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October 10, 2006

Leslie Anderson, Director  
Office of Licensure  
Department of Mental Health, Mental Retardation  
and Substance Abuse Services  
PO Box 1797  
Richmond, VA 23219

Dear Ms. Anderson:

Thank you for the opportunity to provide comment on the current *Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation, and Substance Abuse Services* (Chapter 105). The Virginia Board for People with Disabilities is an important partner in policy and planning for effective and meaningful systems change and is representative of many, but certainly not all, constituent groups involved in and profoundly affected by systems change decisions.

In submitting these formal comments, the Board is fulfilling state and federal legislative mandates as well as the agency's mission and strategic vision for people with disabilities. Under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000 (P.L. 106-402, the DD Act) the Board is directed to "support and conduct activities to eliminate barriers to access and use of community services by individuals with developmental disabilities, [and to] enhance systems design and redesign...." (Sec.125).

Under the Virginians with Disabilities Act (Code of Virginia, Title 51.5, the VDA) the Board is directed "to advise the Secretary of Health and Human Resources and Governor on issues and problems of interest to persons with disabilities" (§51.5-33). The Board's mission statement is

"to improve the lives of people with disabilities by providing a voice for their concerns" and finally, its strategic vision includes a strong commitment to community inclusion to ensure that individuals with disabilities," be given equal opportunity to achieve independence, contribute to society, and enjoy full inclusion into educational, economic, political, social, and cultural life of the community".

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The general comments that we are providing on the current regulations support many of the recommendations found in the Department's *Integrated Strategic Plan*, particularly those from the Mental Retardation Special Populations Workgroup (now The Advisory Council on Intellectual Disabilities).

Once again, we appreciate the opportunity for input.

Sincerely,

*Heidi Lawyer*  
Heidi Lawyer

*Lisbet Ward*  
Lisbet Ward

Cc: The Honorable Marilyn Tavenner  
Secretary of Health and Human Resources

Gail Jaspen  
Deputy Secretary of Health and Human Resources

James Reinhard, M.D., Commissioner  
Dept. of Mental Health, Mental Retardation, & Substance Abuse Services

*Providing a VOICE for Virginians with Disabilities*

**Chapter 105: *Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation, and Substance Abuse Services***

**General Comments:**

The Board strongly supports changes in provider licensure that will help shape the system consistent with both the state's *Interagency Integrated Strategic Plan* and the DMHMRSAS report, *Envisioning the Possibilities: Integrated Strategic Plan*. Key elements for the provider system identified in each plan include:

- “Services that promote individual and family choice, self-determination, community integration, and independent living;
- A wide range of services and supports that address the diverse need of Virginians with disabilities; and
- Oversight to monitor program performance and measure consumer outcomes ...” .

DMHMRSAS State Board Policy 1036(SYS)05-3 further emphasizes the vision of: “a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health and the highest possible level of consumer participation in all aspects of community life including work, school, family, and other meaningful relationships”.

The Board therefore recommends that significant revisions be made to current licensure regulations for providers in order to achieve the aforementioned goals:

1. Reduce the maximum number of beds for new group home providers and ICF-MRs to no more than six (6) at any one location. This reflects recommendations made by the DMHMRSAS Advisory Council on Intellectual Disabilities.
2. Develop or increase expectations for the quality of services, to include (but not be limited to):
  - Consumer-based outcomes;
  - Quality assurance programs; and
  - Mandated training for owners, managers, and staff.
3. Promote community integration and participation as well as person centered planning for consumers.
4. Strengthen oversight to better ensure consumer health and safety.
5. Add or revise Definitions for consistency with those found in state code regarding Medicaid Waivers. Specific definitions, as promulgated by the Department of Medical Assistance Services (DMAS), include, but are not limited to: 12VAC30-120-140, 12VAC30-120-211, 12VAC30-120-450, 12VAC30-120-700, and 12VAC30-120-900.
6. Mandate Emergency Preparedness Plans as part of the application.

The Board commends DMHMRSAS for inclusion of persons with brain injury as a service population throughout the licensure regulations.

Specific recommended changes to the regulations are provided below by regulatory section.

## **Article 2. Definitions**

### **12VAC35-105-20**

**Comments:** Of concern to the Board are the definitions for *Behavior Management* and for *Behavioral Treatment or positive behavior support (PBS) program*. These definitions should be in sync with best practices and with person-centered values. First, Behavior Management as defined is overly broad and is unclear. Second, Behavioral Treatment and PBS are viewed as being synonymous. The preferred terminology is Positive Behavioral Support; and the definition should be what is used in the PBS training.

*Revise* definition of Behavior Management to reflect best practices, e.g. as defined by Applied Behavioral Analysis.

*Delete* definition for Behavioral Treatment.

*Revise* Definition of Case Management to be more consistent with Medicaid Waiver definition (12VAC30-120-211)

"Case management service" means: assessing needs and planning services; directly assisting individuals ~~and~~ or their families to locate, access, and obtain services and supports that are essential to meeting their psycho-social and healthcare ~~basic~~ basic needs as identified in their individualized service plan; (ISP); coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making collateral contacts to promote the implementation of the ISP and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education or counseling that guides the individual or their family in achieving the goals of the ISP. Services to be accessed and planned may include: ~~which not only accessing needed~~ mental health, mental retardation and substance abuse services; but also services and supports that address medical, nutritional, social, educational, vocational, employment, housing, economic assistance, transportation, leisure and recreational, legal, and advocacy ~~services and supports that the individual needs. to function in a community setting.~~

Excluded as Case Management Services are activities pertaining to: maintenance of ~~Maintaining~~ waiting lists for services, ~~case management tracking~~ and periodically contacting individuals for the purpose of determining the potential need for services ~~shall be considered screening and referral and not admission into licensed case management.~~

**Comments:** The Board recommends revisions to the label and definition of "Community intermediate care facility/mental retardation (ICF/MR)" to parallel the VAC. An ICF/MR is not a service; it is a facility that provides certain services. An ICF is an ICF, regardless of location.

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"Community-based intermediate care facility/mental retardation (ICF/MR)" means a service facility or distinct part of a facility licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services but not operated by the Department that serve in which care is provided to individuals who have mental retardation or related conditions or a developmental disability due to brain injury who are not in need of nursing care, but who need more intensive training and supervision than may be available in an assisted living facility or group home. Such facilities must comply with Title XIX of the Social Security Act and federal certification regulations, must provide health or rehabilitative services, and must provide active treatment to individuals receiving services. toward the achievement of a more independent level of functioning or an improved quality of life. These facilities must address the total needs of the residents, which include physical, intellectual, social, emotional, and habilitation, and must provide active treatment.

*Add Definition for Positive Behavioral Support (PBS). Using language from the Association for PBS ([www.abps.org/PBSTopics.htm](http://www.abps.org/PBSTopics.htm)), one definition would be:*

"Positive Behavioral Support (PBS)" means a set of research-based strategies used to decrease problem or challenging behaviors (such as self-injury, aggression, property destruction, pica, and intrusive behaviors) by teaching new skills and making changes in a person's environment and to increase the social, personal, and professional quality of life for the individual and others. PBS involves changing situations and events that people with problem or challenging behaviors in order to reduce the likelihood that problem behaviors will occur.

**Comments:** The Board recommends that the definition of QMRP be changed to address the reality that some persons who do not have a bachelor's degree in the human services may have the experience and knowledge needed to provide quality services.

"Qualified Mental Retardation Professional (QMRP) means:

- A. A person who possesses at least one year of documented and verified experience working directly with persons who have mental retardation or other developmental disabilities; and is one of the following:
  - i. a doctor of medicine or osteopathy; or
  - ii. a registered nurse; or
  - iii. a person who holds at least a bachelors degree in a human services field including, but not limited to, sociology, special education, psychology, social work, or rehabilitation counseling. Or
  
- B. A person who holds at least a bachelors degree in a non-human services field, and who has at least three (3) years of documented and verified experience working directly with persons who have mental retardation or other developmental disabilities in the same capacity in which they are currently seeking employment.

**Comments:** Add the following definitions that are consistent with the VAC pertaining to Medicaid Home and Community Based Waivers.

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“Consumer Directed Services” means all services for which the individual or their family (if a minor) or legal guardian is responsible for hiring, training, supervising, and firing of the staff.

"Individual" or “individual receiving services” means the person receiving care, treatment or other services from a provider licensed under this chapter whether that person is referred to as a patient, client, resident, student, individual, recipient, family member, relative or other term. the services or evaluations established in these regulations. When the term is used, the requirement applies to every individual receiving services of the provider.

"Day support service" means the provision of individualized planned activities, supports, training, supervision, and transportation to individuals with mental retardation or related conditions to improve functioning or maintain an optimal level of functioning. Services may enhance the following skills: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, social, medication management, and transportation. Services provide opportunities for peer interaction and community integration. Services may be provided in a facility (center based) or provided out in the community (non-center based). Services are provided for two or more consecutive hours per day. The term "day support service" does not include services in which the primary function is to provide extended sheltered or competitive employment, supported or transitional employment services, general education services, general recreational services, or outpatient services licensed pursuant to this chapter training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his maximum functional level.

"Legal guardian" means a person who has been legally invested with the authority and charged with the duty to take care of, manage the property of, and protect the rights of a recipient who has been declared by the circuit court to be incapacitated and incapable of administering his own affairs. The powers and duties of the guardian are defined by the court and are limited to matters within the areas where the recipient has been determined to be incapacitated.

"Mental retardation" means, as defined by the American Association on Mental Retardation (AAMR), being substantially limited in present functioning as characterized by significantly sub average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests itself before age 18. A diagnosis of mental retardation is made if the person's intellectual functioning level is approximately 70 to 75 or below, as diagnosed by a licensed clinical professional; and there are related limitations in two or more applicable adaptive skill areas; and the age of onset is 18 or below. If a valid IQ score is not possible, significantly sub average intellectual capabilities means a level of performance that is less than that observed in the vast majority of persons of comparable background. In order to be valid, the assessment of the intellectual performance must be free of errors caused by motor, sensory, emotional, language, or cultural factors.

“Person-Centered Planning” means a process-oriented approach which focuses planning on the needs of the individual with a disability, which puts the individual in charge of defining the direction for their lives, and does not base planning on system needs or services that may or may not be available to them.

## Part II. Licensing Process

### 12 VAC 35-105-30. Licenses. (A.)

**Comment:** In general, the Board recommends utilizing more person-centered language.

A. Licenses are issued to providers who offer services to individuals who have one or a combination of the following disabilities~~sy groups: persons with mental illness, persons with mental retardation, persons with substance addiction or abuse problems, persons with related conditions served under the IFDDS Waiver, or persons with brain injury served under the Brain Injury Waiver or in a residential service.~~

**Comments:** In section C, the phrase, “conditions for each service”, is unclear. The desired information needs to be more specific.

C. Each application for license shall include: ~~A license addendum~~ a description of ~~describes~~ the services licensed; the specialized population(s) served, to include but not be limited to types of disabilities and age ranges; specific locations where services are provided or organized and the terms; and conditions for each service offered by a licensed provider. For residential and inpatient services, the license shall identify ~~identifies~~ the number of beds each location may serve. This information shall be a mandatory attachment to the application form.

*Add section (D):* To ensure informed choice of the individual, the addendum described in “C” above shall include a specific description of how the information “C” above shall be provided to individuals and, as appropriate, family members who are considering residential services and shall contain an assurance that the information provided to individuals and families shall be current as to the specific populations served at the time the individual and/or family is seeking services.

### 12VAC35-105-40. Application requirements.

*Add to section A:* (4). An Emergency/Disaster Preparedness Plan.

C. *Change to read:* The provider shall confirm intent to renew the license at least ninety (90) days prior to expiration of the license. ~~and notify the Department in advance of any changes in services or in location.~~

**Comments:** Add a new section (D) on Quality Assurance. The Commonwealth should add a

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new application requirement that mandates a Quality Assurance (QA) plan specific to each residential service site and mandates documentation of staff training on the QA plan. Providers who are currently licensed should be required to develop a plan and have it at each site.

Add D. The provider shall provide documentation of a QA plan specific to each residential site and a plan to provide training and orientation to the QA plan for staff and residents.

**12VAC35-105-50. Issuance of Licenses.** Sections B, C, and D.

**Comments:** The Board recommends that operational definitions be developed of both Conditional and Provisional Licenses, to include a clear rationale for renewals. As written, for example, it is not clear what areas of non-compliance are allowed under a conditional license.

A major concern of the Board is that a provisional license (section C) is granted for 6 months, and then renewable for another 6 months, when the provider or service “has violations of human rights or licensing regulations that *pose a threat to the health or safety of individuals* [italics added for emphasis] being served, has *multiple violations* of human rights or licensing regulations, or has failed to comply with a previous corrective action plan.” In order to better protect persons with disabilities, a hierarchy of non-compliance with regulations should be created so that a shorter time period (3 months with no renewal or renewal of only 3 additional months) would be given under the provisional license. This section then would need to be re-written to reflect the severity of non-compliance.

**12VAC35-105-70. Onsite Reviews.**

**Comments:** The Board shares with DMHMRSAS and stakeholders an ongoing concern about the health and safety of persons in residential programs. The Board therefore recommends that section A specify a minimum number of onsite reviews for each program or service operated by a provider, not just new programs/services and not just single locations. Currently, if a provider operates multiple programs and services, it is possible that only one program at one location will be visited. We recognize that the Office of Licensure will require significant staff additions and funding in order to effectively monitor programs, and that such positions must be approved by the legislature. However, protection of those with disabilities should be a priority for the Commonwealth. The Board also feels strongly that should funds be allocated by the General Assembly for this purpose, such funds would not take away from funding of additional community based services for persons not currently served under the current system. Both priorities are critical.

Change section B to read: The department shall conduct ~~unannounced onsite reviews of licensed providers and each of its services at any time and at least annually~~ on site reviews at least twice yearly of all new programs/locations operated by each provider in order to determine compliance with this chapter. The on site reviews shall be a combination of announced and unannounced visits and must include at least one annual unannounced visit. The ~~annual~~ unannounced onsite reviews shall be focused on

preventing specific risks to individuals, including an evaluation of the physical facilities in which the services are provided and contact with individual residents.

#### **12VAC 35-105-80. Complaint Investigations.**

*Change to read:* The department shall investigate all complaints regarding potential violations of licensing regulations. Complaint investigations may be ~~based on~~ initiated as a result of findings of onsite reviews, a review of records, a review of provider reports, letters, electronic mail or telephone interviews and may include anonymous complaints.

### **PART III: Administrative Services**

#### **12 VAC 35-105-170. Corrective Action Plan.**

*Add 4.*

- C. The corrective action plan shall include a :
1. Description of the corrective actions to be taken;
  2. Date of completion for each action; ~~and~~
  3. Signature of the person responsible for the service; and
  4. Assurance that the correction action plan is in compliance with all state and federal regulations and statutes.
- E. A corrective action plan shall be approved by the department. The department shall review and ensure that the corrective action plan complies with all state and federal statutes and regulations including but not limited to those relating to consumers choice. The provider has an additional 10 business days to submit a revised corrective action plan after receiving a notice that the plan submitted has not been approved.:

#### **12VAC35-105-180. Notification of Changes.**

**Comments:** The Board recommends that sub-sections A and D be revised as follows:

*Change section A to read:* A provider shall notify the department in writing at least ninety (90) days prior to implementing changes that affect:

*Change section D to read:* A provider shall notify the department in writing of its intent to discontinue services ~~30~~ at least ninety (90) days prior to the cessation of services. This notification shall include a plan to ensure the continuing operation of the service in compliance with all state and federal statutes and regulations during the transition period.

**Comments:** Individuals and their family or guardian should have additional time than is currently available in which to examine their service options and to decide what services will best meet their needs. The month between DMHMRSAS and consumer notification is to allow for administrative system planning time.

*Change section E to read:* All individuals receiving services shall be notified of the provider's intent to cease services in writing ~~30 days~~ at least 60 days prior to the cessation of services. ...

### **Article 3. Physical Environment of Residential/Inpatient Service Locations**

#### **12VAC35-105-330. Beds (B)**

**Comments:** The Board recommends that all community-based ICF-MR facilities licensed after January 1, 2008 be limited to no more than 6 beds at any one location. The values and principles recently identified by the DMHMRSAS Advisory Committee on Intellectual Disabilities clearly emphasized creation of small scale, home-like environments. Smaller residences are consistent with the 30-year national trend of serving persons with mental retardation.

*Change section B to read:* A community based Intermediate Care Facility for the Mentally Retarded (ICF/MR) ~~may~~ shall not have more than ~~20~~ 6 beds at any one location. This applies to all new applications for ICF/MR services after ~~September 19, 2002~~. January 1, 2008.

### **Article 4. Human Resources**

#### **12VAC 35-105-450. Employee training and development.**

**Comments:** Higher expectations for staff training are needed so that "best practices" for serving a consumer population, whenever applicable, will be implemented. Programmatic expectations and specific staff training, to include certification and endorsements, to address the needs of the specialized populations served should be developed. The Board recommends changing this section to include training expectations that promote best practices for each specialized population.

Providers should have direct care staff who, by verifiable documentation, have the particular skills and knowledge needed to best serve the individual, thus linking staff training and services to quality assurance. Residential and other supports should be based on: the level of needs of the individuals served, the intensity of supports needed, and "best practices".

*Change current section to be the broad expectation for all providers.* The provider shall provide training and development opportunities for employees to enable them to perform the responsibilities of their job. ~~The policy must address retraining on medication administration, behavior management, and emergency preparedness.~~ Policies and procedures for staff development shall be developed and implemented; and a copy given to all staff. Participation in training and development, to include copies of certificates, shall be documented in each the employee's personnel record.

All employees, administrators, and owners must receive basic training on the following topics:

1. Person centered planning,

2. Positive behavior supports,
3. Emergency preparedness,
4. State Human Rights Regulations,
5. Medication administration, for qualified employees
6. Community integration, and
7. Principles of self-determination; and

## **PART IV: Services and Supports**

### **Article 1. Service Description and Staffing**

#### **12 VAC 35-105-610. Community participation.**

**Comment:** The Board believes that opportunities for community integration should not be limited to those receiving the specified service below but understands that this opportunity would not be available to all populations covered by the regulations such as those residing in correctional facilities.

*Change to read:* Opportunities shall be provided on an ongoing basis for individuals receiving services to participate in integrated community activities that include peer group interactions with persons with and without disabilities. This regulation applies to all services covered by this regulation except where otherwise prohibited by statute or regulation.  
~~residential, day support and day treatment services.~~

#### **12 VAC 35-105-620. Monitoring and evaluating service quality.**

A. The provider shall have an overall mechanism Quality Assurance (QA) Plan to monitor and evaluate service quality and effectiveness on a systematic and ongoing basis as well as a QA plan for each provider site/location. The provider shall implement improvements, when indicated; and shall document monitoring, evaluation, and implementation actions.

### **Article 2. Screening, Admission, Assessment, Service Planning and Orientation**

#### **12VAC35-105-680. Progress Notes or Other Documentation.**

**Comments:** The Board is concerned that expectations are weak regarding the importance of coordination and follow-up for medical or other therapeutic services necessary to consumers as identified in the person's Individualized Service Plan (ISP). We recommend that the regulations be revised to include specific provider expectations to record in the progress notes or other documentation: when appointments are scheduled, the date of the appointment, whether or not the appointment was kept, and if not kept, the reasons and the provider's plans to address them.

### **Article 4. Medical Management**

**12 VAC 35-105-720. Health care policy.**

**Comments:** The provider should be required to document all scheduled appointments and whether or not the appointment was kept. If not, the provider should identify the reasons as well as corrective action, when indicated, to prevent future missed appointments.

- A. The Provider shall develop and implement a written policy appropriate to the scope and level of service that addresses provision of adequate medical care. The provider shall describe how:

Add 8. The provider documents scheduled appointments, missed appointments, the reason for missed appointments and corrective action.

**Article 5. Medication Management Services**

**12 VAC 35-105-770. Medication management.**

**Comments:** All provider policies and procedures on medication management should be written and implemented in compliance with all applicable state and federal regulations including requirements for choice. For example, consumers should not be limited to obtaining medication from a specific pharmacy of the provider's choice.

- A. The provider shall develop and implement written policies addressing:

Add 7. Consumer choice with respect to medication management issues as allowed by state and federal statute and regulation.

**Article 6. Behavioral Management Supports**

**12 VAC 35-105-800. Policies and procedures on behavior support ~~management techniques~~.**

**Comment.** The term behavior management should be eliminated and replaced with language that emanates from research and best practice. Behavior should be recognized as communicative and serving a function for the individual. This section 35-105-800 (A-D) and section 12 VAC 35-105-810 should be completely revised to address and support best practice in behavioral intervention and specifically the concepts of positive behavior supports as defined earlier.

*Change section E. to read:* Injuries requiring medical attention which result from, or occurring during, the implementation of behavioral interventions ~~management techniques~~ shall be recorded in the clinical record. Injuries shall be and reported within 4 hours to: (i.) the employee or contractor responsible for the overall coordination of services; and (ii.) the DMHMRSAS Office of Licensure.

**12 VAC 35-105-810. ~~Behavior Treatment Plan.~~ Behavioral Intervention Plan (or Positive Behavior Support Plan)**

**Comments:** See comment above for section 12 VAC 35-105-800. This section should be revised to address and support best practice in behavioral intervention and specifically the concepts of positive behavior supports as defined earlier. The term Behavior Treatment Plan should be eliminated

**PART VI: Additional Requirements for Selected Services**

**Article 1. Opioid Treatment Services**

**12 VAC 35-105-990. Take-home medication**

**Comments:** The Board is concerned about the requirement of “a level of current lifestyle stability” (items A 3 and 4) as an apparent prerequisite for take-home medications. This appears to be punitive in nature, discriminatory, and unrealistic. Significant behavior (A.3) problems may pertain to inadequate doses of medication or to an ineffective medication. If this item is intended to address a clinical issue, then such should be very clearly identified. In addition this regulation appears to eliminate the opportunity for a parent, spouse or legal guardian to take home medication for the individual.

In regards to item A.4, it appears that anyone who has been involved in criminal activity cannot take home medications, regardless of their progress in recovery. Many substance abusers and addicts have criminal charges or convictions. This is often the motivator for treatment. As this section is currently written, these individuals could be denied opioid treatment.

- A. Prior to dispensing regularly scheduled take-home medication, the provider shall ensure the individual demonstrates a level of current lifestyle stability as evidenced by the following:
1. Regular clinic attendance;
  2. Absence of recent alcohol abuse and other illicit drug use;
  3. ~~Absence of significant behavior problems; and~~
  4. ~~Absence of recent criminal activities, charges or convictions.~~

Add B. A parent, spouse or legal guardians of an individual shall be permitted to take home medication for the individual over whom they have guardianship.

Change current B to C. The provider shall educate the individual and, as applicable, the parent, spouse or guardian on the safe transportation and storage of take home medication.

**12 VAC 35-105-1240. Service requirements for providers of case management services.**

*Change B. 7 to read:* Monitoring service delivery through:

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- a.) face-to-face contacts with individuals receiving services at least once a month to assess service satisfaction, community integration opportunities, and appropriateness of the current level of care and service; and
- b.) a combination of site and home visits or meetings with service providers at least once a month and periodic site and home visits to assess the quality of care. , and satisfaction of the individual. The site and home visits shall include both announced and unannounced visits and shall not be limited to day time hours.

**Article 7. Intensive Community Treatment and Program of Assertive Community Treatment Services.**

**12 VAC 35-105-1360. Admission and discharge criteria.**

**Comments:** The Board is concerned about the exclusion of persons with mental retardation and challenging behaviors, and by inference those with brain injury, from receiving Intensive Community Treatment (ICT) and Program of Assertive Community Treatment (PACT). The DMHMRSAS Advisory Council on Intellectual Disabilities and the Integrated Strategic Plan both have emphasized the need to develop intensive service models, such as ICT and PACT, for these populations as an essential support to help them remain in their communities and to avoid institutionalization. The Board recommends that those with mental retardation and/ related developmental disabilities and brain injury be added to those eligible for ICT and PACT services.