Frequently Asked Questions:
Coronavirus Disease 2019 (COVID-19) and Behavioral Health Administration Partners

Updated March 23, 2020

The Maryland Department of Health (MDH) Behavioral Health Administration (BHA) continues to develop coordinated prevention and response plans for COVID-19. BHA will provide COVID-19 updates as they become available and accurate information for behavioral health providers, partners, and the greater community. For the latest COVID-19 information and resources, visit the BHA website or coronavirus.maryland.gov. For additional questions or concerns, contact your Local Behavioral Health Authority.

We expect ongoing referrals from BHA, but what should we do if a BHA referral arrives with a high fever and seems symptomatic for COVID-19? Would BHA expect us to allow the client in?

As a prerequisite for final acceptance of referrals to residential settings, referral sources with health care staff (emergency departments (ED), clinics, detention centers, inpatient units, residential treatment centers (RTC), etc.) should screen the client referred for possible COVID-19, as per the Centers for Disease Control and Prevention (CDC) guidelines.

In addition to symptom questions, the screening should include a temperature check. The temperature check should be daily beginning with the initial referral until the time of their last contact with the client and should be communicated to the receiving program. The receiving program should also screen per the CDC guidelines immediately upon arrival, whether there has been previous screenings. Clients and referral sources should understand that admission to a program may be denied if there are positive findings in screenings before or upon arrival. The decision to deny admission should be made in consultation with medical staff. If a medical decision is unable to be made until arrival, an alternative plan should be established for the client that is consistent with CDC recommendations, including transportation.
For facilities who serve older adults please see MDH's Recommendations for Infection Control & Prevention of COVID-19 in Facilities Serving Older Adults.

Is it possible that BHA will stop all placement activity for a period and there will be no new intakes?

Any possible COVID-19 mitigation strategy designed to protect medical health would have to be carefully thought through if it potentially puts behavioral health at risk.

Does BHA have a position on temporarily limiting or restricting visits for residential treatment centers? For example, declining an overnight visit from a patient's children and approving an abbreviated visit instead.

We support this particular visit restriction plan, since it replaces the overnight visits with an abbreviated visit, balancing the risk versus benefit for the family. Following CDC guidelines, as part of the visit, the children should be screened for COVID-19, as should all visitors to a residential health care setting. The use of phones or other technology for videoconferencing should also be considered as appropriate to replace visits, especially if visits have to be suspended. If consents are in place for other agencies already involved, such as Child Protective Services, as appropriate they should be notified about changes in the visits.

What emergency plan should we follow if there is a community outbreak or surge?

Jurisdictions are advised to use their All Hazards Plan and Continuity of Operations Plan (COOP) which includes a list of essential functions. Please be sure the essential functions include the primary person responsible for carrying out the function and what information is needed to maintain operations. It is the responsibility of the local addictions authority (LAA), core service agency (CSA), and local behavioral health authority (LBHA) to work with their local health department regarding closures and alternative arrangements, if any. BHA will provide a copy of the BHA Surge Plan to an LAA/CSA/LABHA, if requested.

Providers have expressed staffing concerns with houses staffed 24/7. Are there resources for outsourcing care to community agencies for Certified Nursing Assistant (CNA) support?

As of March 19, the CDC allows asymptomatic healthcare personnel (HCP) with an exposure to continue to work under specific circumstances if they wear a mask. The CDC guidelines state, "Updating recommendations regarding HCP contact tracing, monitoring, and work restrictions in selected circumstances. These include allowances for asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program."

Both LBHAs/CSAs and Residential Rehabilitation Program (RRP) agencies are required to have an All Hazards Plan and COOP which anticipate staffing shortages in the event of an emergency. It is critical that the LBHAs/CSAs coordinate their planning efforts with residential providers within their jurisdictions to ensure that contingencies are in place for staff coverage. In an emergency, not all staff functions are critical; thus, agencies should plan for alternative coverage by cross training their staff members. For example, if the on-site psychiatric rehabilitation program (PRP) is closed, PRP day program staff can be redeployed to staff the RRP. This is the time to build on the strengths and natural supports of residents who are doing

relatively well (e.g., residents of General Level RRP) so that more staff time can be allocated to residents who are vulnerable and most at risk.

Providers are encouraged to develop innovative staffing models to meet immediate and short-term staffing needs. This may include pooling or sharing of staff across health care programs or providers or enlisting agency volunteers or Board members to serve in administrative or supportive roles in order to free up staff to provide direct care. The LBHA and CSAs should continue to engage RRP providers to assess staffing needs and to identify community resources. If a jurisdiction anticipates that a certain RRP will no longer be able to provide 24/7 staffing coverage, the BHA Clinical Services Division should be immediately notified. If a resident is subject to conditional release and is required by judicial order to have 24/7 coverage, then any staffing reduction may not occur without judicial consent. It is BHA's expectation that RRP providers work collaboratively with the LBHA/CSA and, as applicable, the MDH Office of Court Ordered Evaluation and Placement to ensure that RRP residents receive needed services and that such services fulfill any requirements that may exist as part of a resident's conditional release orders.

What should a provider do if clinicians do not present to work due to illness or care for family members or children with potential school closure?

Clinicians have an ethical obligation not to abandon their clients. If a clinician is unable to continue to provide needed care to a client, the clinician should facilitate a warm-transfer to another clinician. Clinicians are expected to triage their caseload to determine the nature and intensity of services needed.

Is there service delivery support on medication-assisted treatment (MAT) prescribing?

The State Opioid Treatment Authority is providing guidance to opioid treatment programs (OTP) and working closely with the Maryland Association for the Treatment of Opioid Dependence (MATOD). The Substance Abuse and Mental Health Services Administration (SAMHSA) has also provided guidance for OTPs that allow for increased take-homes.

Clinics limiting hours or services?

For non-OTPs this is determined by the LBHA/CSA/LAA and clinic provider. Any changes in provider services should include as appropriate the referral of clients to another program or alternative manner of providing services to clients in crisis.

Any OTPs requesting clinic hour or service changes must receive approval from SAMHSA and the SOTA, who then notify the LBHA/CSA/LAA. However at this time limiting hours or services

at OTPs is not being routinely authorized without sufficient justification. OTPs need to maintain normal hours in the event guest dosing is needed.

For group therapy sessions, are there recommendations for ratio or size?

On March 16, 2020, the White House provided guidance that social gatherings should not exceed 10 people. However, if groups are held, they should be smaller than 10 people in order to be carried out in compliance with the CDC guidelines that include social distancing of six feet.

Will it be communicated that there is mandatory social distancing for providers that are offering round the clock care?

There is already guidance in effect from the CDC, SAMHSA, and MDH.

Will BHA suspend fidelity reviews for dates of services delivered for evidence-based practices during the state of emergency?

CMS announced that it is suspending non-emergency survey inspections in order to focus on the most serious health and safety threats like infectious diseases and abuse. BHA will likewise suspend all fidelity reviews for evidence-based practices.

Will providers have to submit their emergency preparedness plan for COVID-19 to Maryland Association of Behavioral Health Authorities (MABHA)?

The LBHA/CSA/LAA in cooperation with the local health department should be working with their providers to ensure that an emergency preparedness plan is in place and up-to-date. As to avoid multiple and sometimes contradictory messages, the provider should communicate directly with the local behavioral health authority.

With hand sanitizer getting more and more difficult to find, is there an alternative?

The CDC provided hand hygiene recommendations.

As Personal Protective Equipment (PPE) is not easily accessible, are there recommendations on clothing and facemasks?

BHA has coordinated with MDH Office of Preparedness and Response to submit requests and inquiries regarding the need for PPE to sns.mdh@maryland.gov. The distribution and allocation

of PPE is being coordinated with Local Health Departments. Providers are encouraged to submit their requests to the aforementioned email and remain in constant communication with their Local Health Department.

The CDC provided Strategies for Optimizing the Supply of PPE. As one of the various options to consider when facemasks are not available, the CDC does discuss homemade masks as a last resort.

Are custom-made or homemade masks something that BHA recommends?

In their Strategies for Optimizing the Supply of PPE, as one of the various options to consider when facemasks are not available, the CDC does discuss homemade masks as a last resort.

How can we ensure that patients do not lose the ability to use public transportation to get to their clinic as restrictions are being imposed on public transportation?

Currently, non-essential travel in Maryland is still available. However, in the face of potential restrictions on travel as COVID-19 cases continue to rise, it is vital that patients are still able to make it to their clinic. One possible practice could be to provide patients with a form that they must carry with them when traveling to their clinic that certifies that they are on an essential trip for medical treatment.

Although the Governor recently signed an executive order allowing the delivery of alcohol, access to alcohol could still decrease with in-person business no longer allowed at bars and restaurants. How can the issue of alcohol withdrawal be addressed?

ASAM has released a draft Guideline on Alcohol Withdrawal Management. It includes a section on ambulatory withdrawal management, which now also can be done via telehealth.

Operations adjustments: Waiting room management

The CDC provided information for healthcare professionals.

Standardized Screening Guidance and Resources Needed

CMS issued COVID-19 guidance on infection control and protective equipment. The Centers for Medicare and Medicaid Services has issued several statements recently with regard to infection control, patient care, and provider safety precautions in a variety of settings. The CDC provided

screening guidance for Home Health Agencies, Nursing Homes, Hospice Agencies, Emergency Medical Team, etc.

Stability concerns with fee-for-service and Optum issues that are already in existence.

BHA recognizes that many Maryland providers may face financial issues as a result of the state of emergency. BHA and Medicaid have loosened regulations surrounding telehealth and telephonic services to ensure that individuals may continue to receive medically necessary services, as well as assist providers. Medicaid and Optum continue to work hard to address the various issues around their authorization and claims payment systems and still plan to have them operational in the near future.

Access to MAT and prescribing needs: If a consumer presents at the hospital with COVID-19 and they had been at their agency, how do they share with the HD all the individuals that may have encountered the sick individual? Do they release their list of clients? Is this a HIPAA violation?

HIPAA regulations have been relaxed in an effort to address the emergency medical needs of the patient. The Health Department will provide guidance. The agency could advise or use the following language to address this, "A fellow client (unnamed) has tested positive for COVID-19, and they should self-monitor and self-quarantine for symptoms for 14 days". The Health Department may broadcast to the public that a patient at the agency tested positive, that the patient was last at the agency on such date and time, and likewise advise all to self-monitor and self-quarantine.

Universal Correspondence and Updates for Providers: Communication/Conference Call Scheduling

BHA will provide FAQs weekly. Information will be disseminated through provider alerts and posted on the BHA website.

Support with Optum Communications with COMAR and Regulatory/Billing Code allowances during COVID-19

Medicaid and BHA are in regular communication with Optum to discuss regulatory and billing code allowances during COVID-19. Provider Alerts posted on Optum's website and disseminated by email, will note the billing codes.

Would BHA be opposed to the systems manager (Local) conducting a desk compliance audit in lieu of a face-to-face compliance audit for a Coordinated Care Organization (CCO) providers who may or may not have had a Quality Improvement Plan (QIP) or Technical Assistance Requirement (TA) requirement in the past year?

Unless an emergency situation exists, all face-to-face audits are suspended until further notice. The systems manager may utilize a desk audit, or if appropriate, a telephonic interview.

Substance Use Disorder (SUD) Intensive Outpatient and Outpatient Treatment as it relates to holding groups. Per the Governor's orders, SUD providers who provide IOP/OP treatment services should not be holding group sessions unless it is for 10 individuals or less. For example, could the provider utilize 3 staff and 7 clients or some combination of that or are the 10 individual clients only, with the minimum # of staff needed/required to facilitate the group activity?

Addressed above.