DBHDS – Frequently Asked Questions

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Q 1.1: What do I do if a resident in our group home becomes symptomatic? What steps should be taken for residents and staff?

A 1.1: Symptoms of COVID-19 include, fever, cough, and shortness of breath. If a resident in your group home becomes symptomatic you should contact the individual's health care provider for guidance. In addition, you should follow the follow CDC guidelines for household preparedness to help reduce the likelihood of others becoming infected.

Source:

https://www.cdc.gov/coronavirus/2019-ncov/community/home/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcommunity%2Fget-your-household-ready-for-COVID-19.html

Q 1.2: How should programs serving individuals with intellectual or developmental disabilities take social distancing prevention measures with regard to community engagement and face to face requirements?

A 1.2: The program should take appropriate precautions to assure the health and safety of all the individuals that they support including avoiding high risk situations for exposure to any communicable disease. It is equally important for the program to document the rationale for the change in schedule or service and put in place alternative activities to keep individuals engaged.

When providers determine a need to reduce any community integration activities, providers should ensure the services record clearly reflects the following [12VAC35-115-60]:

- The reasons for limiting or suspending community activities
- Alternative activities offered/provided and
- The anticipated date for resumed normal community activities

When limiting interactions with the community, all possible practical steps should be taken to avoid negative ramifications for the individual. Such steps include, for example, direct communication with individuals' employers to explain reasons for missing work.

Q 1.3: What guidance is there around how licensed providers may restrict visitors to mitigate risk around the spread of COVID-19?

A 1.3: While providers shall not limit or restrict the rights of individuals more than is needed to maintain a safe and orderly environment, based on a temporary waiver to the Regulations by the Commissioner, a provider that is going to limit visitation for individuals in the program, shall ensure the following:

- Each individual and his authorized representative (if applicable) must receive a copy of revised visitation policy,
- The information should include a clear explanation about the change in visitation and information about when the change will be discontinued; and
- The change to visitation shall be posted in a summary form in all common areas (12VAC35-115-100).

No further action is required; however, consult with the Regional Advocate if there are questions.

Q 1.4: If we need to separate or quarantine an individual that may be sick, how do we do so while remaining in compliance with human rights regulations?

Technically, isolation meets the definition of "seclusion" in the human rights regulations. Thus, if a provider isolates an individual, the requirements for seclusion contained in the regulations would apply. Based on a temporary waiver to the regulations by the Commissioner, if a provider is going to isolate an individual who has COVID-19, is suspected to have COVID-19, or has been exposed to someone with COVID-19, the provider should:

- Explain the process to the individual/AR if applicable
- Document a conversation with the qualified healthcare professional recommending isolation,
- Indicate the symptoms or circumstances that warrant isolation,
- Notify DBHDS via email to the Regional Advocate and,
- Comply with internal emergency/infectious disease policies.

If the isolation lasts longer than 7 days the provider must document the need for the restriction in the individual's services record. Any individual/AR who believes his or her rights have been violated can make a complaint directly with the provider or through the advocate.

You may also review information from the CDC:

- Preventing the Spread of Coronavirus in Homes and Residential Communities
- What To Do IF You Are Sick
- Caring for Someone Who is Sick

Q 2.1: What precautions can I take as a DBHDS licensed providers to prevent COVID-19?

A 2.1: Please review guidance from the Office of Licensing here.

In addition, if you have not implemented or fully implemented tools and guidance related to screening, visitors, healthcare staff expectations, the Massachusetts General Hospital Novel Coronavirus Toolkit may be a helpful starting point. The Centers for Medicare and Medicaid Services (CMS) has also issued guidance for infection control in nursing facilities that may provide useful information.

Sources:

http://www.dbhds.virginia.gov/assets/doc/QMD/OL/03.05.2020-coronavirus-memo.pdf

https://www.massgeneral.org/assets/MGH/pdf/disaster-medicine/2019-Novel-Coronavirus-(2019-nCoV)-Toolkit-version-1.29.2020.pdf

https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

Q 2.2: Can we ask new or current employees about their recent travel?

A 2.2: Local agencies should continue to follow human resources policies set forth by respective human resource departments, and those policies should be consistent with the "*The U.S. Equal Employment Opportunity Commission; Pandemic Preparedness in the workplace and the Americans with Disabilities Act.*"

Q 2.3: When an employee returns from travel during a pandemic, must an employer wait until the employee develops flu-like symptoms to ask questions about exposure during the trip?

A 2.3: No. These would not be disability-related inquiries. If the CDC or state or local public health officials recommend that people who visit specified locations remain at home for several days until it is clear they do not have pandemic influenza symptoms, an employer may ask whether employees are returning from these locations, even if the travel was personal.

Q 2.4: Are there ADA-compliant ways for employers to identify which employees are more likely to be unavailable for work in the event of a pandemic?

A 2.4: Yes. Employers may make inquiries that are not disability-related. An inquiry is not disability-related if it is designed to identify potential non-medical reasons for absence during a pandemic (e.g., curtailed public transportation) on an equal footing with medical reasons (e.g., chronic illnesses that increase the risk of complications). The inquiry should be structured so

that the employee gives one answer of "yes" or "no" to the whole question without specifying the factor(s) that apply to him. The answer need not be given anonymously.

Below is a sample ADA-compliant survey that can be given to employees to anticipate absenteeism.

> EXAMPLE - ADA-COMPLIANT PRE-PANDEMIC EMPLOYEE SURVEY
> Directions: Answer "yes" to the whole question *without specifying the factor that applies to you*. Simply check "yes" or "no" at the bottom of the page.
> In the event of a pandemic, would you be unable to come to work because of any one of the following reasons:
> - If schools or day-care centers were closed, you would need to care for a child;
> - If other services were unavailable, you would need to care for other dependents;
> - If public transport were sporadic or unavailable, you would be unable to travel to work; and/or;
> - If you or a member of your household fall into one of the categories identified by the CDC as being at high risk for serious complications from the pandemic influenza virus, you would be advised by public health authorities not to come to work (e.g., pregnant women; persons with compromised immune systems due to cancer, HIV, history of organ transplant or other medical conditions; persons less than 65 years of age with underlying chronic conditions; or persons over 65).
>
> Answer: YES_____ , NO_____

Source:

https://www.eeoc.gov/facts/pandemic_flu.html

Q 2.5: What should licensed providers do if they come in contact with an individual suspected of having COVID-19?

The Virginia Department of Health (VDH) has developed an FAQ document for healthcare providers. It includes guidance around identifying and reporting a person under investigation, including information around who is being tested for COVID-19 and when to be in touch with your local health department.

Source:

http://www.vdh.virginia.gov/content/uploads/sites/13/2020/03/Provider_FAQ_03082020.pdf

Q 2.6: What considerations should be made regarding the impact of COVID-19 on mental health?

The CDC has issued some guidelines reg arding mental health and coping in light of the COVID-19 pandemic. In addition, please refer to guidance posted by DBHDS and by The Center for the Study of Traumatic Stress.

Source:

https://www.cdc.gov/coronavirus/2019-ncov/about/coping.html

Q 3.1: How should home health aides monitor or restrict home visits for health care staff?

A 3.1: Health care providers who have signs and symptoms of a respiratory infection should not report to work. Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:

- Immediately stop work, put on a facemask, and self-isolate at home
- Inform the HHA clinical manager of information on individuals, equipment, and locations the person came in contact with
- Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment)

Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work.

Source:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Q 4.1: How can my agency obtain personal protective equipment (PPE) for staff and clients?

A 4.1: Currently many PPE including face masks and eye goggles are in short supply. It is possible that companies specializing in other fields that require PPE may have inventory. For example, restaurant supply companies may still have latex gloves and eye goggles. PPE should be prioritized for healthcare workers who are coming into direct contact with individuals with known or suspected COVID-19. Other healthcare workers can take everyday precautions such as regular had washing, covering coughs and sneezes, and staying home when sick.

Q 4.2: Are there alternatives that can be utilized if we are unable to obtain CDC recommended respirators?

A 4.2: The CDC updated their guidance to indicate that facemasks may be used as an alternative to respirators in specific situations. In addition, the CDC has received emergency authorization through the FDA to allow the use of respirators that are approved for industrial use, to be utilized in healthcare settings.

Sources:

https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-and-cdc-take-action-increase-access-respirators-including-n95s

Q 4.3: Do all healthcare workers need to be wearing face masks?

A 4.3: Healthcare workers involved in the care of patients with known or suspected COVID-19 should take precautions by adhering to the CDC's Standard, Contact, and Airborne Precautions

including eye protection, respirators, gowns, gloves, etc. CMS has released additional guidance around the use of facemasks and respirators for these healthcare workers. Those staff who are not involved in the care of patients with known or suspected COVID-19 should take everyday preventive actions.

Sources:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe.html

https://www.cms.gov/files/document/qso-20-17-all.pdf

Q 5.1: How can REACH programs limit staff and individuals' potential exposure to COVID-19?

A 5.1: REACH is a program designed to mitigate the risk of psychiatric and psychological crisis. As such this is a critical service to ensure the safety of the individuals supported particularly during a pandemic that has the potential to increase anxiety of the individuals were serve, their families, and staff. Staff should take all precautions outlined through the Virginia Department of Health and the CDC when responding to individuals in crisis to mitigate risk of contracting any communicable disease and always engage in behaviors that are indicative of training related to universal precautions. Additionally, staff should adhere to any protocols established by the programs or emergency rooms that they are responding to ensure that they do not inadvertently spread a communicable disease.

Sources:
http://www.vdh.virginia.gov/surveillance-and-investigation/novel-coronavirus/
https://www.cdc.gov/coronavirus/2019-ncov/about/index.html

Q 5.2: Are there options for requesting an alternative site for our intervention and can video conferencing be used (this is in particular related to hospital responses) for REACH?

A: 5.2: Crisis intervention/stabilization are core functions of the REACH program and critical to ensuring that individuals are supported through increased anxiety as a result of altered schedules and pandemic related fears. All staff should follow the precautions outlined through the CDC, VDH and the place where they are responding (hospitals, etc.). DBHDS is working on guidance about when a telehealth response is appropriate. This will be forthcoming and will align with expectations of emergency services.

Q 5.3: What are the "essential" services for REACH so that we can ensure that each program prioritizes staffing and that it is consistent across state?

A 5.3: Crisis services are essential services. Prevention services are not essential at this time and should be completed telephonically or through secure video chat.

Q5.4: What are the best practices for when/how to support folks in crisis who are symptomatic without increasing our staff's risk?

A 5.4: Best practices for mitigating risk are posted on VDH website as well as the CDC website. If an individual is not in active crisis. Staff should minimize contact with any symptomatic individual.

Q 5.5: Should REACH be providing services in homes where people are presenting with symptoms?

A5.5: REACH should follow best practice guidelines for screening related to COVID-19 and limit contact when appropriate, particularly if the individual is not in an active crisis but the service is preventative in nature.

Q 5.6: Should REACH be responding to ERs? Will hospital consults by phone / telemedicine vs in person be permitted?

A 5.6: Crisis intervention/stabilization are core functions of the REACH program and critical to ensuring the support of individuals who may be experiencing increased anxiety as a result of altered schedules and pandemic related fears. All staff should follow the precautions outlined through the CDC, VDH as well as the location where they are responding (hospitals, etc.). DBHDS is working on guidance about when a telehealth response is appropriate. This will be forthcoming and will align with expectations of emergency services.

Q.5.7: Will REACH be permitted to cap our community therapeutic home (CTH) census if staffing shortage becomes critical?

A 5.7: CTH programs should utilize best practices strategies as outlined for residential type providers on mitigating and containing the spread of communicable diseases. This includes staff remaining at home if they are ill or have been exposed to coronavirus. At this time, we will not be capping admissions to the program but can discuss and review this as needed depending on the status at the home.

Q 6.1: What guidance is there for licensed providers around the use of telemedicine services as a way to mitigate risk and limit exposure to COVID-19?

A 6.1: We do not yet have any updated guidance on the use of telemedicine services and reimbursement for them in place of face to face visits.

Pages 9 through 12 of this Office of Licensing FAQ document addresses common telemedicine questions for the Commonwealth's behavioral health and developmental services providers. Additionally, you can find guidance from Virginia's Board of Medicine regarding telemedicine here.

For now, providers may utilize telemedicine to the extent that they have previously been authorized or contracted to do so. Questions regarding billing may be directed to specific payers. Future guidance will be provided when available.

Sources:
http://www.dbhds.virginia.gov/assets/document-library/archive/library/ol%20-%20faq_2017/faq%20licensing%20062017.pdf
https://www.dhp.virginia.gov/medicine/guidelines/85-12.pdf

Q 6.2: In the case of services that can be provided remotely via phone or electronically, is there a protocol for screening patients who may have contracted COVID-19?

A 6.2: If you are able to provide a service remotely, and the individual to whom you are providing that service is presenting with flu-like symptoms, it may make sense to provide that service via the phone or electronically. Make sure to adhere to guidelines set forth by the Equal Employment Opportunity Commission.

Source:

https://www.eeoc.gov/facts/pandemic_flu.html

Q 6.3: Is it okay to conduct SIS assessments remotely?

A 6.3: Yes, SIS assessments may be conducted via video call or other electronic means. During the assessment, the assessor should make sure to be in a secure room (without others entering and exiting), and the individual being assessed should also be advised to be in a place that affords privacy.

Q 7.1: Should emergency services pre-screeners become compromised or quarantined, can Community Services Boards leverage other licensed clinicians on staff to complete necessary prescreens?

A 7.1: DBHDS is currently working to provide additional guidance on this issue. We will provide more information as soon as it is available.

Q 8.1: Will DBHDS take measures to offer trainings via computer or extend compliance deadlines?

A 8.1: As the situation evolves, DBHDS will be considering cancelling large group trainings or conducting them electronically. With respect to required competency-based trainings for direct support and other staff, all efforts to conduct training to protect health and safety should be made. If you require additional guidance specific to training your staff, please use the email address in the FAQ link to request additional clarification.

Q 8.2: What additional steps is DBHDS taking to reduce the potential exposure of program staff or individuals receiving services?

A 8.2: DBHDS is aligning with guidance issued by CMS and reducing the frequency of on-site visits by licensing specialists and human rights advocates to those necessary to ensure the health and

safety of individuals. Further details are available in this memo to providers. In addition, The Partnership for People with Disabilities will be pausing NCI visits to minimize the travel, exposure and health risks associated with COVID-19.

Source: http://dbhds.virginia.gov/assets/doc/QMD/OL/314-ol-ohr-covid-19-updates.pdf

Q 9.1: Case Management - Will the expectation for 30- and 90-day face to face case management visits during the COVID-19 outbreak be waived?

A 9.1: The 90-day face to face visits are a targeted case management requirement under CMS, and we are working with our partners at DMAS around what the federal expectations for these visits will be.

The 30-day face-to face-visits are a DBHDS requirement pursuant to the Settlement Agreement related to individuals with enhanced support needs. DBHDS supports the suspension of 30-day face-to-face visits for the next 30 days as long as there is not an emergency that would indicate a visit was needed and it does not violate the CMS requirement for a 90 day face-to-face. It is expected that, in lieu of the 30-day face-to-face visit, the case manager will conduct a telephonic review to address areas of need similar to what they would do during a face-to-face visit. DBHDS will re-evaluate this suspension as the 30 day period nears it completion and will provide additional guidance at that time.

Q 10.1: Is there any guidance for ACT programs?

A 10.1: Please refer to this guidance, which was sent directly to all ACT programs.