



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

Updated March 20, 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 regular updates 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.

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, because 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.

Clinic suspension or limited hours?

This is determined by the LBHA/CSA/LAA and clinic provider. Any suspension must include the transfer of clients to another program or alternative manner of providing services to clients in crisis. If a licensed program closes or suspends operations, the BHA Office of Licensing must be notified.

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.