plan routine services and to address or prevent emergency and crisis situations.~~ • This language was removed and pulled down into 1390 for consistency. B. ~~C. ICT teams shall operate a minimum of eight hours per day, five days per week and shall provide services on a case-by-case basis in the evenings and on weekends.~~ 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. ~~D.~~ The ~~ICT or~~ 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. D. ~~E.~~ The ACT team shall operate an after-hours on-call system and shall be available to individuals by telephone, ~~or~~ and in person when needed as determined by the team. ~~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 served by 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.~~ • Requirements related to crisis response by ACT teams were amended following individual provider meetings and the public comment period to clarify the crisis response responsibilities of the team

		E. 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 served by 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.	and that the team may arrange for crisis coverage through another crisis provider if the team coordinates with the crisis services provider daily. E. A transition plan shall be required of ACT teams that will allow for "start-up" when newly forming teams are not in full compliance with the ACT model relative to staffing patterns and individuals receiving services capacity. • Language was originally removed during the emergency action but restored during the proposed stage.
12VAC35-105-1380		A. The ICT and 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 ICT or 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.	A. The ~~ICT and~~ ACT team shall ~~have the sufficient capacity to~~ provide multiple contacts per week to individuals experiencing severe symptoms or significant problems in daily living.~~, for an.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 ~~ICT or~~ 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. • Language related to the aggregate average of contacts was removed following individual provider meetings as well as the public comment period as the requirement no longer seemed appropriate for licensing regulations and enforcement.
12VAC35-105-1390		A. ICT teams and ACT teams shall conduct daily organizational meetings Monday through Friday at a regularly scheduled time to review the status of all individuals and the outcome	A. ~~ICT teams and~~ ACT teams shall conduct ~~daily~~ organizational meetings Monday through Friday at least four days per week at a regularly scheduled time to review the status of all individuals and the outcome of the most recent

		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 served in the ICT or 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.	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. • The language requiring team meetings at least four days per week was moved down from section 1370 to provide greater clarity following the public comment period. B. A daily log that provides a roster of individuals served in the ~~ICT or~~ ACT services program and documentation of services provided and contacts made with them shall be maintained and utilized in the ~~daily~~ team meeting. Daily logs shall not be considered progress notes. C. There shall also be ~~at least a weekly~~ individual progress notes documenting services provided in accordance with the ISP each time the individual receives services which shall be included within the individual's record. ACT ~~Providers~~ teams shall also document within the individual's record attempts at outreach and engagement. ~~or attempts to engage the individual in services.~~ • Language related to daily logs and progress notes was amended for greater consistency with billing requirements for DMAS and to provide greater clarification to providers regarding their responsibility to record attempts at outreach and engagement.
12VAC35-105-1410		ICT and 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	~~ICT and~~ ACT teams shall document that the following services are provided consistent with the individual's assessment and ISP. 1. Ongoing assessment to ascertain the needs, strengths, and preferences of the individual; 2. Case management; 3. Nursing; 4. Support for wellness self-management, including the development and implementation of individual recovery plans, symptom assessment, and recovery education;

		recovery plans, symptom assessment, and recovery education; 5. Psychopharmacological treatment, administration, and monitoring; 6. Co-occurring diagnosis substance use disorder services that are non-confrontational, trauma informed, person-centered, consider interactions of mental illness and substance use, and have goals determined by the individual; 7. Empirically supported interventions and psychotherapy; 8. Psychiatric rehabilitation, which may include skill-building, coaching, and 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	5. Psychopharmacological treatment, administration, and monitoring; 6. Co-occurring diagnosis substance use disorder services that are non-confrontational, trauma informed, person-centered, consider interactions of mental illness and substance use, and have goals determined by the individual; 7. Empirically supported interventions and psychotherapy; 8. Psychiatric rehabilitation, which may include skill-building, coaching, and facilitating access to necessary resources to help individuals with personal care, safety skills, money management, grocery shopping, cooking, food safety and storage, purchasing 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, ~~and~~ 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 development of family and other natural supports ~~assistance to individuals with children~~; 13. Assistance in obtaining and maintaining safe, decent, and affordable housing that follows the individual's

		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.	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; ~~and~~ 15. ~~Mobile c~~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. • Clarifying edits were made to this section based on feedback received during the public comment period.

VAC	12VAC35-105
Window:	2/1/2021 - 3/3/2021

#	Commenter Name	Commenter Organization	Date	Time	Comment Title	Comments	Response
1	Kala Hodge,	Mount Rogers Community Services	2/3/21	10:47 am	**Assertive Community Treatment Regulation Changes**	I would like to speak to the regulation change requiring for Assertive Community Treatment (ACT) Team Lead to be LMHP. My programs are in a rural area in Southwest Virginia. We have extreme difficulty in hiring LMHP's in our area. I would ask that either a waiver process be put in place, for areas such as ours, to allow LMHP-E's to be considered for ACT Team Leads and other positions. In order to draw the LMHP pool of applicants to our rural area, it is often necessary to open our positions for LMHP-E's with supervision for licensure provided. Could we consider including LMHP-E's within this requirement or having a waiver process for situations such as we may face in rural areas? Thank you for your consideration. CommentID: 95112	The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the team leader: • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness. The draft has been amended based on public comment to include the following individuals as those who are eligible to

#	Commenter Name	Commenter Organization	Date	Time	Comment Title	Comments	Response
							serve as the co-occurring disorder specialist. • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10.
2	Bob Horne,	Norfolk CSB	2/9/21	1:23 pm	**Comments on proposed ACT regulations**	**General, Top Three Concerns:** 1. New requirement for ACT teams to *directly* respond and be the *first-line crisis evaluator* for PACT clients 24/7. **We are advocating the current regulation stands for 24/7 response**; it allows for coordinating outside the team for coverage. More justification below. 2. The use of QMHP and LMHP in several places, versus also **allowing for LMHP-Es and QMHP-Es**. We are advocating that any time an LMHP or QMHP is required, that Es are also eligible considering work force shortages.	The draft has been amended based on public comment to clarify ACT teams 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 draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the team leader: • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of

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						3. **Some requirements seem better suited for a fidelity measures versus regulation**. This may help smaller CSBs, or those in the highest workforce shortage areas, to still operate ACT to the best of their ability. This would be in line with the new per diem proposals related to fidelity levels. **Crisis Response:** • **Concerned some regulations and code need more consistency**; will the administrative Code of Virginia also change? • **Recommend keep D. This makes sense and consistent with Virginia Code. The practice has worked well over many years of providing PACT and ICT around the state.** D. The ICT or ~~PACT~~ 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. • **Recommend strike changes to E.** As long as clients have access to competent professionals for coverage 24/7, it does not need to be required	experience in the provision of mental health services to adults with serious mental illness; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness. The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the co-occurring disorder specialist. • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; and

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						that ACT team staff are also the 24/7 first line evaluators. Accomplishing this with teams as small as ACT is virtually impossible. This requirement will increase staff turnover which is a detrimental to clients. This will be difficult for many CSBs to make happen. This could be a high fidelity measure versus regulation. T This can also be construed to mean ACT teams need pre-screeners to do and appropriate crisis evaluation. Adding a crisis evaluator pre-screeners to ACT, would not cover 24/7 and may result in higher hospitalization rates. New Mobile Crisis services may be better suited to stabilize a crisis without hospitalization and coordinate with ACT. - E. The ~~PACT~~ ACT team shall ~~operate an after-hours on-call system and shall be available to individuals by telephone or in person~~ 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 served by the team; and	• A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10. The ACT regulations were developed to generally reflect a score of three (low fidelity) on the Tool for the Measurement of Assertive Community Treatment. Thus, regulations are intended to serve a minimally acceptable standard of practice and do not reflect the degree to which elements can or should be implemented to achieve base or high-fidelity status.

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						3. The team shall have access to the practical, individualized crisis plans developed to help them address crises for each individual receiving services. CommentID: 97229	
3	**Commenter:** Tam ara Starnes,	BRBH CSB	2/10/2 1	10:51 am	**ACT Regulations**	1. New requirement for ACT teams to *directly* respond and be the *first-line crisis evaluator* for PACT clients 24/7. **Advocating the current regulation stands for 24/7 response**; it allows for coordinating outside the team for coverage. More justification below under crisis response section. 2. The use of QMHP and LMHP in several places, versus also **allowing for LMHP-Es and QMHP-Es**. We are advocating that any time an LMHP or QMHP is required, that Es are also eligible considering work force shortages. 3. **Some requirements seem better suited for a fidelity measures versus regulation**. This may help smaller CSBs, or those in the highest workforce shortage areas, to still operate ACT to the best of their ability. This would be in line with the new per diem proposals related to fidelity levels. 4. Recommendations for changes under **Team Staffing and Service Requirements.** See below. **Crisis Response:**	The draft has been amended based on public comment to clarify ACT teams 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 draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the team leader: • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services

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						• **Concerned some regulations and code need more consistency**; will the administrative Code of Virginia also change? • **Recommend keep D. This makes sense and consistent with Virginia Code. The practice has worked well over many years of providing PACT and ICT around the state.** D. The ICT or ~~PACT~~ 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. • **Recommend strike changes to E.** As long as clients have access to competent professionals for coverage 24/7, it does not need to be required that ACT team staff are also the 24/7 first line evaluators. Accomplishing this with teams as small as ACT is virtually impossible. This requirement will increase staff turnover which is a detrimental to clients. This will be difficult for many CSBs to make happen. This could be a high fidelity measure versus regulation. This can also be construed to mean ACT teams need pre-screeners to do and appropriate crisis evaluation. Adding a crisis evaluator pre-screeners to ACT, would not cover 24/7 and may result in higher hospitalization rates. New Mobile Crisis services may be better suited to	to adults with serious mental illness; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness. The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the co-occurring disorder specialist. • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10. The ACT regulations were developed to generally reflect a score of three (low fidelity) on the Tool for the Measurement of Assertive Community Treatment. Thus,

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						stabilize a crisis without hospitalization and coordinate with ACT. E. The ~~PACT~~ ACT team shall ~~operate an after-hours on-call system and~~ shall ~~be available to individuals by telephone or in person~~ 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 served by 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. **Treatment Team Staffing:** • **Several items seem better suited for a Fidelity Measures versus Regulation.** This may make it difficult for some CSBs to offer ACT. Fidelity Measure versus regulation would fit with current proposed Behavioral Health Enhancement rate structure. • **Recommend LMHP-E be allowable anywhere LMHPs are required**, for all relevant positions throughout. These are hard to fill positions due to work force shortages and duties can be successfully	regulations are intended to serve a minimally acceptable standard of practice and do not reflect the degree to which elements can or should be implemented to achieve base or high-fidelity status. The requirements related to ICT have been removed from the proposed stage draft. DMAS will no longer reimburse for ICT services beginning July 1, 2021 and the Office of Licensing will be phasing out the ICT license in favor of the Small ACT Team service license to more closely align with the standards and practices of high-fidelity Assertive Community Treatment. Any requirements within the Licensing Regulations are part of the Virginia Administrative Code. It is not clinically appropriate to have non-psychiatric nurse practitioners in the role of psychiatric care provider, as the intent is to have someone tasked with providing psychiatric care. The full-time vocational specialist and full-time substance use specialist position are fundamental to the establishment of an ACT team. The requirements related to meetings have been amended to state ACT teams shall conduct daily organizational meetings Monday through Friday at least four days per week at a regularly scheduled time to

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						completed by LMHP-Es under supervision. • **Recommend QMHP-Es be allowable anywhere QMHPS are required**, for all relevant positions throughout. This will help with workforce shortages and duties can be successfully completed by QMHP-Es under supervision. • **ICT Peer specialist- recommend removing requirement to also be QMHP**. The role of peer is more appropriate for peer training than QMHP. This would be an additional set of certifications and cost for the peer. This may also confuse the role of peer. • **Recommend striking F that require a Psychiatrist versus Nurse Practitioner to** be more consistent. There are conflicting sections related to "psychiatrist" (f) and "psychiatric provider" (g) – • **Recommend allowing for more general Nurse Practitioner versus "Psychiatric" Nurse Practitioner.** Certified "psychiatric" nurse practitioners are very rare. Many Nurse practitioners currently, and successfully, work with mental health patients under more general NP board certifications. Most NPs working in mental health have	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. The language related to mobile crisis has been amended for clarity.

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						collaborative agreements with psychiatrists. • **Recommend striking 2. QMHP and mental health standards for ICT teams**. This item includes 50% requirement for staff to have Master's Degrees in the Human Services Field. Due to this regulation, we had to move a great employee with a Master's Degree in Public Health off our PACT team. This is also a burden to a team in terms of work force issues. In addition, to qualify for QMHP, the Board of Counseling narrowed what qualifies as Human Services Field, for example, a bachelor's degree in Social Work is also not included. • **Recommend striking requirement related to Full Time Vocation and Substance Use specialist.** This amount of time may not be needed for small teams. The amount should be more general and dependent on team size. Also hard to staff these positions due to work force issues. • **Language regarding ACT and ICT is confusing**. Example: 3. Staffing for ICT teams, includes several items about ACT. • **Concerned the code may not allow for anything other than high fidelity which may be difficult for some teams.** Confusing understanding what	

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						is required by “code” and what may be considered “high fidelity” for licensing and reimbursement purposes. • **Recommend striking item 3.H** – Generalists. Does not seem to be needed as other required staffing requirements are noted in detail. If included, allow LMHP-E. • **Daily Meeting Times inconsistency.** Recommend keep B. that notes “at least four days per week” to review and plan routine services and to address or prevent emergency and crisis situations. And amend/deleted A. ICT teams and ~~PACT~~ ACT teams shall conduct daily organizational meeting~~s~~ Monday through Friday~~ ~~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. **Service Requirements:** • **Recommend deleting service requirement 11 related to services provided to non-clients.** Will this be added to an allowable reimbursement under	

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						ACT? Not currently a billable service for non-clients. 11. Support, education, consultation, and skill-teaching to family members, ~~and~~ significant others, and broader natural support systems, which shall be directed exclusively to the well-being and benefit of the individual; • **Recommend delete item 15 related to mobile crisis** and the ACT team documenting that the services are provided consistent with the individual's assessment and ISP. This is not a PACT service. Mobile Crisis teams would document their services in the record. If the intervention is emergent, do not believe it needs to be on the ISP. CommentID: 97230	
4	Rebecca Cash,	Valley Community Services Board	2/16/21	1:36 pm	**Comments concerning ACT regulations**	1. New requirements related to after hours and the requirement that PACT teams directly respond for clients 24/7 places additional burden on small teams and will likely increase staff turnover which has negative impacts on the program, agency, and most importantly individuals being served. We would like for the requirement of 24/7 response to be left as is which allows for additional flexibility for PACT to coordinate with other providers to ensure client needs are met. Current regulation: *"D. The ICT or ACT team shall make crisis services directly available 24*	The draft has been amended based on public comment to clarify ACT teams 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 draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the team leader:

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						hours a day but may arrange coverage through another crisis services provider if the team coordinates with the crisis services provider daily." 2. Please consider allowing LMHP-Es and QMHP-Es under supervision in the program in regulation where requirement is specified for LMHPs and QMHPs. We have faced challenges recruiting for PACT programs as it is. CSBs face workforce shortages and LMHP-Es and QMHP-Es should also be considered eligible for work in the program. 3. Request that the QMHP requirement for ICT Peer Specialist be removed. Peer training is a more appropriate skill set for this staff member. 4. Recommend allowing for general Nurse Practitioner be considered as eligible to provide psychiatric medication management services to the program instead of "Psychiatric Nurse Practitioner." Psychiatric nurse practitioners are rare. 5. Will Code of Virginia also be updated to be consistent with new regulations? 6. The language surrounding ACT and ICT is confusing and does not appear to be consistent throughout the regulation. 7. Many of the regulation requirements would impact the ability of smaller CSBs to effectively implement ACT program. Some requirements seem to fit in best with fidelity	• A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness. The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the co-occurring disorder specialist. • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling;

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						measures rather than a requirement in regulation. CommentID: 97242	• A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10. The requirements related to ICT have been removed from the proposed stage draft. DMAS will no longer reimburse for ICT services beginning July 1, 2021 and the Office of Licensing will be phasing out the ICT license in favor of the Small ACT Team service license to more closely align with the standards and practices of high-fidelity Assertive Community Treatment. It is not clinically appropriate to have non-psychiatric nurse practitioners in the role of psychiatric care provider, as the intent is to have someone tasked with providing psychiatric care. DBHDS is not aware of any provisions within the Code of Virginia that are inconsistent with the proposed regulations. The ACT regulations were developed to generally reflect a score of three (low fidelity) on the Tool for the Measurement of Assertive Community Treatment. Thus, regulations are intended to serve a minimally acceptable standard of practice and do not reflect the degree to which

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							elements can or should be implemented to achieve base or high-fidelity status.
5	Region Ten CSB	Region Ten CSB	2/16/21	5:21 pm	**ICT regulations**	I agree with all other comments to date. I would add for the Peer, to remove the requirement to be QMHP as peer now has a registration/certification. Also I would recommend not limiting this to a peer with SMI history as the peer movement now trains peers to help cross disability so someone with SUD background could be effective with those with mental health challenges as well as the opposite. It should not be based on disability but their ability to use their peer experience within their work on the team and with consumers. CommentID: 97245	The requirements related to ICT, including requirements related to peer recovery specialists on ICT teams, have been removed from the proposed stage draft. DMAS will no longer reimburse for ICT services beginning July 1, 2021 and the Office of Licensing will be phasing out the ICT license in favor of the Small ACT Team service license to more closely align with the standards and practices of high-fidelity Assertive Community Treatment. The draft including the following requirements for 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 as a peer recovery specialist (PRS) in accordance with 12VAC35-250, 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.
6	Gabriella Caldwell	Miller, Hanover Community Services Board	2/24/21	3:42 pm	**Comments regarding proposed ACT regulations**	Fidelity standards and Licensure regulations • Some requirements seem better suited for fidelity measures versus the regulation. Aligning regulations to the base level of compliance with TMACT standards may help smaller CSBs, or	The ACT regulations were developed to generally reflect a score of three (low fidelity) on the Tool for the Measurement of Assertive Community Treatment. Thus, regulations are intended to serve a minimally acceptable standard of practice and do not reflect the degree to which

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						those in the highest workforce shortage areas, to still operate ACT to the best of their ability. • The proposed changes to the Code that exceed fidelity requirements handicaps programs that can provide based on TMACT standards, but for myriad reasons, cannot attain the additional DBHDS licensure requirements. • Confusion about the difference between base TMACT fidelity, Licensing regulations, and medical necessity criteria could result in MCOs denying payment to teams providing services based on TMACT fidelity. Staffing • The requirement to hire additional personnel to be compliant with new ACT requirements penalizes boards that have been providing services that meet TMACT fidelity standards but lack resources to fund additional positions. A team in compliance with the current ICT licensing guidelines will have to reduce its census, resulting in a loss of revenue that is essential to operate the program. • Licensed practitioners - LMHP-Es are essential to our workforce. As a	elements can or should be implemented to achieve base or high-fidelity status. The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the team leader: • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness. The draft has been amended based on public comment to include the following individuals as those who are eligible to

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						smaller locality, we have difficulty recruiting LMHPs (salary competitiveness and many licensed staff exiting the CSB system). • ICT Peer specialist- recommend removing the requirement to be a QMHP. Requiring that the ICT Peer specialist earn the CPRS credential is more in line with the expectations and the professional path DBHDS has established for Peers. • Nursing staff - Do not regulate 2 FTE nursing positions (1 RN and 1 LPN) for a medium-sized ACT team. Let the nursing FTE ratio be measured in fidelity reviews rather than mandated by regulations. Hiring additional nursing staff may not be fiscally feasible for smaller boards. CommentID: 97255	serve as the co-occurring disorder specialist. • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10. The requirements related to ICT have been removed from the proposed stage draft. DMAS will no longer reimburse for ICT services beginning July 1, 2021 and the Office of Licensing will be phasing out the ICT license in favor of the Small ACT Team service license to more closely align with the standards and practices of high-fidelity Assertive Community Treatment. It is not clinically appropriate to have non-psychiatric nurse practitioners in the role of psychiatric care provider, as the intent is to have someone tasked with providing psychiatric care.
7	Connie Vatsa	, H-NNCSB	2/24/21	5:55pm	**Proposed ACT regulation changes**	For the co-occurring disorder specialist the qualifications are LMHP, QMHP, or CSAC. I thought I recalled during the workshops	The draft has been amended based on public comment to include the following individuals as those who are eligible to

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						that LMHP types (LMHP-E, RIC) would also be allowable in this position. Not all LMHP types maintain their QMHP registration. I can't imagine why if a QMHP would be qualified an LMHP type would not qualify as well. The crisis coverage language contradicts itself. Under D it says an ACT team may arrange coverage through another crisis provider to make coverage available 24/7 but E2 says the team shall be the first line crisis evaluator. Requiring the team to be the first line crisis evaluator is going to result in significant increase in staffing resource need. Given the fact that the grant allocation is not increasing this would be a significant burden that I am not sure we could meet with our current financial resources. We currently arrange coverage with our emergency services department after hours and that staff has the number for the team on-call. This has worked well and ES routinely calls our on-call. CommentID: 97257	serve as the co-occurring disorder specialist. • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10. The draft has been amended based on public comment to clarify ACT teams 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.
8	Norfolk CSB	Norfolk CSB	2/25/21	7:28 am	**Regulation comments**	I agree with all other comments listed. Specifically: 1. New requirement for ACT teams to *directly* respond and be the *first-line crisis evaluator* for PACT clients 24/7. **We are advocating the current regulation stands for 24/7 response**; it allows for coordinating	The draft has been amended based on public comment to clarify ACT teams 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 draft has been amended based on public comment to include the following

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						outside the team for coverage. More justification below. 2. The use of QMHP and LMHP in several places, versus also **allowing for LMHP-Es and QMHP-Es**. We are advocating that any time an LMHP or QMHP is required, that Es are also eligible considering work force shortages. 3. **Some requirements seem better suited for a fidelity measures versus regulation**. This may help smaller CSBs, or those in the highest workforce shortage areas, to still operate ACT to the best of their ability. This would be in line with the new per diem proposals related to fidelity levels. CommentID: 97258	individuals as those who are eligible to serve as the team leader: • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness. The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the co-occurring disorder specialist. • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and

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							who is registered with the Virginia Board of Counseling; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10. The ACT regulations were developed to generally reflect a score of three (low fidelity) on the Tool for the Measurement of Assertive Community Treatment. Thus, regulations are intended to serve a minimally acceptable standard of practice and do not reflect the degree to which elements can or should be implemented to achieve base or high-fidelity status
9	Theresa Pritchard,	Colonial Behavioral Health	2/25/21	11:47 am	**ACT changes**	Requiring the team to be the first line crisis evaluator is going to result in potential staff turnover. I would recommend allowing teams to triage with Emergency Services for crisis contacts. For staff requirements, we have some staff that are LMHP-E, but are not registered as a QMHP. I would recommend allowing LMHP-E staff to fill these positions in addition to QMHP. CommentID: 97260	The draft has been amended based on public comment to clarify ACT teams 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 draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the team leader:

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							• A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness. The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the co-occurring disorder specialist. • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling;

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							• A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10.
10	Jonina Moskowitz,	Virginia Beach Dept. of Human Services	2/25/21	3:18 pm	**ACT changes**	VB DHS has concerns regarding the addition of an expectation that ACT teams "shall be the first-line crisis evaluator and responder". Although ACT teams are expected to have staff members available for assistance in crises at all times, this on-call access is best suited to help with de-escalation and connection to crisis evaluators when de-escalation is unsuccessful. ACT staff are also available to Emergency Services pre-screeners to help coordinate care. Inclusions of a requirement for a first-line crisis evaluator blurs the boundary between two Licensed services – ACT and Emergency Services. Per state legislation, Emergency Services evaluations must be provided by Community Services Boards and those staff members must have specific training. Therefore, it falls beyond the purview of any ACT provider to assume this role. The current language of making crisis services directly available 24 hours a day sufficiently articulates that a high level of responsiveness is expected. Removal of the option to coordinate coverage via another crisis provider may make it	The draft has been amended based on public comment to clarify ACT teams 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 draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the team leader: • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and

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						challenging to provide this level of responsiveness is rural localities, ultimately having a negative impact on the availability of this service. In addition to the role-diffusion, there are concerns regarding the impact of additional requirements to members of ACT teams. Requirements to provide a higher level frequency and intensity of crisis services will contribute staffing shortages, both in the short-term (as staff members can only work a certain number of hours safety) and in the long-run (due to increased staff turnover), again detracting from the overall ability to provide this valuable service. We also advocate to have LMHP-Es specifically referenced as being able to provide ACT services. Although Residents in Psychology, Residents in Counseling, and Social Work Supervisees inherently meet the requirements of being a QMHP, omission of this qualification will result in increased, unnecessary financial and administrative burdens – applicants will need to register with their Licensing Board for their supervision *and* with the Board of Counseling as a QMHP-A; the Board of Counseling will have to process these duplicative applications. CommentID: 97262	who has three years of experience in the provision of mental health services to adults with serious mental illness; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness. The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the co-occurring disorder specialist. • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10.

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11	Leslie Sharp,	NRVCS	2/26/21	10:23 am	**ACT regulations**	Please consider allowing LMHP-Es and QMHP-Es., we are asking that any time an LMHP or QMHP is required, that Es are also eligible considering workforce shortages. Please consider allowing for a Nurse Practitioner be considered as eligible to provide psychiatric medication management services to the program instead of “Psychiatric Nurse Practitioner.” Psychiatric nurse practitioners are rare and result in variances being asked for with this credential. CommentID: 97263	The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the team leader: • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness. The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the co-occurring disorder specialist.

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							• A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10. It is not clinically appropriate to have non-psychiatric nurse practitioners in the role of psychiatric care provider, as the intent is to have someone tasked with providing psychiatric care.
12	Shenee McCray	RBHA	2/26/21	12:49 pm	**ACT draft regulations**	I recommend that the following revisions are made to draft regulations for ACT services: **1.** *The ACT team shall have 24-hour responsibility for directly responding to psychiatric crises...the team shall be the first-line crisis evaluator and responder for individuals served by the team.* **1) This regulation would force PACT teams to respond in person around the clock which would have a negative impact on staff retention; 2) ACT services are heavily based upon rapport with the individual. Having the ACT worker serve as the prescreener and evaluator**	The draft has been amended based on public comment to clarify ACT teams 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 draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the team leader: • A resident who is under the supervision of a licensed professional counselor in

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						will potentially impair relationships built with individuals served; 3) Many ACT team workers are not prescreeners and doing so would force clinicians to focus on crisis management as primary role on the team. **2. DMAS considers LMHP and LMHP-E to be equivalent in terms of allowances related to service provision. Please change language to allow LMHP and LMHP-E to be used interchangeably.** CommentID: 97265	accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness. The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the co-occurring disorder specialist. • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the

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							Virginia Board of Psychology in accordance with 18VAC125-20-10; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10.
13	Julia Campbell,	PCS CSB	2/26/21	4:51 pm	**ACT**	I agree with the comments as stated. I do think that QMHP-E and LMHP-E should be allowed in their respective capacity to provide client services. I am also in agreeance with removing the requirement of ACT being first line of response for Crisis. I believe most CSB's are providing this service thru Emergency Services and Prescreen processing, while implementing needed coordination of care to ensure client is taken care of. Our agency works very close with our Emergency Services Program to ensure client safety and to promote client's positive mental health. Please consider all (demographics, location of services, access of professionals to provide said services, etc) when final decision is made. Please also consider how client services/ outcome may be impacted by proposed changes. Please consider how proposed changes may have the potential to decrease availability of qualified providers to provide the said service. CommentID: 97267	The draft has been amended based on public comment to clarify ACT teams 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 draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the team leader: • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services

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							to adults with serious mental illness; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness. The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the co-occurring disorder specialist. • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10.
14	Daniel Rigsby	Henrico Area Mental Health & Developmental Services	3/1/21	2:49 pm	**Proposed ACT regulations**	Definition section:	The requirements related to ICT have been removed from the proposed stage draft. DMAS will no longer reimburse for ICT services beginning July 1, 2021 and the

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						" a team of medical, behavioral health , and rehabilitations professionals…." Comment—seems like we could just say a team of behavioral health professionals.. "to meet the needs of ~~an~~ individuals with severe and persistent… 1. "Provide person-centered services addressing the breadth of an individual's needs, helping ~~him~~ the individual achieve ~~his personal~~ identified goals." 2. "serve as the primary provider of all the behavioral health services that an individual ….. 10. "promote self-determination, respect for…, and engage peers in promoting recovery…. Comment—does this use of "peers" refer to the individual being served, Peer Recovery Specialists, other professionals…? <u>Treatment team and staffing plan:</u> 1d. QPPMH or QMHP-A—the language from the Department of Health Professions is "Registered Peer Recovery Specialist". It would be helpful to use the same language. 4b. Nurses—ACT nurses shall be full-time employees or contractors…. Comment: Does this exclude the use of permanent part-time nursing staff? The	Office of Licensing will be phasing out the ICT license in favor of the Small ACT Team service license to more closely align with the standards and practices of high-fidelity Assertive Community Treatment. The language related to program assistants has been amended to require one full-time or two part time program assistants. The signature of the team leader on the ISP would be sufficient. It is up to the discretion of the provider to determine the best way to document the psychiatric care provider's participation in the development and implementation of the ISP. The draft has been amended based on public comment to clarify ACT teams 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 language related to the aggregate average of contacts has been removed from the proposed stage draft. The requirements related to meetings have been amended to state ACT teams shall conduct daily organizational meetings Monday through Friday at least four days per 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

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						requirement that medium and large ACT teams can only hire full-time nurses limits flexibility in a very competitive job market for nurses. 4f. Program Assistant—"one full time…" Comment: Is this indicating that even a small ACT team would need a full-time program assistant? This standard is also very specific about job functions. In large boards some of these functions like "maintain accounts and budget records" are farmed out to other parts of the agency—not totally sure what "budget records" is referring to. 4g. Psychiatric Care Provider: "…The psychiatric care provider shall be a fully integrated team member who attends team meetings and actively participates in developing and implementing each ISP." Comment: regulations like this often prompt licensure specialists to ask how we can document the psychiatric care provider's development and implementation of each ISP? Would this require the Psychiatric Care Provider's signature on the ISP? 5. Staff to individual ratios for ACT Teams: There is labeling error in this section—it goes from a,b,c, to B, C, D D-E. 5D states that an ACT team may arrange coverage through another crisis	service contacts that are identified as needed. DBHDS believes that the language requiring services to be directed exclusively to the well-being and benefit of the individual is clinically appropriate and would not be subjective as long as the individual was consulted on their own individual preferences.

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						services provider. 5E 1-2 indicates that the “team shall be available to individuals in crisis 24 hours per day…” and “the team shall be the first-line crisis evaluator….” Section D and E seem to be in conflict with each other. Contacts: Section A. –It is unclear how the aggregate average will be determined. Will this be based on one week randomly selected by the licensure specialist, a span of time, etc? This appears to be more of a fidelity measure than a licensure regulation. ICT and ACT service daily operation and progress notes: Section A indicates that ICT and ACT teams “shall conduct daily organizational meetings Monday through Friday…” Section 5B indicates that teams “shall meet daily Monday through Friday or at least four days per week…” These two sections are in conflict with one another. Service requirements 11. “which shall be directed exclusively to the well-being and benefit of the individual…” This requirement seems unnecessary and very subjective. For example, if we are teaching parents appropriate limit setting skills, the individual being served may not think this is beneficial.	

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						CommentID: 97272	
15	Michele Ebright,	Crossroads CSB	3/3/21	9:33 am	**ACT Regulations-Draft**	I agree with all of the comments posted. In particular, not allowing for QMHP-E's and other licensed eligible clinicians to work in these programs. Workforce shortage issues are real and exist across programs. "Growing our own" is one way many CSB's have successfully mitigated this problem. I also strongly agree that utilizing staff from these intensive services to provide on site responses to crises 24/7 will place undue burden on these staff, which may well result in high turnover and the destabilization of the team approch. CommentID: 97279	The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the team leader: • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness. The draft has been amended based on public comment to include the following individuals as those who are eligible to

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							serve as the co-occurring disorder specialist. • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10.
16	Fairfax-Falls Church CSB	Fairfax-Falls Church CSB	3/3/21	3:29 pm	**Amendments to align with enhanced behavioral health services -ACT Regulations-Draft**	**Fairfax-Falls Church CSB agrees and supports all other comments to the date.** **12VAC35-105-1370 Treatment team and staffing plan.** 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	The requirements related to ICT have been removed from the proposed stage draft. DMAS will no longer reimburse for ICT services beginning July 1, 2021 and the Office of Licensing will be phasing out the ICT license in favor of the Small ACT Team service license to more closely align with the standards and practices of high-fidelity Assertive Community Treatment.

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						in understanding and supporting individuals' recovery goals. d. ~~Peer~~ ICT peer specialists - one or more full-time equivalent QPPMH or QMHP-A who is or has been a recipient of mental health services for severe and persistent mental illness. 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. These regulations require dual credentials as a peer and paraprofessional/professional. The state's Registered Peer Recovery Specialist (RPRS) Credential is higher than the CPRS. **Comments:** **These regulations require dual credentials as a peer and paraprofessional/professional. The state's Registered Peer Recovery Specialist (RPRS) Credential is higher than the CPRS.** **Recommend removing the QPPMH/QMHP, and CPRS requirements. Replace with the RPRS credential only. Recent legislation making its way through the general assembly requires RPRS for peers on mobile crisis teams. It would be inconsistent for PACT teams to require more peer credentials than**	

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						those required for peers on Mobile Crisis teams. **In addition, there is an inherent conflict in clinical/peer dual credentialing. One of the defining features of peer support services is they are "non-clinical." Requiring a clinical credential for a peer specialist implies they are providing clinical rehabilitative services. In addition, due to workforce issues very few peer specialists can obtain both credentials. And, those who can will generally choose to work in a clinical role with higher pay.** CommentID: 97282	
17	Loudoun MHSADS	Loudoun MHSADS	3/3/21	10:41 pm	**ACT Regulations**	Loudoun MHSADS agrees with and supports all comments to date. Definitions: Definition for ACT describes the provider being the primary provider for ALL services. As ACT is not the provider for all medical (e.g., eye, dental, physical) we recommend removing "all" from the definition. Definition for ICT no longer is consistent with new criteria within the regulations. 12VAC35-105-1360 Admission and discharge criteria Will the admission criteria be consistent with DMAS criteria?	The term "services" is defined in the Licensing Regulations as "(i) planned individualized interventions intended to reduce or ameliorate mental illness, developmental disabilities, or substance abuse (substance use disorders) through care, treatment, training, habilitation, or other supports that are delivered by a provider to individuals with mental illness, developmental disabilities, or substance abuse (substance use disorders). Services include outpatient services, intensive in-home services, opioid treatment services, inpatient psychiatric hospitalization, community gero-psychiatric residential services, assertive community treatment and other clinical services; day support, day treatment, partial

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						Discharge There are also times when the individual disengages and ICT or ACT staff do not know where the individual is, so revising the ISP is n/a if the person is not located. What is the evidence-based decision for two years? This seems paternalistic in the absence of data indicating two years as the recovery mark. Plus if you add #5 under the heading in B ("discharged for failure to comply or other expectations"), it seems that sustained recovery is considered a failure. Recommend either remove five or change the header in B. 12VAC35-105-1370 Treatment team and staffing plan Recommend inserting some language allowing CSBs to hire the most qualified applicant for each position even if the qualifications fall short of licensure requirements if no applicants meet the qualifications set forth in licensure. There is a shortage of professionals especially with this many years of required experience. For ICT and ACT staffing ratios: we cannot discharge individuals for two years of sustained recovery with minimal contacts, or inpatient treatment for over a year, or incarceration for a year (which means we would have someone being counted as a client who is not receiving the intensive levels of service). Recommend language that allows for additional individuals to be enrolled per individual in monitoring or transitioning status.	hospitalization, psychosocial rehabilitation, and habilitation services; case management services; and supportive residential, special school, halfway house, in-home services, crisis stabilization, and other residential services; and (ii) planned individualized interventions intended to reduce or ameliorate the effects of brain injury through care, treatment, or other supports provided in residential services for persons with brain injury. Therefore, when used in the definition of the term ACT, the term "service" is as defined and would not include all medical care. The discharge criteria related to two years has been amended in the proposed stage draft to state: The individual and team determine that ACT services are no longer needed based on the attainment of goals as identified in the person centered plan and a less intensive level of care would adequately address current goals. The requirements related to ICT have been removed from the proposed stage draft. DMAS will no longer reimburse for ICT services beginning July 1, 2021 and the Office of Licensing will be phasing out the ICT license in favor of the Small ACT Team service license to more closely align with the standards and practices of high-fidelity Assertive Community Treatment. The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the team leader:

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						Peer Specialists who are certified or become certified within a year of employment as a Peer Specialist. REcommend removing reference to QPPMH or QMHP. Keep this consistent with ACT Peer Specialist. Also, remove the description of what type of mental illness is required for the peer recipient of services for "Severe and Persistent" mental illness. Recommend LMHP-E anywhere it says LMHP Recommend ICT and ACT allow a physician and/or advance practice nurse working within the scope of the medical training and license to provide psychiatric medication services. "2. The team shall be the first-line crisis evaluator and responder for individuals served by the team if clinically appropriate." It would not make sense clinically to make an individual in need of a TDO talk to an ACT therapist first and then repeat the whole evaluation with Emergency Services. CommentID: 97283	• A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling with three years of experience in the provision of mental health services to adults with serious mental illness; • A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10 and who has three years of experience in the provision of mental health services to adults with serious mental illness. The draft has been amended based on public comment to include the following individuals as those who are eligible to serve as the co-occurring disorder specialist. • A resident who is under the supervision of a licensed professional counselor in accordance with 18VAC115-20-10 and who is registered with the Virginia Board of Counseling;

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							• A resident in psychology who is under supervision of a licensed clinical psychologist and is registered with the Virginia Board of Psychology in accordance with 18VAC125-20-10; and • A supervisee in social work who is under the supervision of a licensed clinical social worker and who is registered with the Virginia Board of Social Work in accordance with 18VAC140-20-10.