Virginia Department of Behavioral Health & Developmental Services

DBHDS – Frequently Asked Questions

Updated: May 25, 2021

Contents

For questions about the prevention, testing, treatment, and vaccination of COVID-10, please visit the Virginia Department of Health (VDH) and the Centers for Disease Control and Prevention (CDC).

For questions related to Medicaid flexibilities during the pandemic, please visit the Department of Medical Assistance Services (DMAS).

What to do if someone presents with COVID-19 symptoms

Group homes and residential settings

1. **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. Isolation separates and restricts the movement of sick people (confirmed or suspected cases of COVID-19) from people who are not sick. This is different from quarantining a person, which refers to separating and restricting their movement to see if they become sick if they were exposed to someone with a confirmed or suspected case of COVID-19.

   Based on a temporary waiver to the regulations by the Commissioner, when a provider determines the need to isolate an individual who has COVID-19 or is suspected to have COVID-19, or quarantine an individual who has been exposed to someone with COVID-19, the provider should:

   - Explain the process to the individual or authorized representative (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 or quarantine lasts longer than 7 days, the provider must document the need for the restriction in the individual's services record. Any individual or AR who believes his or her rights have been violated can make a complaint directly with the provider or through the advocate.

   For additional information, see this recent memo (March 2021) about returning to operations.

2. **Does a provider of a residential care have an obligation to notify a consumer that a peer or staff member has been diagnosed?**

   Yes, the provider should inform existing patients and potential new patients during the admission process that they have confirmed cases of COVID-19 in their program. The provider could post a sign within the residential setting, excluding the name and any other identifying information of the individual with the confirmed case.

Licensed providers

3. **What should licensed providers do if they come in contact with an individual suspected of having COVID-19?**

   Please refer to VDH's resources for healthcare providers.

   In addition, please review this information regarding when to report cases of COVID-19 in CHRIS.

   Sources:
   https://www.vdh.virginia.gov/coronavirus/health-professionals/
   https://www.dbhds.virginia.gov/assets/doc/EI/serious-incident-reporting-of-covid-19.pdf

Preventing the spread of COVID-19

4. **What precautions can I take as a DBHDS-licensed providers to prevent COVID-19?**

   Please review guidance from the Office of Licensing here.

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

DBHDS on-site visits

5. **Will DBHDS be limiting on-site visits to reduce the potential spread of COVID-19?**

   On April 1, 2021, OL and OHR began to shift from its current disposition where the majority of visits, inspections, and investigations were virtual, to one where some, but not all, field operations are conducted face to face. This transition began April 1, but it will take some time and is predicated on several factors; such as the evolving COVID-19 situation in Virginia, serious incident reports of provider outbreaks, and additional data from the Virginia Department of Health (VDH) and the Centers for Disease Control and Prevention (CDC). In addition, the DBHDS's Quality Service Review provider, the Health Service Advisory Group (HSAG), will commence with conducting face-to-face interviews and direct observations. DBHDS staff and HSAG staff will attempt to coordinate visits and record requests whenever feasible in order to minimize disruption and risk of infection wherever possible.

   Please note, any activities that were initiated before April 1, 2021 by OL or OHR, will be completed virtually. As OL, OHR, and HSAG transition back to onsite activities, staff will conduct prescreening assessments for safety, to identify concerns for infections, and request that staff and individuals (when able) wear masks, adhere to social distancing guidelines and adhere to current CDC and VDH guidelines. All DBHDS and HSAG staff will be wearing personal protective equipment (PPE) which may include masks, gloves, and gowns as appropriate to the location and set up of the onsite activity. OL and OHR staff will also discuss all provider safety protocols prior to going onsite in order to ensure the safest environment for providers, their staff, individuals, and our team members.

Source:
https://dbhds.virginia.gov/assets/doc/QMD/OL/return-to-field-operations-(march-2021).pdf

Day support programs

6. Can day support services be authorized and provided by staff in a residential setting?

If a residential provider serves individuals who typically attend day support, but can no longer due to COVID-19, the provider should plan to provide appropriate services to the individuals during the daytime for the period in which they are unable to attend day support. These services should be provided by staff that have the appropriate training and qualifications to do so. The provider would need to contact DMAS to determine if the provision of these services would be payable as day support. DMAS released guidance indicating that requests for telehealth service delivery for plans authorized after March 12, 2020 may be submitted for consideration.

If a provider is licensed to provide both residential and day support services, and would like to have their day support staff come to the residential setting to provide day support services, this is permissible. The provider should notify their Licensing Specialist that they will be engaging in this practice and temporarily changing the location where day support services are offered.

Source:
https://dbhds.virginia.gov/assets/doc/EI/81020-HCBS-Flexibilities-Extension-Final.pdf

Social distancing and restricting visitors

7. Are providers able to restrict visitors to prevent the spread of COVID-19?

The Commissioner waived the human rights regulations around visitation. 12 VAC 35-115-50 states that each individual has the right to receive visitors. A waiver to this regulation allows a provider to limit visitation for all individuals in the program in order to maintain a safe environment. As Virginia has begun the phased re-opening process, providers should explore relaxing COVID-related limits on visitation. Providers may refer to VDH guidance for nursing homes for examples of linking eased visitation restrictions with criteria based on the locality's current Forward Virginia Phase status and the provider's current readiness to implement infection control. While this guidance is not directly applicable to group homes or sponsored residential programs, it can serve as a useful guide.

Providers who have restricted individual's ability to travel outside of a residence previously should also consider easing these restrictions. In doing so they should consider what evidence is needed to ensure that an individual understands and can practice the necessary infection control, hand hygiene, face covering, social distancing, etc. while away from the service setting. When considering off-site visitation, providers should have a plan in place to support the individuals return to the congregate setting which may involve additional screening and precautions (e.g., use alcohol-based hand rub and temperature scan upon entry) as well as the potential for quarantine. Please ensure appropriate notifications to individuals/authorized representatives and maintain the requirement for documentation and DBHDS oversight.

The community remains a source of outbreaks, which are still an active problem in the Commonwealth. Providers should incorporate VDH guidance/CMS guidance for visitation into their process planning and continue to adhere to recent mandates by the President and Governor to prevent community spread.

Sources:
https://www.vdh.virginia.gov/content/uploads/sites/182/2020/10/VDH-Guidance-for-Nursing-Homes_Table.pdf
https://www.cms.gov/files/document/qso-20-39-nh.pdf

Preventing COVID-19 among staff

8. **Will providers be penalized for closing administrative offices and allowing administrative staff to telework?**

   No. Providers should encourage telework among administrative staff whose work can be completed remotely.

9. **Are direct support professionals considered essential personnel?**

   Yes. Still, any staff who are sick or who have come in close contact with an individual with COVID-19 should stay home.

   Source:
   http://www.vdh.virginia.gov/content/uploads/sites/13/2020/03/MM_Close_Contact_03082020.pdf

Testing Pre-Admission

10. **Are licensed residential providers permitted to ask incoming residents to take a COVID-19 test?**

    Yes, providers can ask incoming residents to take a COVID-19 test prior to admission. The test should be used as another medical screening to help the provider determine appropriate care for the individual. Providers should assist individuals in identifying available testing in the area. Individuals who test positive should stay in isolation upon admission until he or she is cleared.

Telemedicine and providing services electronically

11. Is it okay to conduct SIS assessments remotely?

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.

12. Will the Office of Licensing allow flexibility within Sponsored Residential providers to provide oversight through video or telephone if an extension is needed beyond 3 months?

are allowing sponsored providers to conduct the quarterly inspections for each sponsored residential home as required by 12VAC35-105-1190 via video and this will be in effect until the end of the state of emergency. They should document in their records how these inspections were conducted.

13. Has DMAS issued guidance around telemedicine flexibility during the public health emergency?

Yes, you can find more information from DMAS around use of telemedicine, including providing services via telephone and the waiving of certain program requirements, on DMAS's website here.

Source:
https://www.dmas.virginia.gov/for-providers/general-information/emergency-waivers/

DLA 20

14. Can the DLA 20 assessment be completed telephonically?

Yes, DLA 20 assessments may be performed by telehealth or telephonic means.

- The DLA 20 assessment must be completed during the month it is due if the consumer has been seen (through the use of telehealth, in person, or spoken to by phone).
- If the consumer has NOT been seen within the last 30 days, complete the DLA 20 at the time of the next interaction. NOTE: This will not change the timeframe for the next DLA 20. The DLA 20 should align with the Quarterly even if there is a truncated period between due to absenteeism.

Staffing

Pre-screeners and emergency services

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

    Please review guidance for CSB emergency services staff regarding this question [here](https://www.dbhds.virginia.gov/assets/doc/EI/dbhds-emergency-services-covid-19-guidance-updated-3-19-20.pdf).

    Source:
    https://www.dbhds.virginia.gov/assets/doc/EI/dbhds-emergency-services-covid-19-guidance-updated-3-19-20.pdf

16. **Is alternative transportation available during the pandemic?**

    Patients needing transportation to an inpatient psychiatric facility will be able to access alternative transportation by G4S unless the patient has symptoms of COVID-19. More information from G4S about their response to COVID-19 is available [here](https://www.dbhds.virginia.gov/assets/doc/EI/covid-19_g4s-healthcare-continued-response-and-guidance.pdf).

    Source:
    https://www.dbhds.virginia.gov/assets/doc/EI/covid-19_g4s-healthcare-continued-response-and-guidance.pdf

17. **Is there any flexibility around training for Certified Preadmission Screening Clinicians?**

    Please see [this guidance](https://www.dbhds.virginia.gov/assets/doc/EI/dbhds-guidance-on-certifying-cpsc.pdf) (4/20/20) regarding the preadmission screening certification process.

    Source:
    https://www.dbhds.virginia.gov/assets/doc/EI/dbhds-guidance-on-certifying-cpsc.pdf

Transfer of direct care staff

18. **As a licensed provider, may I transfer direct care staff between licensed services based on need and staff availability?**

    The Office of Licensing anticipates that provider staffing struggles will be exacerbated by the ongoing COVID-19 public health crisis. Providers who operate multiple licensed services, each with its own unique staffing portfolio, may find it necessary to reallocate staff from one licensed service to another licensed service in order to accommodate staffing shortages in one or more of the provider's licensed services. Please find below clarification regarding the regulatory requirements for these staff sharing arrangements.

    - As you know, providers must submit documentation to run criminal history background checks and central registry searches for any new applicant who accepts employment in any direct care position per Virginia Code § 37.2-416. In addition, per recent changes to the Virginia Code § 37.2-408.1, results of the criminal history background check must be received *prior to* permitting a person to work in the children's residential facility.

- Under the Licensing Regulations, when a provider operates multiple licensed services, the provider *may reallocate* staff in direct care positions from one licensed service to another licensed service *without submitting documentation to run a new criminal history background check and central registry search*. This would constitute a re-allocation of existing staff, and not a newly hired employee. The provider should ensure, however, that documentation of the criminal history background check and registry search that was completed at the initial point of hire is maintained in the individual's personnel file.

- When a licensed provider reallocates staff from one licensed service to another, they shall ensure that the staff has received all necessary orientation and training for the new position pursuant to 12 VAC 35-105-440 & 12 VAC 35-46-310. If the orientation/training requirements for the two positions are the same, and the employee has already completed all required orientation/training for the prior position, no additional training is necessary. In addition, providers shall ensure that the reallocated staff still meets the minimum qualifications of the specific direct care position as determined by the job description for the position pursuant to 12 VAC 35-105-420 & 12 VAC 35-46-290.

Background checks

19. In the event of a temporary layoff, will providers need to obtain new background checks when employees return to providing services?

If a provider terminates an employee, the provider will need to submit all required documentation in order to obtain a criminal history background check and central registry search when the employee is re-hired.

- If a provider temporarily places an employee on leave or chooses not to schedule an employee to work during this emergency period, then the provider will not need to obtain a new background check or central registry search when the employee returns to work.

20. If a provider would like to hire direct care staff who was employed by another licensed provider, do they still need to submit proper documentation for background checks and central registry searches?

Anytime a provider hires direct care staff, the provider must submit all documentation in order to conduct a criminal history background check and central registry search pursuant to Virginia Code § 37.2-416.

- The employee must also submit to the provider a disclosure statement stating whether they have ever been convicted of or are the subject of pending charges for any offense pursuant to 12 VAC 35-105-400.
- The hiring provider shall maintain the disclosure statement from the applicant stating whether he has ever been convicted of or is the subject of pending charges for any offense; and documentation that the provider submitted all information required by the department to complete the criminal history background checks and registry

checks searches, memoranda from the department transmitting the results to the provider, and the results from the Child Protective Registry check search.

- For providers of non-children's residential services, the provider may allow staff to work in the period while they wait for the results of the background check/central registry search to be returned, if this is what their policies allow for.
- If the provider intends to temporarily amend their policy during this emergency period to allow staff to work prior to the transmittal of the results, they should alert their Licensing Specialist to this temporary change.
- *Please remember that per Virginia Code § 37.2-408.1, providers of children's residential services are prohibited from allowing all volunteers, contractors, and staff to work in the service until the results of the criminal history and central registry searches have been returned.*

21. What steps should we take if Fieldprint temporarily closes their office(s) in our area?

All Fieldprint offices within the Commonwealth have reopened.

DSP orientation and competencies

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Staffing ratios

22. Is the Office of Licensing allowing flexibility with staffing for residential and inpatient if there are shortages due to COVID-19? Such as lifting any staff/patient ratios?

DBHDS recognizes that the pandemic has created a number of challenges for providers, including ensuring that sufficient staff are available to meet the needs of the individuals they serve. DBHDS does not mandate specific staffing ratios, with the exception of children's residential services.

- The Licensing Regulations for children's residential facilities state that at all times the ratio of staff to residents shall be at least one staff to eight residents for facilities during the hours residents are awake, except when the department has approved or required a supervision plan with a different ratio based on the needs of the population served. Providers requesting a ratio that allows a higher number of residents to be supervised by one staff person than was approved or required shall submit a justification to the department that shall include: a. Why resident care will not be adversely affected; and b. How residents' needs will be met on an individual as well as group basis.
- If a children's residential provider would like to deviate from the required staffing ratio, they will need to submit a request to their Licensing Specialist including how resident care will not be adversely affected and how residents' needs will be met on an individual as well as group basis. The Office of Licensing understands that these requests will be time sensitive and will be prioritizing them accordingly.
- For acute inpatient psychiatric services, the Licensing Regulations do not include specific staffing ratios. The regulations require that providers admit only those

individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served receiving services. In addition, the provider must have adequate staff to safely evacuate all individuals during an emergency. If a provider must reduce staffing levels below those described in their program description, they should notify their specialist of the change as soon as possible.

23. Can the Sponsored Residential direct support professional to individual ratio be temporarily changed from 1:2 to 1:3 during the state of emergency?

The Office of Licensing will not be granting a blanket exemption to this regulatory requirement. If a sponsored location has an identified need to increase capacity from 2 to 3 individuals due to the emergency at hand, and does not feel that the increased capacity will affect the health and safety of individuals served, they may submit a variance request directly to their Licensing Specialist.

Services and programs

Medication

24. Will patients be able to access their medications if non-essential healthcare visits are postponed?

Yes, pharmacists have some discretion regarding dispensing of new prescriptions or refills. The Virginia Board of Pharmacy has issued information for pharmacists here.

Source:
https://www.dhp.virginia.gov/pharmacy/news/PharmacyCoronavirusInfoUpdate12172020.pdf

25. Is there any guidance around dispensing clozapine during the public health emergency?

Yes, DBHDS is supportive of FDA guidance related to clozapine dispensing during the COVID-19 pandemic and has issued this memo for clozapine prescribers with additional information.

Source:
https://dbhds.virginia.gov/assets/doc/EI/dbhds_clozapinememo_040820.pdf

Case management

PACT

26. Are there any recommendations for PACT teams?

Please refer to this document, which was sent directly to all PACT programs. In addition, this FAQ includes information on leveraging nurse practitioners on PACT teams.

Source:
https://dbhds.virginia.gov/assets/doc/EI/covid-act-recs_3_13.pdf

Discharge

27. If a client discontinues services after a possible quarantine, can we pick up services afterwards as long as clinically appropriate?

Individuals who have not participated in a service in 30 days do not have to be discharged from the service. If the service authorization period ends, a new authorization request shall be made for the service to continue.

Waiver individuals who receive fewer than once service per month will not be discharged from a HCBS waiver. They shall receive monthly monitoring when services are furnished on less than a monthly basis. More information on this can be found on the DMAS website.

The Office of Licensing regulations do not require discharge if an individual does not receive services for 30 days. If an individual temporarily suspends services, we would expect for the provider to re-assess the individual when services begin again to ensure that the services previously offered are still appropriate.

Sources:
https://www.dmas.virginia.gov/for-providers/general-information/emergency-waivers/

Services for DD population

28. Can providers request a service authorization to adhere to the original expiration date, or are service authorization extensions mandatory?

Service authorization (SA) staff will not be changing the DMAS automatically extended end dates. If services are due for renewal during that two month window, SA staff will authorize them with a start date of the day following the auto-extended end date *unless* an increase in services is being requested. In that latter case, the start date for the increase will be honored (assuming all proper documentation is present). This does not pose a problem with the per diem residential services that are limited to 344 days of billing per ISP year due to the fact that DMAS and DBHDS have implemented an allowance for providers of those services to continue to bill during the two month service authorization extension without penalty.

Individual service plans (ISPs)

29. Is the intention that the individual service plan (ISP) and the provider's plan for support (PFS) dates remain unchanged even with the extension of authorizations by 60 days?

Dates on the ISP, PFS, and quarterlies should stay on the same schedule, regardless of any authorization extension.

30. Do ISPs and PFSs for the DD population need to be updated if the service is being provided via remotely via phone or video conferencing?

The ISP and PFS should only be updated if the methodology of service delivery changes what is delivered. If the service remains the same even as it is provided via phone or videoconferencing, the ISP and PFS do not need to be updated. The notes should, however, reflect the delivery method and indicate if the service was provided via phone or videoconferencing.

Community Engagement

31. To increase group day hours to account for losses in community engagement, do we need to send in new authorization requests via WaMS?

Providers would need to submit a modification to current group day request to increase hours. There is no need to discontinue Community Engagement authorization, but the provider may need to adjust its group day hours back down once returning to providing both services.

Face masks and personal protective equipment (PPE)

32. Can a provider require an individual to wear a mask/face covering?

Consistent with their responsibility to provide services in a safe environment, providers may require individuals to wear a mask or face covering during the provision of services. The decision to require face coverings in a program should be based on the service setting and balanced with all other infection control strategies such as social distancing, hand washing stations, and plexiglass barriers where appropriate. Providers must have policies to address the use of face coverings in the program and inform individuals/authorized representatives of this requirement prior to service delivery. These policies must take into account individuals who choose not to wear a face covering or for whom it is contraindicated as well as individuals that do not have the ability to provide their own mask/face covering. Providers must also document individual/AR consent or objection to wearing face coverings as well as communication from medical professionals about contraindications in the services record. Providers that implement a policy requiring a face mask, should assist any individual who does not want to wear a face mask to find alternative services and ensure an integrated discharge.

Source:
https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-faq.html

33. **Does this mean a group home can ask an individual to move out if he or she refuses to wear a face mask?**

    No. This guidance recognizes that programs providing services in a community-based setting may set such requirements for safety and individuals/AR's may decide not to participate based on his/her choice not to wear a mask. When the choice is made not to continue with a service an individual's entire support team, including the provider, should assist in identifying alternative services to meet the individual's needs and preferences, to the extent possible.

34. **Can providers use plexiglass in vehicles when transporting individuals?**
    Providers have a responsibility to maintain a safe environment, which extends to use of transportation in the delivery of a service. Providers should be advised that the use of plexiglass for the purpose of infection control in a vehicle may have other unintended effects.

    If a provider determines to utilize the plexiglass they must inform individuals ahead of time to include information about how it will impact them and what the provider will consider in order to discontinue the usage. The provider should consider some level of assessment to ensure individuals can tolerate the plexiglass (i.e. will not have an adverse behavioral reaction or trauma), and the provider must not compromise the safety mechanisms in the vehicle (i.e. plexiglass cannot take the place of seat belts or cover access to air flow by a vent).

    Additionally, providers may consult DMAS and the MCO NEMT Programs for information and criteria regarding suggested seating arrangements for different types of vehicles to help with infection control. https://www.logisticare.com/covid19

Trainings

35. **Will the Office of Licensing grant at least a 3-month extension of competencies and annual trainings?**
    DBHDS licensed providers need to follow the guidelines of the qualified providers of any specific training such as CPR, First Aid and Crisis Prevention Training (CPI). Each of these qualified training providers has policies around distance learning and new / renewal certifications.

    For example, the American Red Cross (ARC) offers a two – part blended learning courses for both CPR and First Aid. Details on First Aid Certification are at this link: https://www.redcross.org/take-a-class/first-aid/first-aid-training/first-aid-certification. For CPR certification, the learner receives a provisional certificate and has one year to complete the skills test. Details on the American Red Cross (ARC) CPR certification process are at this link: https://www.redcross.org/take-a-class/skills-sessions/provisional-first-aid-cpr-aed-certification. In addition, the American Heart Association (AHA) continues to offer lifesaving-training courses are online. The courses that do not require hands on skills the learner can complete the course on – line. For courses that teach CPR, they require that the student complete an in-person skills practice and testing session with an AHA Instructor after they complete the online portion.

For Medication Aide Training (32 hour curriculum and additional modules approved for DBHDS licensed providers) the same applies; for the topics and components of Medication Aide training that require hands on observation or competency check, these cannot not be completed via distance learning.

Any questions related to competencies should be directed to Heather Norton, Acting Deputy Commissioner, Developmental Services, DBHDS, at Heather.Norton@dbhds.virginia.gov or Ann Bevan, Director, Division of Developmental Disabilities, DMAS at ann.bevan@dmas.virginia.gov.

36. **Should providers hold medication administration refresher trainings for groups of employees?**
Providers are expected to follow their own policies related to medication administration training. If a provider would like to extend the period for which they require staff to receive refresher training, they should include this in an emergency protocol and alert their Licensing Specialist to the change. If trainings are scheduled, providers should adhere to CDC guidelines regarding social distancing, sanitizing common surfaces, and other infection control processes.

DBHDS licensing regulations

Initial applications

37. **Are applications being processed? Will Licensing Specialists be doing inspections?**

The Office of Licensing is continuing to process initial applications. Licensing Specialists will be conducting onsite inspections necessary to issue a conditional license.

Conditional licenses and renewal applications

38. **My agency is on a conditional license for community coaching, will this be extended or does the agency have to stop billing?**
During this emergency period, the Office of Licensing will continue to process renewal applications. If your agency is on a conditional license, you should submit a renewal application.

Source:
https://dbhds.virginia.gov/assets/doc/QMD/OL/return-to-field-operations-(march-2021).pdf

Communication with DBHDS

39. **What kinds of changes do DBHDS-licensed providers need to notify the Office of Licensing about?**

As always, DBHDS-licensed providers are expected to inform their Licensing Specialist of any major changes to their service(s) during this emergency period. This includes:

i. Temporary or permanent closure of services;
ii. Temporary or permanent closure of locations;
iii. Changes to administrative staff;
iv. Changes to service description; and
v. Implementation of any emergency policies or protocols.

CHRIS Reporting

40. If during the provision of services it is determined that a patient or individual may have COVID-19 symptoms and the patient is presumptive positive or laboratory confirmed to have COVID-19, is a hospital required to report the case as a Level II Serious Incident in CHRIS?

When to Report Confirmed Cases of COVID-19 in CHRIS:

a. **Children's Residential Services - 12VAC35-46-1070(C):** Anytime an individual has a confirmed diagnosis of COVID-19 during the provision of a children's residential service, this shall be reported to the Department using the Department's web-based reporting application (CHRIS). Regulation 12VAC35-46-1070(C) requires providers to notify the Department within 24 hours of any serious illness or injury, any death of a resident, and all other situations as required by the Department. COVID-19 constitutes a serious illness, and confirmed cases shall be reported to the Department as such.

b. **Level II Serious Incident - 12VAC35-105-160(D)(2):** For non-children's residential services, where it is determined that the individual is diagnosed with COVID-19 during the provision of services or on the provider's premises, this shall be reported using the Department's web-based reporting application (CHRIS) as a Level II Serious Incident. A "Level II Serious Incident" is defined as a "a serious incident that occurs or originates during the provision of a service or on the premises of the provider that results in a significant harm or threat to the health and safety of an individual." Because of the 2 severity of symptoms that some individuals suffer and the ease with which the virus appears to spread, a case of COVID-19 that is confirmed during the provision of services, or on the provider's property, would constitute a Level II Serious Incident as defined in 12VAC35-105- 20.

   The Office of Integrated Health (OIH) is notified of all positive COVID-19 cases and will continue to offer technical assistance related to health and safety, personal protective equipment, educational resources and problem-solving.

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II. Providers are NO LONGER required to report:

a. Positive cases of COVID-19 when an individual who is receiving center based or non-children's residential services has a confirmed diagnosis of COVID-19, when the diagnosis occurred outside of the provision of the provider's services and off of the provider's property. However, if a provider determines an individual was present at a provider's service while they were infected, and that individual does not receive licensed residential services, the center based provider should still report this incident as a Level II serious incident as the individual had a condition that may jeopardize the health, safety or welfare of other individuals.

   For example: an individual living at home, attending day support, contracts Covid-19 while at a family gathering over the holidays; the individual then attends day program all week; and then receives a positive Covid-19 test result at a medical clinic with their parents following the administration of a rapid test. Even though the diagnosis of Covid-19 did not occur at the day support program or on the premises of the provider's property, the individual was attending the program while positive and exposed others. Therefore, the day support provider must report the exposure as a Level II serious incident.

b. Providers of case management services are NO LONGER required to report positive cases of COVID-19 unless an individual is diagnosed with COVID-19 during the provision of case management services or on the premises where case management services are provided.

Source:
https://files.constantcontact.com/99370647701/49dac076-9d67-4da1-a9ef-505bca37aef9.pdf

41. Is the hospital or other provider required to do a root cause analysis for each case reported to CHRIS as defined above in bullet 1 and 2?

No. The Office of Licensing has deemed that an individual contracting COVID-19 is beyond the provider's control. In such cases, the provider should make sure that their CHRIS report includes a description of the event and any additional precautions taken by the provider to mitigate risks to other patients.

42. What is the intended outcome/goal of reporting these cases in CHRIS?

The goal is for DBHDS to be able to monitor the ongoing situation regarding COVID-19 infections and potential hotspot areas where additional resources may be necessary.

Physical examinations and PPD tests (TB tests)

43. Can providers exceed deadlines for physical examinations and PPD tests when unable to see a doctor?

If an individual is unable to attend their routine physical exam appointments with a physician due to limited hours or appointment cancellations imposed by doctors' offices and clinics, the provider shall document evidence as to why the appointment could not occur within the individual's progress notes. All attempts shall be made to reschedule the individual's appointment as soon as possible.

TB Testing

44. What guidance is there around tuberculosis screening and testing for healthcare providers?

Guidance around who can ask questions included in a TB risk assessment as well as who can assess risk for TB infection and/or disease based on the answers is available from VDH here. At this time, current licensing requirements for TB screening remain in place; DBHDS will continue to monitor.

Source:
http://www.vdh.virginia.gov/content/uploads/sites/175/2020/02/Tuberculosis-Screening-and-Testing-for-Occupational-Purposes_2020.pdf

Other licensing questions

45. Can the 90-day operating capital requirement be waived temporarily during the state of emergency?

The requirement for 90 days of operating capital exists to assist providers during emergency periods such as this. The Office of Licensing will not be actively citing providers for failure to maintain 90 days of operating expenses during this period.

46. Can the licensure process be expedited to allow for use of additional, available space?

Yes, please see these FAQs to learn more.

47. Must providers adhere to normal discharge and admission processes during the state of emergency including signed notifications by guardians?

Providers are always expected to provide notice to an individual's authorized representative regarding discharge, and make all attempts possible to include the authorized representative in discharge planning. During this period, if a provider is unable to get signed verification from an authorized representative, they should attempt to receive confirmation over the phone or via e-mail. If a provider is not able to receive confirmation prior to moving, they shall document all attempts to receive confirmation within the individual's record.

The requirements regarding discharge and assessments are in place to protect the health and safety of individuals served and will not be waived during the emergency period.

For providers of residential services for individuals with developmental disabilities, the individual's case manager may look over their current assessment and ISP and confirm in writing to the new provider that all information is still accurate.

48. Can an individual be temporarily transferred between licensed services during the state of emergency when a provider has multiple licensed services?

Individuals should never be placed into a service for which admission is not appropriate based on the individual's needs. If a provider is no longer able to provide the appropriate level of services to an individual due to COVID-19, they should consider the following options:

1. If, due to the COVID-19 emergency, a provider is unable to provide all required aspects of a service, including service hours, they may consult with their Licensing Specialist about a temporary service modification to continue to serve individuals with the resources at hand during the emergency (all service modifications must be approved by the specialist prior to implementation);
2. Temporarily suspend services to the individual; or
3. The individual should be formally discharged and admitted to another provider who can provide this service.

If a provider needs to transfer an individual from one licensed service location to another licensed service location (same service, different location) they should fill out a transition summary pursuant to 12VAC35-105-691.

Expanding capacity

49. Can licensed residential providers serving individuals with confirmed or suspected cases of COVID-19 temporarily open an additional location and/or expand bed capacity during the state of emergency?

Yes, licensed residential providers serving individuals with confirmed or suspected cases of COVID-19 may temporarily open an additional location or expand bed capacity for a residential service that they are already licensed to provide during the COVID-19 emergency. To do so, providers must complete this service modification form and await approval from their Licensing Specialist.

Please note, the support coordinator/case manager should complete a Regional Support Team (RST) referral as well as a Virginia Informed Choice form if the individual is moved to another location.

50. Can inpatient psychiatric hospitals get approval to temporarily flex beds currently used for licensed for children to provide services to adults or vice versa?

Yes, during the COVID-19 state of emergency, licensed inpatient psychiatric providers may temporarily flex currently licensed beds between adult and children populations if there is an identified COVID-19 related need to do so. More information around the requirements and process for requesting approval for this temporary bed flexing is available here.

Source:
http://dbhds.virginia.gov/assets/doc/EI/dbhds-flexing-beds-during-covid-19-4-17-20.docx

Nurse Practitioners on PACT Teams

51. If a PACT provider is unable to employ a psychiatrist due to the COVID-19 emergency, may we employ a nurse practitioner instead?

Please note: Per the Office of Licensing's March 2, 2021 and April 5, 2021 memos, the PACT team license will be phased out as of July 1, 2021 and will be replaced with ACT. All PACT providers should submit their abbreviated service modification forms to transition to the ACT license by May 15, 2021. The new emergency regulations for ACT require one physician who is board certified in psychiatry or who is board eligible in psychiatry and is licensed to practice medicine in Virginia, or a psychiatric nurse practitioner practicing within the scope of practice as defined in 18VAC90-30-120.

Pursuant to 12VAC35-105-1370.1.f, a Program of Assertive Community Treatment (PACT) team must include a psychiatrist who is board certified in psychiatry or who is board eligible in psychiatry and is licensed to practice medicine in Virginia. For each individual served, 20 minutes of psychiatric time for each individual served must be maintained. Additionally, the psychiatrist shall be a fully integrated team member who attends team meetings and actively participates in developing and implementing each individual ISP.

PACT teams frequently have difficulty satisfying the requirements of 12VAC35-105-1370.1.f due to a shortage of qualified individuals. The ongoing COVID-19 public health crisis has exacerbated this and other preexisting personnel challenges. In recognition of these challenges, and in recognition of the critical need to continue providing PACT services to individuals in the community during the public health crisis, DBHDS will liberally exercise its authority during the crisis, pursuant to 12VAC35-105-120, to grant temporary variances to providers of PACT services, which shall last throughout the COVID-19 public health emergency period and for up to 30 days after the emergency period ends, under the following circumstances:

1. The provider is unable, in whole or in part because of the COVID-19 public health emergency, to employ a psychiatrist as defined in 12VAC35-105-1370.1.f; and
2. The provider is able to employ a psychiatric nurse/mental health practitioner, licensed by the Board of Nursing and operating within the scope practice as defined by 18VAC90-30-120, who shall otherwise meet the requirements of 12VAC35-105-1370.1.f; and

3. The provider submits a completed provider variance request form explaining why the variance is being requested. For your convenience, the department has already included language within the form related to the need for a temporary variance based on the COVID-19 emergency. The department must approve a variance prior to implementation.

Source:
http://dbhds.virginia.gov/assets/doc/EI/4.13-pact-covid-19-variance-request-form.docx

52. What should we do if an individual requests treatment only from fully vaccinated staff?

DBHDS has received inquiries from providers about how to respond to individuals or their authorized representatives (AR) who request that treatment only be provided by staff members who are fully vaccinated against COVID-19. Because DBHDS cannot provide legal advice, we encourage providers to check with their own legal counsel for guidance in this regard but are providing the following general information.

Vaccination status is considered protected health information, and it is up to each individual provider to determine how to manage use or disclosure of the personal information that it may hold about staff in its role as employer. While DBHDS encourages vaccination, the DBHDS regulations governing licensed providers do not require staff members to be vaccinated against COVID-19. Thus, requiring COVID-19 vaccination of staff members is at the discretion of each licensed provider in consultation with its own legal counsel. The Virginia Department of Health issued vaccination FAQs for employers in March, which can be found at: https://www.vdh.virginia.gov/covid-19-faq/vaccination/. The FAQs include a link to recent guidance issued by the Equal Employment Opportunity Commission. These resources may be helpful to you.

Individuals do not have an explicit right to treatment only by staff members who are fully vaccinated against COVID-19 under DBHDS regulations. However, individuals do have a right to make their treatment preferences known to providers, and providers are required to honor those preferences to the extent possible. If a provider cannot honor such a request and the individual/AR decides that they would like to seek services somewhere else, the DBHDS licensed provider is responsible for providing integrated discharge planning and transition assistance in accordance with the requirements of 12 VAC 35-105-693, 12 VAC 35-115-60, and 12 VAC 35-115-70.